COMMISSIONERS' LETTER

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, as called for by the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for improving veterans' health care. We are confident these recommendations will ensure that our nations' veterans receive the care they need and deserve, both now and in the future.

We have worked with a firm commitment to putting the veterans themselves 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 life of the Commission on Care, we have evaluated the 4000-page *Independent Assessment Report*; listened to a broad range of experts and stakeholder, including veterans and veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; exchanged ideas with individual veterans, providers, members of Congress, and others.

The Commissioners agree, in general, with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. From this evidence, it is clear that care delivered by VA is in many ways of superior in clinical quality to that generally available in the private sector. The Commissioners agree, however, that America's veterans deserve better, and that many profound deficiencies in VHA operations require urgent reform.

These deficiencies include problems with access. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary Choice Program. The Commission finds, however, that the design and execution of the Choice Program are deeply flawed. In its place, we offer specific recommendation 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, and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires profound changes in governance and leadership of VHA to guide the institution during the next 2 decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care delivery 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 applaud this important work.

Implementing the recommendations in this report will enhance and support VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Key among these changes is forming a governance board to set long-term strategy and oversee the building of 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, 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 they deserve.

Respectfully Submitted,

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EXECUTIVE SUMMARY

Section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) established the Commission on Care (the Commission) and charged it "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 resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of [VACAA]."[1] As a component of this charge, the Commission also evaluated and assessed the results of an independent, private-sector assessment mandated in Section 201 of VACAA.[2]

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.[3] 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. Using this study as a starting point, the Commission has worked to develop a set of comprehensive, high-level recommendations to frame reforming veterans' health care in the course of the next 2 decades. 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.*
- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

[1] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 202, 128 Stat. 1754.
[2] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201, 128 Stat. 1754.
[3] Veterans Access, Choice, and Accountability Act of 2014, Act, Pub. L. No. 113–146, § 201(a)(1).

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 report begins with an *Introduction* that addresses the controversy over veterans' health care, the Commission's vision for improving it, and a brief description of the transformation process. There are four main recommendation sections: transforming the Veterans; Health Care System, Governance, Leadership, and Workforce; Contracting and Supply Chain; 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. These format for each discussion includes identification of the problem, the Commissions 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, all additional content is provided in the appendicies. Of particular interest are appendcies on *Financing the Vision and Model*, *Leadership Implementation, Proposed Pilot Projects for Evaluating VA Buy-In Program, History as a Context for Systemic Transformation, Veteran Feeback*, and resources for *Additional Reading*. These and other appendices are intended to provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context in which the recommendations are framed.

These recommendations are not meant 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.

The recommendations are presented with several key points in mind. They include recognition that VHA provides health care that is in many ways of superior clinical quality to that offered in the private sector. The Commission also recognizes, however, that the quality of that care is inconsistent from facility to facility, and that access to timely VHA care remains a monumental challenge in many parts of the country.

In part, these challenges reflect large-scale problems in the U.S. health system, such an acute shortage of primary care doctors and lack of health care capacity in poor and rural areas. But

these challenges also reflect deficiencies within VHA itself, in areas such as scheduling processes, information technology, staffing, facilities, leadership, and governance.

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 reform can be implemented in a manner that is sustainable. Both of these issues are addressed in this report.

Recommendations

Transforming the Veterans' Health Care Delivery System

Problem

The quality of VA health care is generally comparable to that of the private sector and by some measures superior, but it is inconsistent from facility to facility and serves some populations better than other. At the same time, timely access to VA care remains a challenge in many parts of the country. Going forward, changes in the size, health status, and demographic composition of the veteran population, along with large-scale changes in the U.S. health care system as a whole, will make modernization of the VHA's delivery model an imperative.

Solutions

- Develop integrated delivery networks in partnership with community providers to expand veterans' access to high-quality health care.
- Establish an environment of cultural competence, with cultural sensitivity to patient diversity as well as identify and address health inequities to assure that each and every enrolled veteran receives comprehensive quality care, and to assure that health disparities are eliminated.
- Enhance clinical operations and more effectively deliver care by making adjustments to organiztion, staffing, and technology use.
- Consolidate best practices and continuous improvement efforts under one office within VHA to facilitate ease-of-use and widespread adoption of appropriate approaches to transformation and sustainable change.
- Create the vital framework for meeting and managing VHA's capital-asset needs.
- Modernize VA's IT infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Governance, Leadership, and Workforce

Problem

VA leadership is often buffeted by political interference while also suffering from rapid turnover and poor ability to pursue long-term strategies.

Solutions

- Establish a fiduciary-like board of directors (not subject the Federal Advisory Committee Act) to provide VHA overall governance, set long term strategy, and direct and oversee the transformation process.
- Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.
- Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applies to recruitment, development, and advancement within the leadership pipeline.
- Transform organizational structures and management processes to promote decision-making at the lowest level of the organization, eliminate waste and redundancy, promote innovation, and foster the spread of best practices.
- Streamline and focus performance measurement in VHA using core metrics that are identical to those used in the private sector and establish a 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.
- Foster cultural competence among VHA leadership and all personnel to promote cultural sensitivity to patient diversity and improve health outcomes.
- Create a simple-to-administer alternative personnel system, in law and regulation that governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Contracting and Supply Chain

Problem

Brief description of the overarching problem for this section.

Solutions

- Transform the management of the supply chain in VHA.
- Transform contracting support and culture to create a more flexible and responsive approach to business functions across VHA.

Eligibility

Problem

Brief description of the overarching problem for this section.

Solutions

- Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.
- Develop pilot programs to test the feasibility of enabling veterans' spouses and higher-income veterans to obtain VA care through their health plans.
- Establish an expert body to develop recommendations for VA care eligibility and benefit design.

INTRODUCTION

The Controversy Over Veterans Care

Much of the public controversy over veterans' health care has focused on access issues, specifically wait times for obtaining appointments and the delays in receiving treatment. In 2011, VHA adopted the goal of providing new enrollees with initial primary care visits within 14 days of their desired date. VHA did not, however, provide any additional resources to meet this goal. Subsequent investigations by the VA's inspector general uncovered widespread and long-standing *gaming* of wait time statistics by front line personnel and field managers.

Evaluating how wait times in VHA compare to those in the private sector is complicated by methodological and data limitations. The independent assessment included evidence, however, that given certain reasonable assumptions, "wait times at the VA for new patient primary and specialty care are shorter than wait times reported in focused studies of the private sector."[4] Moreover, no conclusive evidence has emerged of veterans dying because of excessive wait times.

The Commission's review of the evidence clearly shows veterans' efforts to receive care at VHA facilities are too often an unnecessarily complicated ordeal compounded by unwarranted delays.[5] The problem is particularly severe in rural areas, in VHA facilities near major military installations, and in certain locations, such as Phoenix, that see large, seasonal migrations of retired veterans.

This report devotes considerable attention to the issue of veterans' access to care at VA facilities. Yet it would fall well short of fulfilling the Commission's mandate if it failed to provide a broader and more comprehensive review of veterans' health care, to include addressing the quality and comprehensiveness of that care and the degree of choice over how care is provided and by whom it is provided.

To be sure, the quality of care provided to veterans by VA and its affiliates is on average as good as or better than care provided elsewhere for the same or similar medical conditions.[6] Indeed, VA has been repeatedly cited by health care quality experts as the model for how care should be provided, especially in complex care cases, including the daunting challenge of

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[4] Rand Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* 195, accessed May 30, 2016. http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

[5] Rand Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* 196-200, accessed March 31, 2016, 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 B (Health Care Capabilities),* 191, accessed March 31, 2016,

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

effectively treating mental illness.[7] There remains too much variability, however, in the quality of care veterans receive.[8] Make no mistake, unacceptable variability in the quality and timeliness of health care provided is a serious, systemic problem that undermines the confidence veterans have in VHA.[9]

A Vision for Veterans Health Care

To guide efforts to transform health care for enrolled veterans, the Commission prepared a vision statement: "*Transforming veterans' health care to enhance quality, access, choice, and well-being.*" The Commission believes the transformational mission of the VHA should be to *provide eligible veterans prompt access to quality health care*. Additionally, the Commission believes the following values should serve as a basis for reconfiguration of veterans' health care:

- 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.

Transforming Veterans Health Care

Ensuring that veterans receive comprehensive, quality health care will require evolution in VA's health care delivery system model. In many parts of the country, the population of veterans is projected to shrink rapidly in coming years due to out-migration and the general decline in the number of Americans with military experience since the end of the Vietnam-war era. These changes mean many VA hospitals in the future may lack the volume of patients needed to maintain safe and efficient operations. At the same, veterans will be ill served if VHA fails to develop sufficient capacity in high-demand areas, or if veterans are left with poorly coordinated fragmented care from non-VA providers.

During the next 2 decades, the Commission envisions VHA creating local, networked systems of care that integrate traditional VHA care with the health care resources available in each community. These community networks will offer a full spectrum of care, treating veterans' physical, mental, and emotional conditions by making optimial use of each community's unique health care assets.

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[7]Oliver Adam, "The Veteran's Health Administration: An American Success Story?," *The Milbank Quarterly*, 85, no. 1, (2007): 5-35, http://doi.org/10.1111/j.1468-0009.2007.00475.x.

[8] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, B-2, accessed February 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

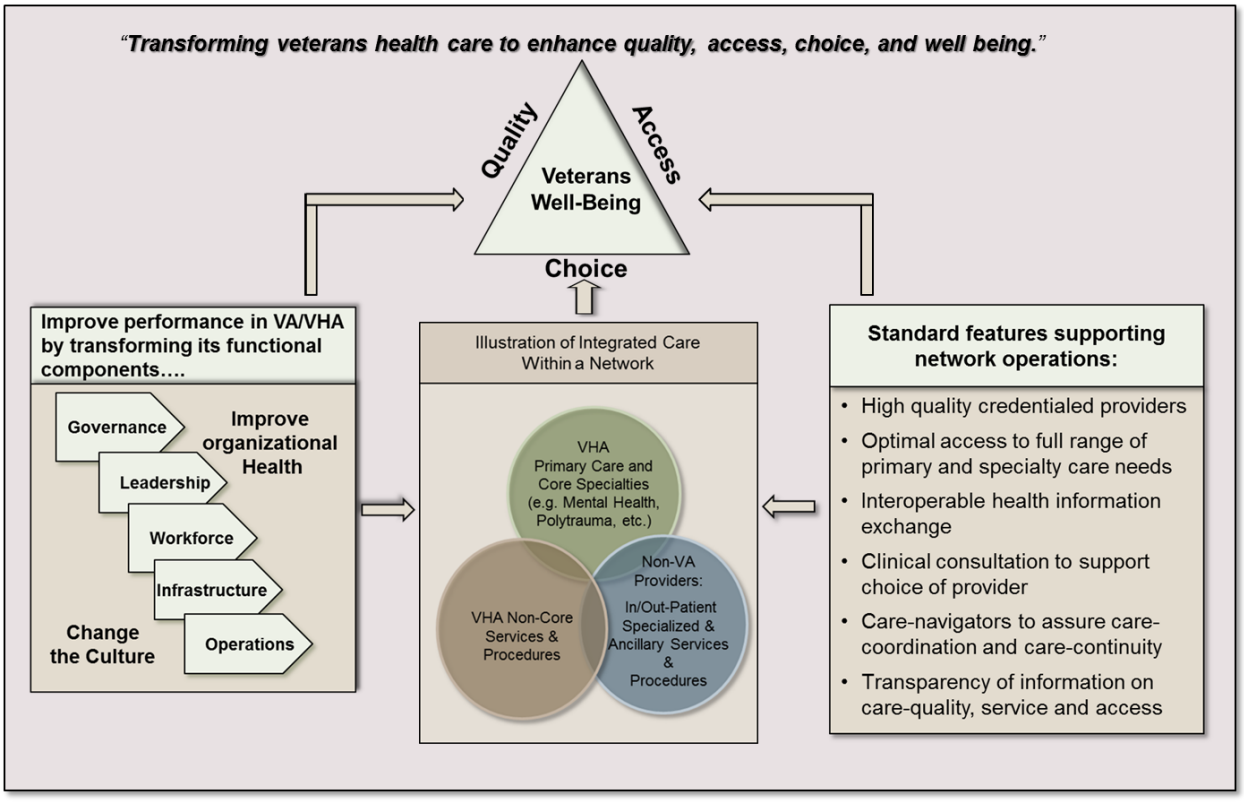
[9] "Majority of U.S. Veterans Say Access to VA Care Difficult," Jeffrey M. Jones, accessed March 31, 2016, http://www.gallup.com/poll/172055/majority-veterans-say-access-care-difficult.aspx.

In some way, this is a change in degree rather than in kind. VHA has long purchased specific types of specialty care, for example, in areas where its lacks capacity. Moreover, under the Choice Program established by Veterans Access, Choice, and Accountability Act of 2014, it has made much more extensive use of purchased care. To date, these efforts have been poorly designed and implemented, have not resulted in neither meaningful improvement in access nor greater integration and coordination of care.

The Commission believes that veterans deserve much better. Like all Americans, veterans need help in navigating among different specialists and services. Like all Americans, veterans need doctors and other providers who coordinate with each other to optimize care and avoid deadly medical errors, redundant tests, and unnecessary treatments. Like all Americans, veterans also need care that emphasizes prevention and wellness, and that is focused on the whole patient, rather than on one ailing body part at a time. Finally, veterans need a health care system that is sensitive to, and competent in, treating the unique and diverse health care needs of those who have served in the military, including growing ranks women and minority veterans.

The figure below illustrates a conceptual framework for this transformation.

Figure XX. One Option



To reach these goals, VHA must embark on two major endeavors. First, VHA itself must undergo an institutional transformation that provides the capacity to build out and sustain extensive, local, integrated-care provider networks. Second, VHA must put in place the infrastructure necessary to support these networks.

VHA has already done important work toward developing the framework for establishing integrated care networks. In its 2014 report, *Blueprint for Excellence,* VHA identified a strategy that involves innovative academic, intergovernmental, and community relationships; information exchange; and public–private partnerships.[10] With Congressional adoption of needed legislative authority, these efforts can continue moving forward; however, their successful implementation will also require broader changes in the governance and leadership of VHA.

An extensive body of research confirms that successful organizational transformations primarily depend on changes in culture driven by strong and sustained leadership.[11] A healthy organization internally aligns and successfully executes change in the context of shared objectives across the enterprise, a the same time adapting continuously to the forces that shape its environment. Healthy organizations also foster a culture of shared values that encourage and reward prudent, responsible risk-taking and innovation. No matter how well-conceived the strategy, how competent the employees, or how efficient the business processes, if culture is compromised, the organization's mission suffers.[12]

Moreover, transformational change requires a systems approach in which individual reforms become mutually reinforcing. The chart in Appendix XX illustrates how the recommendations, which address many cross-cutting issues, create an integrated systems approach that is veteran-centric.

[10] Department of Veterans Affairs, *Blueprint for Excellence,* 33-37, accessed February 23, 2016, http://vaww.ush.va.gov/docs/VHA-Blueprint-for-Excellence-09302014_FINAL.pdf.
[11] Scott Keller and Colin Price, *Beyond Performance: How Great Organizations Build Ultimate Competitive Advantage*, (Hoboken: John Wiley & Sons, Inc., 2011), 36-39.
[12] Sergio Fernandez and Hal G. Rainey, "Managing Successful Organizational Change in the Public Sector," *Public Administration Review*, 66, no. 2, (2006): 168-176, http://doi.org/10.1111/j.1540-6210.2006.00570.x.

REDESIGNING THE VETERANS' HEALTH CARE DELIVERY SYSTEM

Problem

Veterans Health Administration (VHA) operates the largest integrated health care system in the country. Its facilities include more than 150 medical centers offering inpatient care, as well an extensive network of community-based outpatient clinics, Vet Centers with social and psychological readjustment outreach programs, and Community Living Centers across the country providing nursing-home care for Veterans

While the quality of VHA care is generally comparable to that of the private sector, and by some measures superior to its integration and coordination, VHA care is nonetheless uneven across the system and has other deficiencies that threatened to much more daunting over the next two decades.

These challenges start with problems of misaligned capacity. Some VHA facilities and services have dangerously low volumes care. Meanwhile, in high demand areas, the VHA often lacks the capacity to avoid lengthening wait times and other access issues. Overall wait time may be comparable to those found in private sector, but wait times are still unacceptable long in many areas.[13]

For example, the number of veterans waiting for more than 30 days to obtain VHA care has grown by about 15,000 veterans from May 15, 2015 to May 16, 2016.[14] Perhaps most disturbing is the growth in the number of veterans waiting more than 120 days for care, which has more than doubled from 8,800 to about 19,900 during that time frame. Between May 1, 2015 and May 1, 2016 VHA showed 70,000 more veterans with completed appointments who waited more than 30 days.[15] A National Public Radio report indicated VHA clinics have stopped accepting new patients and resorted to referring new patients' care elsewhere.[16] VHA is not turning these veterans away, but refers them to other, more distant, VHA care sites or to private sector providers.

Insufficient capacity in mental health services is another ongoing challenge that contributes to the wait-time issue. Despite continuing to increase staffing, demand for mental health care is growing exponentially. [17] Mental health providers' productivity is higher for VHA providers

[13] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans, Assessment B (Health Care Capabilities),* xiv, accessed January 12, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[14] Veterans Health Administration. Electronic Wait List Summary. https://securereports2.vssc.med.va.gov, accessed May 17, 2016.
[15] Veterans Health Administration. Electronic Wait List Summary. https://securereports2.vssc.med.va.gov accessed 5/17/16.
[16] Citation needed.
[17] Citation needed.

than for those in other systems, yet the need is still outpacing VHA's ability to meet it. Overall about 400 veterans are waiting more than 30 days for mental health services. Some of these individuals may be waiting for more intensive therapies while receiving standard care.

The absolute numbers and percentage of veterans enrolling for care with the VHA is swelling due to many factors. In addition to the wave of veterans returning from the conflicts in Iraq and Afghanistan, these include rising cost of health care outside the VHA, rising numbers of veterans seeking mental health services, and an increase in the numbers of veterans suffering the consequences of traumatic, service-related injuries that would have been fatal in previous conflicts.

The high numbers of veterans enrolling with the VHA also reflects in part the comparatively high rates of patent satisfaction that the system continues to achieve despite its many challenges. To the extent that the VHA succeeds in reducing overall wait times and otherwise improving patient experience, it also induces more veterans of enroll with the system.

Going forward, changing demographics make the problem of matching VHA capacity with demand even more daunting. Currently dominated by aging veterans from the Vietnam War-era, the total veterans population is projected to grow smaller in the future due the decline in the numbers of Americans with military service. Yet most long-range projections show VHA patient population holding even or growing as a higher percentage veterans come to rely on the VHA health services.[18]

Adding to these changes in demographics is a large, on-going migration of older veterans, typically from areas such as the "Rust Belt" and the upper-Midwest to retirement centers in the "Sun Belt." This migration leaves the VHA with excess capacity in some regions, and shortages of capacity in others. The population served by the VHA is also becoming far more racially and ethnically diverse, and includes rapidly rising number of women veterans.

Other challenges going forward include problems that affect the U.S. health care system as a whole. These include severe shortages in primary care and mental health professionals in many parts of the country, as well as mounting shortages of nurses and capacity for long-term care.

Analysis

To address these challenges, VHA must make transformative changes to its delivery system model. As described in greater detail in the next section, the commission believes these changes must include the creation of community-based integrated delivery networks (IDNs) designed to increase access and quality care, while also providing veterans with greater choice of provider.

As these networks are constructed, an important factor in their design and implementation will be ensuring that providers within them possess cultural competence to meet the distinct needs of veterans, including women and members of minority populations. To that end, the Commission believes establish health equity as a VHA priority is imperative.

[18] Assessment A

The VHA will also need to address clinical workflow issues, by instilling a culture of continuous improvement and patient safety, developing the tools, data and staff to drive change, and improving productivity and value. Finally, as VHA builds out its integrated health care networks, it will need to consider what facilities existing facilities may need closed, modernized, or reconfigured.

Integrated Delivery Networks

Develop integrated delivery networks in partnership with community providers to expand veterans' access to high-quality health care.

Problem

Due to changing demographics, increasing demand for Veterans Health administration (VHA) care, and other factors, VHA faces a misalignment of capacity that threatens to grow worse. Some facilities and services have dangerously low volume of care. Meanwhile, 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 *Choice Program*. It was designed to alleviate access issues by allowing for greater use of purchased 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 deeply flawed. VHA must instead create high-performing integrated delivery networks (IDNs) in partnership with local-community health care providers. Implementing such networks, however, requires extensive changes to VHA's conflicting purchased-care authorities, and well as fundamental changes in governance structure and leadership.

The Commission Recommends . . .

- That Congress consolidate VHA's current purchased-care authorities into a single provision supporting the establishment of a new integrated delivery networks (IDNs).
- That VHA offer access to its IDNs to veterans regardless of waiting time or distance from VHA facilities. VHA should allow clinicians and veterans to decide together if purchased care is in respective patients' best interest.
- That VHA make performance data consistent and comparable with private-sector providers.
- That VHA should 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.
- That VHA employ the most current payment approaches that incentivize quality and appropriate utilization of health care services.
- That VHA, in establishing integrated care networks, carry out the process on a phased basis that gives initial priority to areas where VHA's quality measures reflect that overall quality of care at the area medical center is substandard.

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.[19] In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under a Patient-Centered Community Care (PC3) Program.[20] In all cases, purchased care was a secondary means of providing care, to be used "when VA health care

[19] 38 U.S.C. § 1703(a).

[20] 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.

facilities are not feasibly available."[21] Even before the creation of the Choice Program in 2014, some 10 percent of VHA medical spending went for purchased services.

By creating the Choice Program, Congress tasked the 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.[22]

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 a) generally live more than 40 miles away from the nearest VHA facility offering needed care, and/or b) face a wait time for VHA care in excess of 30 days.[23]

This standard is difficult to reconcile with other statutory priorities for VA care.[24] 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. [25] Similarly, the standard ignores any clinical criteria in determining which veterans are treated where: What is best for the health of the patient literally does not figure into the determination of where care should take place.

Implementing the Choice Program has posed severe challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers[26] 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.[27]

Adding to the confusion is the fact the 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

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[21] Department of Veterans Affairs, Veterans Health Administration, January 2013. VHA Directive 1601, *Non-VA Medical Care Program*.

[22] Section 101, Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146 (2014)

[23] Sec. 101, Pub. L. No. 113-146, as amended by sec. 3, Pub. L. No. 114-19. 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 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[23]." Sec. 101, Pub. L. No. 113-146, as amended by sec. 3, Pub. L. No. 114-19. 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 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[23]."

[24] See 38 U.S. Code sec. 1705.

[25] Id.

[26] See, Independent Assessment, supra, 43; Letter from Pete Henry, etc.

[27] 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.

aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.[28]

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.[29] 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."[30] As further articulated by Dr. David Shulkin, USH:

> *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.*[31]

Analysis

Meerly clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, does not go far enough. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with new IDNs that are available to all enrolled veterans.

Importantly, the new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or scope than is available in the private sector, either locally or nationally (discussed in more detail in Section Name X or Appendix X, page X).[32] 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.[33] These and similar programs and services are core competencies and special capabilities that serve the needs of combat

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[28] National Public Radio. "Attempted Fix for VA Health Delays Creates New Bureaucracy". Aired 5/16/16. http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy accessed 5/16/16.

[29] Department of Veterans Affairs, Plan to Consolidate Programs, supra.

[30] 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.

[31] David J. Shulkin, M.D, *Beyond the VA Crisis — Becoming a High-Performance Network,* N Engl J Med 2016; 374:1003-1005, March 17, 2016

[32] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A.*

[33] 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.

veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.[34]

The IDNs will be formed according to national policies and guidelines to assure consistent quality and services; however, in each community, the makeup of the IDNs will necessarily reflect local circumstances, including VA's and community providers's capabilities. The range of services VHA itself offers directly will likely vary accordingly from network to network. Community providers will comprise Department of Defense facilities, federally qualified health centers, private-sector providers (both for-profit and nonprofit), and community mental health providers, as optimally configured based on local capacity.

Care-quality must also be a core element of network designand consistently monitored with metrics that are routiniely 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 share a common health IT platform and work together to maximize each patient's 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 particularly 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.[35] 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.[36]

Scope of Provider Networks

In setting up integrated care networks, 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). Money the VHA

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[34] David J. Shulkin, MD, *Why VA Health Care Is Different*, Fed Pract., vol. 33, no. 5 (May 20160, 9-11., http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdbe726bddcbceea81f27.html

[35] Kenneth Kizer, M.D., MPH, *Veterans and the Affordable Care Act*, JAMA, vol. 307, no. 8 (Feb. 22/29, 2012), 789-790. http://jama.jamanetwork.com/article.aspx?articleid=1356002

[36] http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm . Kenneth Kizer, MD MPH, Feb 2012. Veterans and the Affordable Care Act. JAMA 307(8): 789-790. Brigham R. Frandsen, PhD; Karen E. Joynt, MD, MPH; James B. Rebitzer, PhD; and Ashish K. Jha, MD, MPH - See more at: http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients#sthash.DFdEg2ox.dpuf. Am J Manag Care. 2015;21(5):355-362. Chuan-Fen Liu, Michael Chapko, Chris L Bryson, James F Burgess, Jr, John C Fortney, Mark Perkins, Nancy D Sharp, and Matthew L Maciejewski. Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics Health Serv Res. 2010 Oct; 45(5 Pt 1): 1268–1286.

spends on expanding choice is not available to spend on other programs and services vital to its mission. [37]

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 also maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.[38] 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.[39]

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 VA will play a role in steering patients to different providers within the network. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans often require all specialty care to be preapproved through a referral from a primary care physician. This practice helps to control overutilization, and can help patients with essential navigation through the complex health care system. At the same time, however, primary care is a scarce resource and is not necessarily best deployed as a gatekeeper controlling patients' direct access to specialist so they can obtain equipment such as a hearing aid or glasses.

Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. In 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 while a patient is in the hospital to ensure the care and tests ordered and the length of stay in the hospital are appropriate.[40]

These and other design features of a health care plan will dramatically affect its cost. This fluctuation is illustrated by the cost estimates below of illustrative policy options (more fully discussed Appendix X).

- Option 1: VA would establish an integrated care network with community-delivered services focused on tertiary and quaternary care, but not primary care, special emphasis care, and some types of specialty care. Veterans would have greater choice of specialty providers than currently, but would be required to obtain a referral from a VHA

[37] *Integrated Report*, supra, p. 23.
[38] http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you
[39] http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you. Paul B. Ginsburg, Health Care Provider Market Power, Congressional Testimony Sept. 9, 2011 http://www.hschange.com/CONTENT/1235/?words=provider network
[40] Paul B. Ginsburg, *Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers,* Health Affairs, Vol. 32, No. 5 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.

primary care provider. Projected costs for 2019 range from $66 billion to $79 billion,[41] with the middle estimate of $73 billion close to a baseline projection of $71 billion.

- Option 2: Similar to Option 1, VA would establish an integrated care network in which community-delivered services would be focused on tertiary and quaternary care, and veterans would have to consult their VHA primary care physician before seeking community care. But unlike that first option, a referral would not be required. Projected costs for 2019 range from $97 to $154 billion, with a mid-range estimate of $122 billion.[42]

- Option 3: Under Option 3, VA would establish an integrated care network in which community-delivered services would include primary and standard specialty care, but would not include special emphasis care. It would be the most generous in requiring no consultation or referral and give veterans access to a robust network of VA and community providers. Projected costs for 2019 range from $167 billion to $250 billion, with a mid-range estimate of $206 billion.[43]

These models reflect the reality that as the VHA improves the attractiveness of its plan, by offering more choice of providers (and by extension, reduced waiting times), more eligible veterans are likely to enroll with VHA. The models similarly reflect the reality that with expanded choice of provider, current enrollees will likely use private insurance less and VHA-funded care more. Currently, veterans collectively rely on the VHA for only about 34 percent of their ambulatory care needs. As VHA benefit plans offer more choice of provider, a large volume of care currently funded through private health insurance may instead be funded by taxpayers. Though Congress has increased VA health care funding substantially over the last decade, it is not clear that it will continue to do so indefinitely. [44]

Mitigating Risks

Choice involves tradeoffs. Shortening drive times to see a doctor may ultimately lead to longer wait times, for example, if it induces significantly more veterans to seek more care. [45] 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 monopolized 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

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[41] As discussed more fully in the Finance section, it is assumed that 50 percent of care would shift from VA facilities to community care, with potentially wide differences in the degree to which the model would induce increases in veterans' relative use of VA care rather than available alternatives (that is differing degrees of "reliance" on VA care).
[42] This estimate assumes enrollment increasing from a low of 5 to a high of 20 percent; a 20 percent increase in use of healthcare; and increases in reliance on VA care in a range of 60 percent to 100 percent.
[43] As with options one and two, this option assumes no change in cost-sharing policy; the analysis asuymes that 70 percent of eligible care shifts from VA facility-delivered care to community-delivered care; that enrollment rates increase markedly from 80 percent of eligible veterans to 100 percent; and that the extent of reliance on VA-covered care increases markedly from the current average of 34 percent to an average in the range of 80 to 100 percent reliance.
[44] David Auerbach, et al., *Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs,* RAND (2013), p. 3 http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf
[45] 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.

monopolistic prices.[46] 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 that "choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans."[47] These organizations do not support providing unfettered choice, and the 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 in less 'choice' rather than the intended desire for more health care options for many disabled veterans."[48]

These concerns can be mitigated in part by measures discussed elsewhere in this report that will produce offsetting savings. Cost-increases could be mitigated through reducing fixed costs of underutilized facilities and services, improving supply chain management, increasing provider productivity through improved facilities, using information technology to improve quality and efficiency, and improving recovery of third-party payments owed to VHA. Increasing cost-sharing[49] or changing eligibility and/or benefit design could also substantially contain the projected costs of expanding provider choice.

The Commission urges VHA to view maximized choice an aspirational goal and to approach network development in phases. Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of the VHA, as well as flexible and smart procurement policies and contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be areas where VHA quality of care is deficient or capacity is strained.[50]

Where capacity constraints exist within networks, first priority should go to those with greatest medical need, followed by service-connected disabled veterans and indigent veterans.[51] The Commission envisions VHA will develop processes and procedures for insuring that veterans have the knowledge and help they need to make informed health care decision and to navigate effectively through the expanding health care networks. It also envisions that, following principles proven by other managed care plans, VHA will finds administrative means of guarding against inappropriate treatment and wasteful spending.

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[46] David M. Cutler, et al, *Hospitals, Market Share, and Consolidation*, *JAMA*. 2013;310(18):1964-1970. doi:10.1001/jama.2013.281675

[47] The American Legion, Disabled American Veterans, Iraq and Afghanistan Veterans of America, Military Officers Association of America, Paralyzed Veterans of America, Veterans of Foreign Wars, and Vietnam Veterans of America.
[48] Gary Augustine, et al., letter to Nancy Schlichting, April 29, 2016.
[49] Applicable only to those who are not service-connected and not financially needy
[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.

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.

VHA 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 utilization decisions, demonstrating military cultural competency, and coordinating care.

- Establish systems to ensure that primary care providers in the network 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 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 when quality care is available locally.

- Employ the most current payment approaches that incentivize quality and appropriate utilization of health care services.

Clinical Operations

Enhance clinical operations by insuring that VHA clinicians are able to practice at the top of their license and have adequate support staff.

Problem

The Commission Recommends . . .

- Tk, tk
- Tk, tk

To maximize health care talent, VHA must enable all clinical staff to perform at the top of their licenses. Twenty-three percent of VHA providers identified "not working to top of provider licensure" as a barrier in health care provision.[52] Ninty-four percent of VA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.[53] Scopes of practice for the same professionals may vary considerably among states. Some of these differences, particularly for midlevel practitioners such as advanced practice nurses (APRN), center upon autonomy, with particular concern regarding those who may prescribe medications and other interventions.

{The commission applauds these measures….]. However, to realize their full potential they be combined with measures to ensure clinians have adequate support staff. Higher paid staff members 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 less expensive staff.

Background

VHA has recently taken mesasure that will allow full practice authority for nurse practitioners and has already exercised its authority as a federal health provider to allow all nurse practitioners to prescribe noncontrolled substances; {The commission applauds these measures….].

VHA has also recently made its medical support assistants (MSAs) "hybrids" which gives them flexibility in establishing market based pay rates. VHA will also be rolling out implementation of 30-day hiring protocols throughout the enterprise by December 2016.[54]

Analysis

The Commission applauds these changes, but makes the recomendends that the additional measures be taken….

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[52] 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), p. 95

[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), p. 95.

[54] Department of Veterans Affairs. Deputy Secretary of Veterans Affairs. Building on Excellence: Presentation to the Commission on Care, April 18, 2016. P. 31-32.

Legislative Changes

* Tk….

VA Administrative Changes

* Tk

Other Department and Agency Administrative Changes

* Tk

Enhance the safety, quality, and productivity of VHA clinical operations by taking measures to ensure data integrity.

Problem

Tk, tk…

The Commission Recommends . . .

- Tk,TK
- Tk,TK

Background

The Millennium Bill[55] and other requirements have resulted in VA developing guidance that has essentially frozen beds at FY 1998 levels.56 VA is required to complete a complicated reporting, approval, and notification process to identify bed closures. According to the directive, beds are categorized as authorized, operating, or unavailable for 60 days or more. To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates.

Analysis

Tk, tk….

Legislative Changes

- 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

* Tk…

Other Department and Agency Administrative Changes

* Tk…

[55] The Veterans Millennium Health Care and Benefits Act, P.L. 106-117, Sec. 301
[56] Title 38 USC Section 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

Enhance efficiency of clinical operations by deploying Clinical Managers.

Problem

The Commission Recommends . . .
▪ Tk, tk... ▪ Tk, tk...

Clinic managers, widely used throughout the health care industry, play important roles in controlling the resources, including staff, assigned to a patient care activity and developing policies to successfully train and allocate staff. Yet they are underutilized in the VHA….

Background

Tk, tk…

Analysis

Tk, tk…

Legislative Changes

* Tk….

VA Administrative Changes

* Tk…

Other Department and Agency Administrative Changes

* Tk

Enhance efficiency of clinical operations by deploying Case Managers

Problem

Tk, tk…

The Commission Recommends . . .

- Tk, tk
- Tk, tk

Background

Case management is an important component of health care delivery that maximizes value. VA already makes extensive use of case managers. They are assigned to each of the long-term rehabilitation program centers including polytrauma centers, spinal cord injury centers, amputation centers, and blind rehabilitation. It is also customary for VA spokes to assign a team or point of contact--akin to a health care navigator—to coordinate the care of veterans closer to home. VA has also used case managers for veterans returning from recent deployments (Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn). There are presently about 400 case managers assigned to this patient population (often with collateral duties).57 Most of the case managers for the OIF/OEF/OND populations are social workers, rather than registered nurses, suggesting they may be more focused on psychosocial referrals and support than clinical care.

Analysis

Tk, tk…

Legislative Changes

* Tk….

VA Administrative Changes

* Tk…

Other Department and Agency Administrative Changes

* Tk

[57] VHA Information provided by ADUSH for Operations. April 7, 2016.

Enhance the equity of clinical operations by improving the clinical appeal process.

Problem

The Commission Recommends . . .
▪ TK

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections to allow them to obtain medically necessary care within their health benefits package.[58] This is imperative, particularly for care plans under capitated payments, where 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 due to the fact that there is not one policy in place for VHA, but 18 (one for each Veterans Integrated Service Network or VISN).[59]

Background

Tk, tk…

Analysis

Tk, tk…

Legislative Changes

* Tk….

VA Administrative Changes

* Tk…

Other Department and Agency Administrative Changes

* Tk

[58] Musumeci, MB. A Guide to the Medicaid Appeals Process. Kaiser Commission on Medicaid and the Uninsured. March 2012.
[59] VHA Directive 2006-057. VHA Clinical Appeals. October 16, 2006.

Enhance clinical operations through expanded use of Connected Health.

Problem

The Commission Recommends . . .

- TkTK
- TkTK

Connected health creates an environment where patients are treated in the best location, by the best person, using the most relevant and efficient methods.[60] The main objective is to increase access by bringing the full breadth of VA care to locations where these services do not exist (for example, rural outpatient clinics, veterans' homes).[61]

[Yet VHA efforts in this area are deficient in some way…describe here:]

Background

Telehealth has been a focus for VA for more than a decade, and VA is now recognized as a world leader in this area, with no other delivery system offering such an extensive range of telehealth services on such a large scale.[62] Telehealth has been shown to reduce utilization of outpatient visits, reduce inpatient admissions, and result in high patient satisfaction scores.[63] VA's Office of Connected Health (OCH), collaborates with partners throughout VA to leverage technology and innovation to transform the delivery of care for veterans, their families and caregivers with unified, integrated and personalized virtual services that connect them with a state-of-the-art system of care.[64] The OCH includes telehealth, patient portals (i.e., My Health*e*Vet), and mobility (mHealth) programs.

Analysis

Tk, tk.

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[60] University College Dublin, http://www.connectedhealthireland.com/what-is-connected-health/
[61] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans, Assessment B (Health Care Capabilities),* 129, accessed January 12, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[62] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans, Assessment B (Health Care Capabilities),* 129, accessed January 12, 2016, 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, Assessment B (Health Care Capabilities),* 264, accessed January 12, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[63] Neil Evans, Veterans Health Administration Office of Connected Care, briefing to Commission on Care, January 20, 2016.
RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans, Assessment B (Health Care Capabilities),* 132, accessed January 12, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[64] Department of Veterans Affairs, *Office of Informatics and Analytics Strategic Plan*, accessed February 5, 2016, http://vaww.ehealth.va.gov/EHEALTH/docs/OIA_Strategic_Plan_2013-2018.pdf.

Enhance capacity to meet the needs of the coming *age wave* of older veterans.

Problem

The Commission Recommends . . .

- Tk, tk
- Tk, tk

Seventy-five percent of Veterans were age 55 or older in 2014, compared with only 34 percent of the non-Veteran population. "By 2024, this will shift somewhat: mean age will increase slightly; the population will have a higher proportion of both older and younger Veterans."[65]

Wait times affect health care use and impact health for older veterans. "A study of wait times at VA facilities analyzed facility and individual-level data of veterans visiting geriatric outpatient clinics, finding that longer wait times for outpatient care led to small yet statistically significant decreases in health care use and were related to poorer health in elderly and vulnerable veteran populations (Prentice and Pizer, 2007). Mortality and other long-term and intermediate outcomes, including preventable hospitalizations and the maintenance of normal-range hemoglobin A1C levels in patients with diabetes, were worse for veterans seeking care at facilities with longer wait times compared to those treated at VA facilities with shorter wait times for appointments (Pizer and Prentice, 2011b). Reducing wait times for mental health services is particularly critical, as evidence shows that the longer a patient has to wait for such services, the greater the likelihood that the patient will miss the appointment (Kehle et al., 2011; Pizer and Prentice, 2011a)."[66]

Older Veterans lack access to VA's ever expanding digital patient services, and require tailored outreach and patient access information. "Thirty percent of Veterans, especially older Veterans, do not have access to the internet and therefore cannot access VA's digital services, such as the MyHealtheVet patient portal or telehealth (2013 Survey of Enrollees)." [67]

Background

There is a shortage of specialized geriatric care across the country, with private sector systems and VHA having similar challenges.[68] "Today, VHA leads the nation in the provision of specialized geriatric care, with 45 FTE geriatric/palliative providers across the VA system.[69] At present, there is no health system with as many care teams, known in VHA as Geri-PACTS, dedicated to the geriatric population. Geri-PACTS can be established for any geriatric team that assumes responsibility for comprehensive, coordinated primary care and specialized geriatric care of an assigned panel of patients. It is important to note that geriatric services for Veterans in VHA are not limited to only those services provided by Geri-PACTs; however, few VHA geriatricians practice outside of Geri-PACTs. Geri-PACT teams typically have a panel of 642 patients and include 1.0 FTE geriatric PCP, 1.0 FTE registered nurse case manager,

[65] Demographics, page 13.
[66] Access Standards, pg. 21.
[67] Health Care Capabilities, pg. 15.
[68] Telephone Interview with the Office of Geriatrics and Extended Care Services, (January 30, 2015) Richard Allman, Chief Consultant, Geriatrics and Extended Care Services.
[69] Ibid.

1.0 FTE clinical associate (LPN/LVN/Health Tech), social worker, and clinical pharmacy specialist.[70] Discipline-specific team members, such as registered dieticians, geriatric psychiatrists, geriatric psychologist, hospice and palliative care provider, or physical medicine and rehabilitation services clinicians may also be part of the care team." [71]

Providers in "Geri-PACTs" forced into a less productive co-managed care model when older veterans access care from community. "VHA has developed specialized PACTs for unique Veteran health needs, such as geriatrics. These PACTs, termed "geri-PACTs" have unique staffing requirements that may differ from the private sector, influencing both staffing levels and productivity, as support staff is a key driver of productivity. Conversely, because Veterans are given many options for access to care, to include accessing care in the community, providers are sometimes forced into a co-managed care model, which can be significantly less productive as VHA providers lose time looking for test results and care documentation from Veterans' private sector providers. Perhaps more importantly, we provide context of VHA's care model at the start of this report because it is important in reviewing benchmark comparisons of VHA against the private sector, which primarily consists of a volume-driven, non-population health oriented environment, in which providers are incentivized not on patient outcomes or satisfaction, but on volume of services provided."[72]

The aging population accounts for increasingly more hospital admissions, which account for a majority of VHA admissions. "Overall among all patients, 75% of VHA admissions originate in the ED as compared to market averages (50% of admissions) (Pines, 2013).[73] Additionally, VAMCs have longer-admitted ED LOS and a higher rate of LWBS patients, as compared to market averages." [74]

> **Facility resources impact clinical services and ED admittance.** "When comparing VHA performance statistics with private facilities, it is important to note the impact of different clinical services and patient populations on access. For example, if a facility offers fewer surgical services, then it will likely have fewer planned surgical admissions thus its percentage of ED admissions will likely be higher as compared to a hospital with more surgical services."
>
> **Older veterans have a higher prevalence of mental health, suicide risk, co-morbidities, and sociodemographic challenges (e.g., low income and homelessness), "which can lead to increased ED demand (Hastings 2013; Tsai, 2015; Doran, 2013)."** "Patients with mental health diagnoses are less likely to seek regular medical treatment (Hoester, 2012). When they do seek medical treatment it is often in the ED following the advancement of their condition and exacerbation of symptoms (Hoester, 2012). When presenting in the ED, these patients may also require additional resources (e.g., some mental health patients in the ED require a 1:1 clinician ratio)."
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> "Patients with co-morbidities, especially related to cardiac disease, have greater ED use (Doran, 2013). This is noteworthy given the prevalence of hypertension among VHA patients is nearly

[70] U.S. Department of Veterans Affairs. Geriatrics and Extended Care: Geriatric Patient Aligned Care Team (Geri-Pact). Retrieved from http://www.va.gov/GERIATRICS/Geriatric_Patient_Aligned_Care_Team.asp.
[71] Staffing/Productivity, pg. 77.
[72] Staffing/Productivity, pg. 33. Also: "Another key aspect of geriatrics care is the purchased care program. Long term care support is supported by over 10,000 home health care workers at 2,500 community nursing homes, 130 VA CLCs and 130 State Veterans homes.106 The Office of Geriatrics and Extended Care Services is making significant efforts to better monitor whether community nursing home facilities meet eligibility requirements, provide high quality care, and do so in a cost effective manner." Pg. 71.
[73] Workflow (Clinical), pg. 77.
[74] Final report draft, pg. 154.

double that of the private sector, 52 percent compared with 26 percent (Klein, 2011, Unique Veteran Users Report FY12, 2014)."

"Homelessness is a key predictor of ED utilization (Doran, 2013)."

As the need for cardiology specialty increases, there is a current and projected shortage of cardiologists. ***"***A 2012 VA Office of Inspector General report identified cardiology as one of 33 physician specialties with lower than expected productivity levels (VA, Office of Inspector General, 2012a). Dall et al. (2009) found, at the national level, a current shortage and predicted it would worsen over the next 20 years. The study projected greater demand for cardiology services because of an aging population and a workforce nearing retirement (43 percent are older than 55). Fye (2004) predicted a 20 percent decrease in the age-adjusted supply of cardiologists by 2020 and a likely increase in demand resulting from increased incidence and prevalence of cardiovascular disease tied to population aging and obesity (Fye, 2004). While these trends are not VA-specific, they are relevant, as VA competes for cardiologists in the national market.*"*[75]

Mental Health:

- According to the VA's National Registry for Depression, 11% of Veterans aged 65 years and older have a diagnosis of major depressive disorder, a rate more than twice that found in the general population of adults aged 65 and older. (VA, 2011).
- Post-traumatic stress disorder is associated with high rates of morbidity and mortality and is one of the most common sequelae in older veterans. (Dohrenwend et al, 2006; NCPTSD, 2015).
- Many older veterans find they have PTSD symptoms even 50 or more years after their wartime experience. PTSD symptoms can worsen later in life. Demand for treatment of PTSD among Vietnam veterans, in particular, has increased steadily. (Hermes, et, 2015). Vietnam veterans with combat-related PTSD report more current and chronic health problems than combat veterans without PTSD.
- PTSD is associated with greater healthcare use and an increased risk of developing a wide range of medical conditions in veterans.

[75] Health Care Capabilities, pg. 88.

Legislative Changes

* Tk….

VA Administrative Changes

* Tk…

Other Department and Agency Administrative Changes

- Tk
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- PTSD is significantly associated with the development of cardiovascular disease, in particular hypertension and chronic ischemic heart disease (Kange et al, 2006). The deterioration of physical health can exacerbate or even trigger the onset of PTSD symptoms as the veteran ages. (Chaterjee et al, 2009).

- Older veterans are at increased risk of suicide: two-thirds who complete suicide are age 50 or older. Homeless veterans have increased suicide risk. (Durai et al, 2011; Bagalman, 2013; 2016).

Analysis

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Legislative Changes

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VA Administrative Changes

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Other Department and Agency Administrative Changes

* Tk

Consolidate best practices and continuous improvement efforts under one office within VHA to facilitate ease-of-use and widespread adoption of appropriate approaches to transformation and sustainable change.

Problem

Best practices exist in pockets of VHA; however, communication and support for implementation appears to be a challenge. 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.[76]

The Commission Recommends . . .

- That the Veterans Enginereering Resource Centers (VERCs) be tasked with assisting in transformation efforts, particularly in areas such as access and in areas that affect activities systemwide such as human resources management, contracting, purchasing, and information technology that require significant overhauls.
- That VHA develop a culture to inspire continuous improvement of workflow processes by embracing LEAN Six Sigma.
- That VHA evelop a system for ensuring its best practice repositories have recurring processes for scaling and optimizing best practices enterprisewide.

Background

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.[77] VHA needs to have the opportunity to fully leverage and build on of institutional strengths by implementing best practices. VHA needs a mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best-practice sharing and innovation. To progress, a mechanism for sharing best practice information needs to be widely implemented and sustained.[78]

Analysis

Numerous examples of best practice collection offices and sites in VHA business lines exist 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 program. The number of offices with similar missions only adds confusion' offices rquire consolidation.

Despite having a broad array of best-practice repositories, VHA lacks a recurring process to determine how to scale and optimize best practices throughout the enterprise. Although business processes could be standardized, there should be a mechanism that allows the

[76] The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs , Assessment F (Workflow—Clinical), page 14 & Appendix A-2 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.
[77] Institute of Medicine of the National Academies, Transforming health Care Scheduling and Access: Getting to Now, page 41 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.
[78] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs , Assessment F (Workflow—Clinical),* page 4 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

tailoring of practices to fit unique circumstances that will not obscure the intent. 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 regional and local differences in provider supply, veteran needs, and marketplace characteristics.[79]

There are offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get the information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing about them.[80]

VHA's National Leadership Council should propose consolidating these best practice repositories under VA's Veterans Engineering Resource Center (VERC) which now reports to the Undersecretary for Organizational Excellence.[81] Offices like the VERC have been available within VA or VHA but remain widely unknown.[82] 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. VERC offers services to VHA health care facilities upon request, but VHA would significantly benefit if the service was authorized to perform outreach to ensure awareness across the system.[83]

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[84] and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated that veterans' reliance on VHA was strongly correlated to the economic factors such as unemployment rates and availability of other health care coverage.[85]

In an overview of the key gaps between current VHA processes and best practices, the largest gap comes with the lack of a feedback mechanism. Without accountability for project design, delivery, and operations against stated objectives, it is not possible to understand the effectiveness of the planning and prioritization of projects, whether done at the local or national

[79] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes),* page 10 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf
[80] Citation needed.
[81] VHA Website, http://vaww.va.gov/health/programs.asp accessed 4/7/2016.
[82] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* page 27 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf
[83] Citation needed
[84] Amy Kilbourne, QUERI Program Director, QUERI Corner: Surviving and Thriving, Jan. 15, 2015. http://vaww.blog.va.gov/hsrd/category/queri-corner/ accessed April 4, 2016.
[85]

level. Until addressed, this gap could hinder the effectiveness of any other policy or procedural changes in the capital planning process.[86]

A systems approach to health care applies scientific principles to understanding what factors determine health outcomes; creates models that illustrate relationships among pertinent factors; and enhances design, processes, or policies to achieve increased health and decreased cost.[87] VA could benefit greatly from applying systems approaches to its health care system, and VERC personnel could serve as knowledgable guides to doing so.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.[88] 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 following: The Centers for Medicare & Medicaid Services; the Joint Commission; the National Committee for Quality Assurance; and the National Quality Forum.[89]

The tools of operations management, industrial engineering, and system 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.[90]

To become a truly veteran-centric care provider, VHA is working to become a learning organization.[91] As a learning organization, focus on rules compliance will be replaced with a model of worker competenc. Consequently, instead of using results determining high- and low-performers, VHA will identify opportunities to intervene with training or other resources. Employees and patients should benefit from this approach that values listening and encourages risk taking and innovation.[92]

VA and VHA have adopted the tenets of LEAN Six Sigma as the systemic change approach they believe will move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control (DMAIC) approach to system change.[93] LEAN, initially used by manufacturers, has been used successfully by many health care organizations.[94] The goal of

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[86] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* page 72 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf

[87] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* page 27 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf

[88] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* page 15 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf

[89] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* page 60 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf

[90] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* page 27-28 accessed Jan 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf

[91] VHA Learning Organization Transformation website http://vaww.learning.va.gov/learning/default.asp accessed April 3, 2016.

[92] Citation needed.

[93] "Eliminating Waste in U.S. Healthcare," Institute for Healthcare Improvement, accessed march 29, 2016 http://www.ihi.org/resources/Pages/IHIWhitePapers/GoingLeaninHealthCare.aspx.

[94] Richard Scoville and Kevin Little, "Comparing Lean and Quality Improvement," *IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement* (2014).

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 adaptation of LEAN throughout the enterprise[95] to provide a more comprehensive view of quality that balances a results-oriented approach with more process-oriented practice.[96] So far these efforts have been guided by trial and error rather than directives and adapting a LEAN process-driven model.[97]

VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology. VHA will have to use VERC and other trained staff 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 healthcare delivery through the integration of systems engineering principles.

With the 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.

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 Agency Administrative Changes

- None required.

[95] Department of Veterans Affairs. MyVA: Putting Veterans First. MyVA Integrated Plan. July 30, 2015. P. 21
[96] Veterans Health Administration. FISCAL YEAR 2016 PERFORMANCE PLAN TEMPLATE: NETWORK DIRECTOR AND MEDICAL CENTER DIRECTOR, December 7, 2015.
[97] Citation needed

Facilities

Develop and implement a strategy for meeting and managing VHA's capital-asset needs.

Problem

Veterans who turn to VHA to meet health 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 needed 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, as proposed on p. # holds the promise of markedly improving veterans' access to care. But that promise cannot be realized without transformative changes to VHA's capital structure.

The Commission Recommends . . .

- That VA leaders streamline and strengthen the capital asset programs' management and operation.
- That Congress provide VHA greater budgetary flexibility to meets its capital asset needs, and greater statutory authority to divest itself of unneeded buildings.
- That Congress enact legislation to establish a VHA capital-asset realignment process based on the DoD Base Realignment and Closure Commission process.

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.[98] 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.[99] Most of its facilities were designed to meet markedly different needs than today's health care facilities: some were tuberculosis sanatoriums, others for years primarily housed patients with mental health conditions.[100] 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 found that VHA facilities average a *C minus* score,[101] 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.[102]

[98] Robinson E. Adkins, *Medical Care of Veterans*, House Committee on Veterans Affairs, 90th Cong, 1st sess., Com. Print 4 (April 17, 1967), Appendix B.
[99] 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.
[100] Robinson E. Adkins, *Medical Care of Veterans*, supra.
[101] Assessment K, supra, p. 27.
[102] Id.

Over 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.[103] Current facilities, whether they have been maintained adequately or not, often do not support 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.[104] Capital funding during the past 4 years has averaged just $2 billion annually.[105] 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.[106] 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.[107]

Analysis

New Planning Paradigm

As the department has acknowledged, "VA's health care delivery model must . . . change."[108] 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."[109] The acknowledgement that VA 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 that integrated delivery network (IND) model. 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 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 INDs.

The shape of an integrated care network will take different form 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 disposition of unused, unneeded property.

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[103] Id., p. 46.
[104] Id., p. 17.
[105] Id., p. 18.
[106] Id.
[107] Id., pp. 59-61.
[108] 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.
[109] Id.

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.[110] The SECVA recently testified that it costs VA an estimated $26 million annually to maintain and operate vacant and underutilized buildings.[111]

VA's authority to carry out property-management is circumscribed in law,[112] and the department at times faces insurmountable challenges in attempting either to repurpose or divest itself of underutilized or vacant property.[113] 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*.[114] This authority allows VA to lease underutilized capital 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.[115]

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[110] Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, page 92 (October 30, 2015) accessed December 31, 2015, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf

[111] Statement of Robert A. Macdonald, Secretary of Veterans Affairs, Hearing on *U.S. Department of Veterans Affairs Request for Fiscal Year 2017* before House Committee on Veterans Affairs (Feb. 10, 2016), https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2

[112] See 38 U.S.C. §§ 8118, 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.[112] 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. (GAO, Testimony before the House Subcommittee on Economic Development, Public Buildings and Emergency Management, Committee on Transportation and Infrastructure, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain,* GAO-11-520T (April 6, 2011), p. 5. http://www.gao.gov/products/GAO-11-520T)

[113] With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces outright barriers to disposal, while in other instances, VACO staff report that stakeholder concerns have been obstacles.

[114] 38 U.S.C. §§ 8161-8169, as amended by Section 208, Public Law 106-117 (1999), as in effect when GAO testified on this successful program. Government Accountability Office, Testimony before the Senate Veterans Affairs Committee, *VA Real Property: VA Emphasizes Enhanced-Use Leases to Manage its Real Property Portfolio,* GAO-09-776T (June 10, 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. 38 U.S.C. § 8122(a)(1). Government Accountability Office, Testimony before the Senate Veterans Affairs Committee, *VA Real Property: VA Emphasizes Enhanced-Use Leases to Manage its Real Property Portfolio, supra.*

[115] 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. 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. Sec. 211, Pub. L. No. 112-154, https://www.gpo.gov/fdsys/pkg/PLAW-112publ154/html/PLAW-112publ154.htm

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, 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,[116] but did not as clearly address the importance of more modern facilities for delivering high quality care. 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 $1,000,000,[117] a Congressional Budget Office (CBO) ruling[118] has upended the approval process and halted the leasing program.[119],[120] 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.[121] Currently, 24 major VA leases are in limbo.[122]

One of the primary benefits of leasing is that it can provide flexibility and speed.[123] 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,[124] in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.[125]

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* suggested consideration of transformative options, to include alternative vehicles for capital delivery such as public–private partnerships.[126]

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

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[116] Independent Assessment K.
[117] 38 U.S.C. § 8104.
[118] Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office, Hearing on *Assessing VA's Capital Inventory Options to Provide Veterans' Care,* before the House Committee on Veterans Affairs (June 27, 2013), p. 42. https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm
[119] Id. 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.
[120] Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office, Hearing on *Assessing VA's Capital Inventory Options to Provide Veterans' Care,* supra, p. 42. 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.
[121] Statement of Robert A. Petzel, M.D., Hearing on *Assessing VA's Capital Inventory Options to Provide Veterans' Care*, supra.
[122] Statement of Robert A. Macdonald, Secretary of Veterans Affairs, Hearing on *U.S. Department of Veterans Affairs Request for Fiscal Year 2017,* supra.
[123] Assessment K, supra, p. 159.
[124] Id., pp. 159-160
[125] Id., p.160.
[126] Assessment K, supra, pp. vii-ix, 34.

planning efforts and funding decisions, and separation of project execution and facilities management,[127] suggesting a need for transformative changes in operations.[128]

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.[129] 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

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.[130] 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.[131] But that authority may generally not be unilaterally exercised.[132] 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

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[127] Id, pp. vi., 20.
[128] Integrated Report, K-5.
[129] Interviews with VA staff, April 2016.
[130] See, Christopher Scanlon, *VA Chief Seeks Panel to Revamp System*, Philadelphia Inquirer (July 18, 1989) accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital; Department of Veterans Affairs Office of Public and Intergovernmental Affairs, *Distinguished Group Selected for CARES Commission* (March 3, 2003) accessed December 31, 2015, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578
[131] 38 U.S.C. § 510.
[132] 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. 38 U.S.C. § 510(c).

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,[133] 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[134]—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 (CARP) to more effectively align VHA facilities and improve veteran's access to care. Within the CARP framework, VHA would employ criteria set by the VHA board of directors (proposed in section___) to conduct locally-based analyses of capital assests. Information generated would be used to assist an independent commission, established under the legislation, in making recommendations regarding realignment and capital asset needs.[135] The independent CARP 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 board would review, and adopt or revise, the commission's recommended realignment plan. The CARP commission would be empowered to implement the recommendations unless, within a specified timeframe, Congress disapproves the 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 later in the course of an ongoing VHA transformation, the VHA board of directors would assess and direct additional alignment measures, as it might determine necessary.

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

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[133] See H. Rep. No. 106-237 (July 16, 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' Millenium Health Care Act, Pub. L. No. 107-117 (Nov. 30, 1999), Accessed Jan. 12, 2016, https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm

[134] Government Accountability Office, Testimony before the House Subcommittee on Economic Development, Public Buildings and Emergency Management, Committee on Transportation and Infrastructure, supra, p. 1.

[135] 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.

building maintenance.[136] 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.[137]

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.[138] 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 many VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant 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 thoroughgoing realignment process may shrink VHA's 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[139] 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.

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

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

[138] Government Accountability Office, Testimony before the Senate Veterans Affairs Committee, supra.

[139] See sec. 803, Pub. L. No. 113-146.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.[140] Notably, minor construction funds, available for "constructing, altering, extending, and improving"[141] any VA facility, are limited to $10 million,[142] 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.[143] The Commission believes that with the tight controls a board of directors would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

Also, 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.[144]

Capital Asset Management

The Commission emphasizes that VHA has much to do on its own to 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.

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[140] VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, (Dec. 17, 2012), 8. http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf

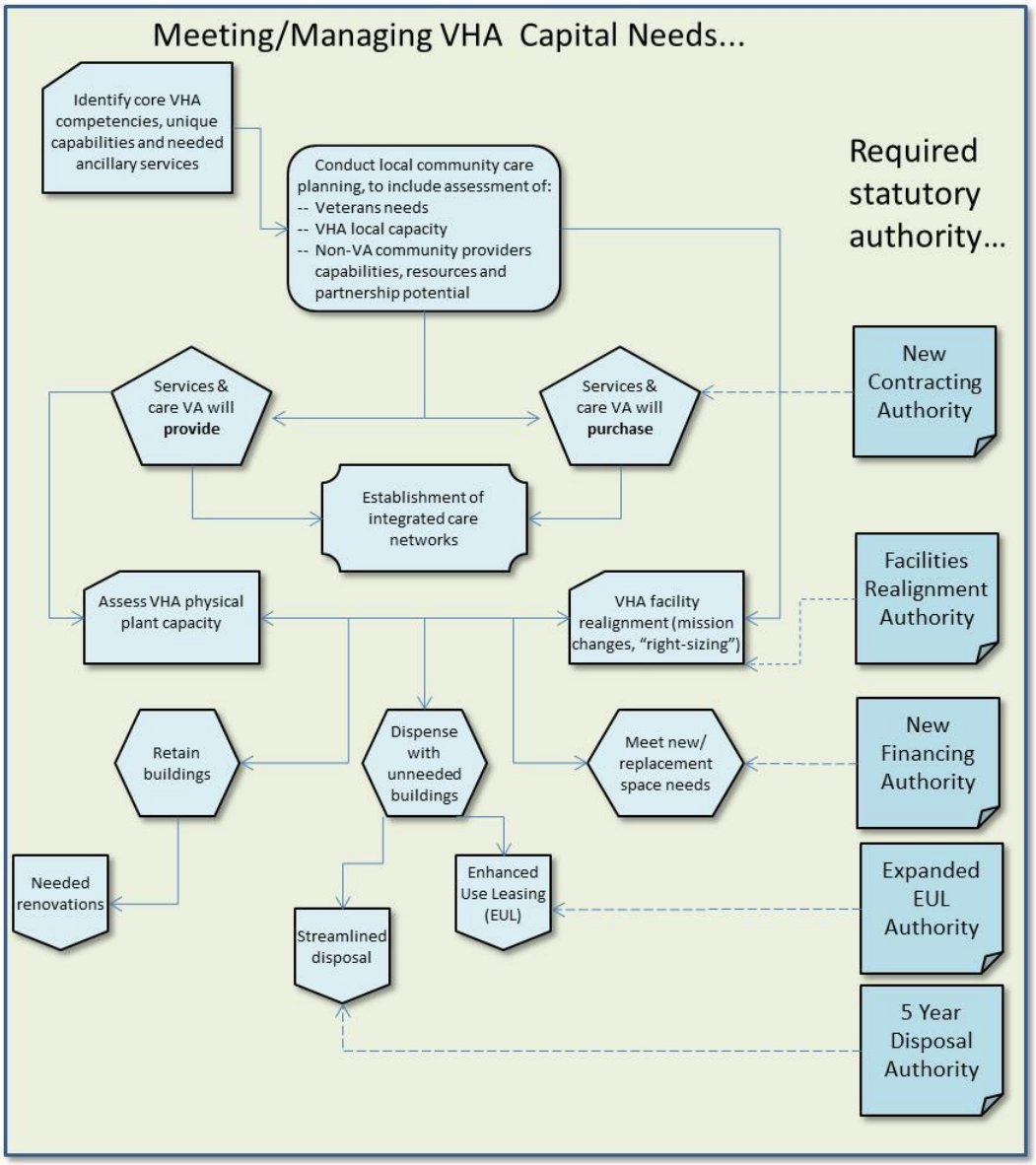
[141] The Consolidated Appropriations Act, wo16; Pub. L. No. 114-113, Div. J., Title II, Department of Veterans Affairs. https://www.congress.gov/bill/114th-congress/house-bill/2029/text?format=txt

[142] A major medical facility project is one involving a total expenditure of more than $10 million. 38 U.S. Code sec. 8104(a)(3)(A).

[143] Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, raised the threshold as to what constitutes a major medical facility project from more than $7 million to more than $10 million. https://www.congress.gov/bill/109th-congress/senate-bill/3421/text/pl

[144] 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,[144] necessarily poses challenges, but merits exploration and support. (Associated Press, VA exploring public-private plan for new facility, Lincoln Journal Star (March 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 construction. (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. 5099would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. https://www.congress.gov/bill/114th-congress/house-bill/5099

Figure X. Title



As depicted in Figure X, above, meeting and managing VHA's capital-asset needs requires 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 below.

Legislative Changes

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

- Congress should enact legislation 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 a independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national CARP that would include recommendations to the VHA board of directors (*proposed on pages ___*) 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 reinvesting (in the pertinent VISN) savings/cost-avoidance resulting from the realignment, (c) the projected care-improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retraining and reemploying displaced employees.

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

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

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

- Congress should amend pertinent provisions of 38 U.S.C. §§ 8161, et seq. to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.

- Congress should provide the VHA board of directors authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) a streamlined process to address historic preservation considerations.

Information Technology

Modernize VA's IT 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 record (EHR) system 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.[145] 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.

The Commission Recommends . . .

- That VHA establish a Senior Executive Service (SES)-level position of VHA Chief Information Officer (CIO), selected by the board of directors and reporting to the Under Secretary for Health with a dotted line to the VA CIO, who is responsible for developing and implementing a comprehensive health IT strategy, and developing and managing the health IT budget.
- That VHA rocure and implement a comprehensive commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can execute the requirements described in this section.

Background

A fully functional electronic health records system can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.[146] Starting in the 1970s, VHA became a leader in the development of electronic health record (EHR) technology with VistA and a Computerized Patient Record System (CPRS).[147] Full implementation of the EHR together with other reforms helped improve the quality of care at VHA.[148] But over the last decade, VHA has not been able to maintain an IT advantage.[149] Although most VHA clinicians have a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VA's EHR at risk of becoming

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[145] 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.

[146] "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.

[147] 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.

[148] Philip Longman, Best Care Anywhere. etc. Perlin JB1, Kolodner RM, Roswell RH, The Veterans Health Administration: quality, value, accountability, and information as transforming strategies for patient-centered care, Healthc Pap. 2005; 5(4):10-24.

[149] 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.

obsolete.[150] Many large U.S. health care systems that were early adopters of home grown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.[151] DoD recently made the same choice.[152]

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 electronic health record 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, and the systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA, it would require exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.[153] VHA appears to lack a majority of the factors required for success.[154]

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.[155] VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending. There was no specific budget line item for the electronic health record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

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[150] 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 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

[151] "$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.

[152] Add information about DoD selecting Cerna.

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

[154] 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.

[155] 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.

VA's IT budget was centralized in 2006, and OIT was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs are only one of the priorities that OIT must accommodate and VHA's priorities do not always prevail.[156]

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.[157]

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 that has the expertise to fully support, manage, and execute complex integrated IT programs.[158]

Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long term development and important IT projects.[159] The budget process is disconnected from total lifecycle IT costs.[160] That disconnect has grown wider with a change in law[161] under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.[162] 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

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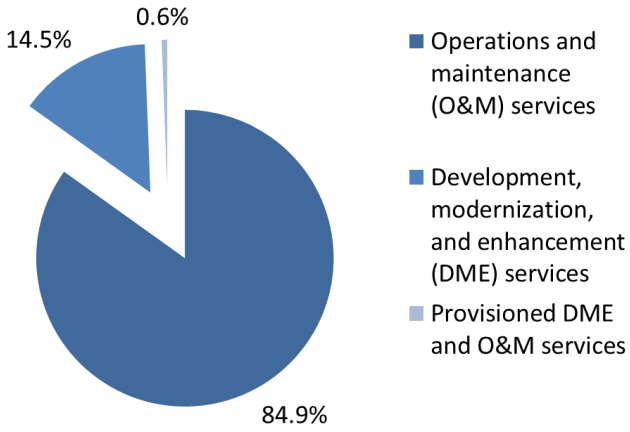
[156] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* 10, accessed April 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[157] "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, https://www.acep.org/content.aspx?id=79744.
[158] 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
[159] "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.
[160] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.
[161] Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).
[162] With Pub. L. No. 113-235 (Dec. 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC)."[163]

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure X),[164] 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.[165]

Figure X. 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 over its potential 18-year life, the contract could be worth just less than $9 billion.[166] The recent Senate appropriations bill for VA OIT allots $63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).[167] 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 their new COTS EHR given the current funding amount of $63 million per year. VA will require a significant 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

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[163] 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*, 111th Congress, 1st Sess., 2009, 60.
[164] Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, https://itdashboard.gov/drupal/summary/029.
[165] 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.
[166] "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.
[167] 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.

maintenance costs.[168] 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.[169] VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform.

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 VAMCs, between VA and non-VA facilities (including those of DoD), and between VA and the individual veteran. 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.[170] 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.[171]

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 ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange so that information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.[172] 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. This includes 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.[173]

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[168] 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.
[169] 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.
[170] 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.
[171] 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),* p. viii, accessed February 23, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[172] "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, https://www.healthit.gov/policy-researchers-implementers/interoperability.
[173] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

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.[174] 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 medical appointment scheduling system in August 2015.[175] 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.[176] 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.[177] 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.[178]

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.[179] 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

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[174] 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),* p. 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[175] "$623M Medical Appointment Scheduling System Contract," G2Xchange, accessed May 3, 2016, https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract.
[176] 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.
[177] 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.
[178] 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.
[179] 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),* 39-40, accessed April 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

managers, planners, and administrators have for accurate and timely data on clinic utilization.[180] For instance, VHA's new Healthcare Operations Dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.[181] However when questioned about this data, VHA notes that it is not correct.[182] 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.[183]

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.[184] VA's current financial management system does not support streamlining and automation of VA's revenue cycle.[185]

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.[186] 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.[187] Barriers to automation are multifactorial, 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.[188] In addition, there are multiple authorities for purchasing community care—all with different business rules[189] 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

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[180] The MITRE Corporation, *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.
[181] Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.
[182] Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.
[183] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling),* p. 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.
[184] 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.
[185] 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.
[186] Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.
[187] 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.
[188] 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.
[189] Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;[190] thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.[191]

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.[192] 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,[193] 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.[194]

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and non-VA 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 DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.[195]

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.[196] 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.[197] The Joint Legacy Viewer (JLV) is a positive step in supporting coordination of care among VA, DoD,

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[190] 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.
[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,* Appendix I, Business Processes (Page I3-I4), accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[192] "$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.
[193] "DoD Awards, Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner.
[194] "$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.
[195] 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.
[196] "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.
[197] Sloan Gibson, Deputy Secretary of Veterans Affairs, et al., briefing to Commission on Care, April 18, 2016.

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.[198]

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 with streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable 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.[199]

VHA does not have everything that is needed in an information technology 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 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 instances 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.[200]

The "lack of a Unique Patient Identifier presents significant problems in 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."[201] To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient identifier. This practice is currently not used.[202] Each health care system uses a unique patient identifier number, but it is specific to that system.[203] VA uses a patient's social security number as a unique identifier; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies suggest that patient

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[198] 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.
[199] Sloan Gibson, Deputy Secretary of Veterans Affairs, et al., briefing to Commission on Care, April 18, 2016.
[200] LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing provided to Commission on Care staff, April 27, 2016.
[201] "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.
[202] "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.
[203] "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.

identification error rates range from 7-20 percent.[204] 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.[205] Recent hacks of U.S. hospital health care systems through the use of ransomware, a virus that holds systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.[206] VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in their annual FISMA audit reports.[207] 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.[208] For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.[209] Interoperability increases the risk to veteran's health records.[210] Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;[211] 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 are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.[212]

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VA/purchased care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged 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.[213] The standard industry policy is to have patients opt out of having their health

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[204] "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.

[205] "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.

[206] "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.

[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),* A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

[208] 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.

[209] "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.

[210] Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

[211] "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, accessed May 17, 2016, http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records.

[212] Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

[213] Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the commission on December 15, 2015

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.[214]

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.[215]

Collaboration between OIT and VHA is paramount to transforming VA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring the IT needs of VA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.[216] But VHA's extensive IT needs require a VHA CIO with authority over the health IT budget. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the USH 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 strategy. Rolling out a new system takes place over multiple years and VA must commit to funding system deployments through to their 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 the 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.[217]

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[214] 38 U.S.C. § 7332 SUBCHAPTER III - PROTECTION OF PATIENT RIGHTS Sec. 7332 - Confidentiality of certain medical records.
[215] Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the commission on December 15, 2015.
[216] "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.
[217] "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.

The Commission recommends that VA purchase a comprehensive COTS health information technology platform; however, 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.[218] 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.[219] 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 instance of an EHR across all VHA sites of care; interoperability within VA, such as with 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. Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.[220]

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 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 VA IT infrastructure

[73] Sloan Gibson, Deputy Secretary of Veterans Affairs, et al., briefing to Commission on Care, April 18, 2016.
[219] "DoD awards, Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner.
[220] 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.

receives proper maintenance and upgrades in preparation for new and successor technologies.

- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account.

- Amend section 7332 of title 38, U.S. Code, to authorize VA to share 7332 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 USH, with secondary reporting responsibility to the 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[221]

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

  - 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 electronitc health platform that executes all of the following requirements:

  - establishes one logical instance of an electronic health record platform in VHA[222]

  - supports customization to match VHA clinical workflows and clinician usability (recognizing that VHA clinical workflow should be modified, when possible, to ensure connectivity with other systems.

  - 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[223]

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[221] 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),* 55, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[222] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

- 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[224]

- 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[225]

- 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 NCA) and between VA and DoD

- supports the development of full interoperability with integrated community care network facilities and providers

- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness

- 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[226]

- 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.

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[223] 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.
[224] 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.
[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,* 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[226] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Other Department and Agency Administrative Changes

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

GOVERNANCE, LEADERSHIP, AND WORKFORCE

Problem

Leading VHA is a challenge; the USH and the leadership team must direct one of the country's largest organizations; must orchestrate this task within the strictures, processes, and public scrutiny that come with being a federal agency; and must succeed within one of the most complex and dynamic industries in the United States—health care. Inseparable from these challenges, VHA leaders must have the discipline and commitment to always privilege the needs of veterans first and inspire and engage employees across the country to embrace VA's mission, to care for those "who have borne the battle" and for their family and their loved ones.

In recent times, the agency has been battered in the press and on Capitol Hill due to mismanagement, poor care to veterans, and an inability to lead VHA effectively through a change process. Employees and senior executives are embattled, lacking psychological safety and a positive organizational culture that fully embraces diversity and inclusion. Employees may well wonder, what happened to the high quality, safe, veteran-focused health care system they knew, once called "the best care anywhere?"[227]

Analysis

If VHA is to continue to be the nation's advocate for veterans' health care and the social services they require to heal from war, then VHA must be reimagined and realigned from the ground up. The Commission envisions transforming veterans' health care to enhance quality, access, choice, and veteran well-being. To accomplish this vision, a new orientation and mindset must take hold in VHA, and it must start at the top with a new governance model, new leadership systems, and a sustained focus on culture change.

At more than 300,000 employees, 1,000 sites of care, and a budget exceeding $63 billion, VHA is among one of the world's largest organizations. Yet, the leadership of the organization—the USH, SECVA, DEPSECVA—stay at VA only a few years. While they are in place, they are subject to close scrutiny of Congress, the White House and the press. As a result, VHA lacks a long-term vision and continuity in the development and execution of plans and programs. To address these issues, the Commission recommends establishing a board of directors to provide VHA overall governance, set long term strategy, and direct and oversee the long term transformation of the VHA.

To support the strategic direction laid out by the board of directors and successfully implement the transformation objectives described in this report, VHA requires a leadership system that results in high caliber leaders, agile and effective decision making, and performance

[227] Phil Longman

accountability at the individual and the organizational levels. This means attracting and developing individuals who can lead and inspire others, set clear expectations for performance and behavior, support staff in achieving success, and be willing to sanction them when they do not. Future VHA leaders must be outward-looking and be able to build partnerships and alliances with for-profit and not-for-profit organizations, academic medicine, military health, and local and state government to deliver high-caliber health care to veterans. VHA leaders must understand these sectors, how they operate, and what interests and values drive their businesses. To accomplish this goal, the Commission recommends rebuilding a system for leadership succession in VHA based on a benchmarked health care competency model that is applied in recruitment, development, and advancement within the leadership pipeline.

VHA leaders and staff at all levels of the organization must be conscious of always putting the needs of veterans first. Meeting this expectation includes keeping administration lean and minimizing bureaucracy: "We are dealing with veterans, not procedures; with their problems, not ours."[228] Accomplishing this mission requires trusting local leaders, closest to the veterans, to control resources and infrastructure to best meet their needs. To accomplish this, the Commission recommends transforming organizational structures and management processes to promote decision-making at the lowest level of the organization, eliminate waste and redundancy, promote innovation, and foster the spread of best practices.

Supporting all aspects of VHA transformation process, effective human capital management is a key enabling function. Yet, significant long term deficiencies in budgeting, planning and management of human resources exist that haven't been engaged by the leadership system in VA. To correct this problem, the Commission recommends that top executives in VA lead the transformation of HR, commit funds, and assign expert resources to achieve a high performing health system.

As a public agency entrusted with the care of our nation's veterans, VHA must meet the highest standards of transparency and accountability. The board of directors will set the direction of the organization and VHA leaders will execute that vision, yet both must have accurate and meaningful performance measures to gauge progress against goals and benchmark the organization against private-sector standards. To accomplish this goal, the Commission recommends streamlining and focusing performance measurement in VHA using core metrics that are identical to those used in the private sector. Furthermore, individual leaders must be supported in the pursuit of a high performing health care system and held accountable for achieving it. To this end, the Commission recommends establishing a 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.

VHA leaders must be innovators and change agents. They must free the extraordinary power of 300,000 employees to make change and take appropriate risks and sometimes to fail. VHA employees will only take risks if they feel safe, respected, included, and engaged as part of a healthy organization that embraces diversity. To create this culture, the Commission recommends that leaders at all levels of the organization champion a focused, clear,

[228] General Omar Bradley

benchmarked strategy to transform VHA culture and sustain staff engagement. VHA leaders must have the courage to support and defend VHA employees on this journey so that all veterans can benefit and be empowered. Staff members who feel respected and included are much more inclined to extend the same respect to veterans and their loved ones, thus leadership commitment to enabling a positive environment and culture for staff is foundational to creating an inclusive environment for veterans. VHA must do much more to embrace diversity in all its dimensions to ensure that all veterans receive high quality, timely, equitable care irrespective of geography, gender, race, age, culture, and sexual orientation or identity. The Commission recommends that VHA establish health equity as a VHA priority, and identify and address health inequities in subpopulations treated by VHA.

Strong governance and leadership create the foundation for a healthy organization, and the workforce comprises the vital team for carrying out the the vision and goals through daily operations. With more than 40,000 unfilled positions in VHA, Congress and VHA need to create a simple-to-administer alternative personnel system that governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector. To transform its personnel system, VHA needs to require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Board of Directors

Establish a fiduciary-like board of directors (not subject the Federal Advisory Committee Act) to provide VHA overall governance, set long term strategy, and direct and oversee the transformation process.

Problem

The Commission Recommends . . .

- That Congress provide for the establishment of an 11-member fiduciary-likeboard of directors accountable to the president, responsible for overall VHA governance, and with decision-making authority to direct the transformation process and set long-term strategy. The board would not not fall under the confines of the Federal Advisory Committee Act (FACA) and would be structured based on the key elements included in Table X on p. #.

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[229]. 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.[230] The report authors observed, "Unlike other healthcare systems, VHA does not have a governance mechanism to fill the role of a board of directors."[231] 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,[232] and VHA's operating in a "dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands"[233] 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

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[229] Needs citation.
[230] Booz, Allen, Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS): Systems Review*, (Sept. 22, 2015), 3.
[231] Booz, Allen, Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS): Systems Review*, (Sept. 22, 2015), 3.
[232] Id.
[233] *Integrated Report,* xiv.

scrutiny.[234] VHA undergoes oversight from several independent bodies, including audits by the internal Office of the Inspector General audits and external Government Accountability Office (GAO) audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group (SRG), which are designated as the principal governance bodies of the department.[235] 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. [236]

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." [237]

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear; leaders have been consumed by crisis and responding to congressional demands, creating a reactive, rather than proactive environment.[238] Additionally, the leadership vision has lacked continuity.[239] The SECVA and DEPSECVA may exercise oversight of VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.[240] 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 USH or to lower officials in VHA.[241]

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[234] 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. http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3

[235] Department of Veterans Affairs, *Department of Veterans Affairs Governance Structure,* VA Directive 0214 (August 11, 2014).

[236] Integrated Report, p. 26.

[237] Integrated Report, supra, p. 23.

[238] Booz, Allen, Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* (Sept. 22, 2015), pp. 52-54.

[239] Assessment L (Leadership) vi-viii; 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

[240] VA Directive 0214, Department of Veterans Affairs Governance Structure, August 11, 2014; Assessment L (Leadership) viii; 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" 38 USC § 305 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 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.

[241] http://vaww.ush.va.gov/docs/USH_Org_Chart_memo_09-22-15.pdf ; Department of Veterans Affairs, Functional Organizational Manual v1.3: Description of Organization Structure, Missions, Functions, Tasks, and Authorities, 2014,258.

Previous studies, dating back 20 years,[242] have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.[243],[244] The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,[245] and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.[246] Although the authors of the 1996 report saw a VHA government 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 USH Kenneth W. Kizer.[247]

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."[248] 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,"[249] 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

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[242] 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.

[243] Klemm Analysis Group, Inc., *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation,* (July 1996), p. 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." Congressional Research Service, "Federal Government Corporations: An Overview," RL30365 (June 8, 2011), 2. https://fas.org/sgp/crs/misc/RL30365.pdf

[244] Booz, Allen, Hamilton, supra.; Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce,* (2015). 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*, (December 2009), p. 3 Veterans Coalition, Inc. Shirlington VA 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." Commission on the Future for America's Veterans, *Preparing for the Next Generation*, supra.

[245] 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. Klemm Analysis Group, Inc., *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation,* (July 1996), p. 23.

[246] 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 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. Klemm Analysis Group, supra.

[247] 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. Klemm Analysis Group, pp. 46, 48.

[248] Booz, Allen, Hamilton, *supra*, p. 59

[249] Id.

that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition."[250]

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[251]making. VHA history shows a connection between longer tenure and transformative accomplishment.[252] 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 years-long focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

VHA needs sustainable transformation that will be complex and take years to implement. To succeed, VHA needs strong 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 both the executive branch and Congress share.

To be effective, a VHA governance model should be empowered with a fiduciary-like board (not subject to FACA) to carry out the following key functions:

- oversee, direct, and make critical decisions (*decide-and-direct authority*) regarding the transformation process
- provide long-term, strategic direction and establish priorities, milestones, and timelines
- review and approve major operational, business, and organizational plans
- set VHA performance objectives
- 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[253] that is

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[250] Id.
[251] Citation needed.
[252] See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).
[253] 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.

independent of department leadership to provide governance, strategic direction, decision-making, and oversight of VHA's operations and transformation,. Collective long-term-focused governance is critically needed. Table XX provides details regarding the board.

Table XX

Detailed Outline for VHA Board of Directors	
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 a large, private, integrated health care system; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, one of each congressional leader's two appointees would be a veteran; one of the appointees of the President would be a veteran who receives VHA care.
Terms	Board members would serve staggered terms of up to 7 years, with the board members electing a chair and vicechair 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.[254]
Funding	Congress would provide a specific budget for the operation of the board as a separate account within the VA's appropriations.
Relationship to the USH	Relationship to the USH: The board would provide the president its recommendation for a VHA chief executive; the president would appoint that executive to a 5-year term; the board would annually review the executive's performance and be empowered to reappoint that official to a second 5-year term.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the USH.
Powers	The board would have the power to do the following: ▪ Direct and exercise decision-making authority regarding the transformation process 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 real property management); strategic and business plans; and goals and metrics relative to established priorities. ▪ Oversee and manage capital-asset operations. ▪ Review, approve, and/or amend VHA's budget request, 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.

A. Michael Froomkin: "Reinventing the Government Corporation" Originally published in the Illinois Law Review, 1995 U. Ill. L. Rev. 543, Accessed at http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm

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

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A board structured to provide continuity of membership—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 USH and the process for selecting candidates for that position.[255] VHA, Congress, and the president would be better served by a VHA leader who holds a 5-year term of office, with the board empowered to reappoint that leader to a second 5-year term.

It is important that that officer 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 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.[256]

A board of directors must be tailored to the unique needs of VHA.[257] It should have appropriate expertise and experience to provide strategic guidance and continuity of leadership and possess authority to exercise the powers needed to realize and sustain a VHA transformation.[258]

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 Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with 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 board of directors.
    - 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:

[255] Current law, at 38 U.S.C. § 305, 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.
[256] 38 U.S.C. § 305.
[257] Booz, Allen, Hamilton, supra, 60.
[258] The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

- Amend subsection (a) to provide for the President to appoint the USH to a 5-year term of office.
- Repeal subsection (c) of that section.
- Provide instead for the board to recommend an USH candidate.
- Authorize the board to reappoint [the USH] to a second 5-year term.

VA Administrative Changes

- None required.

Other Departments and Agencies

- None required.

Management

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

Problem

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 programs and activities around a single, benchmarked concept.
- That VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- That VHA establish a transformation office to drive progress of this transformation and report on it to the USH and VHA new board of directors (See governance discussion elsewhere in the final report).

Background

Healthy organizations successfully align, execute, and renew itself through learning and innovation.[259] It is 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.[260] An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication occur helps engage employees and drive organizational performance.[261] Engaged employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.[262]

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.[263] Similarly, high employee engagement is correlated with better staff and customer experiences that include

[259] Scott Keller and Colin Price. June 2011. *Organizational Health: The ultimate competitive advantage*. McKinsey Quarterly http://www.mckinsey.com/insights/organization/organizational_health_the_ultimate_competitive_advantage
[260] http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx
261 Accessed May 13, 2016, https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/ .
[262] 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, White House *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 .
[263] Scott Keller and Colin Price. June 2011. *Organizational Health: The ultimate competitive advantage*. McKinsey Quarterly http://www.mckinsey.com/insights/organization/organizational_health_the_ultimate_competitive_advantage

higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.[264] Companies with engaged employees outperform those without by more than 200 percent.[265] 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.[266]

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.[267] This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.[268] 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.[269] Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.[270] Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.[271] 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.[272] Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive reinforcement or clear feedback on performance.[273] As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive,[274]) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies[275].

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 X, Cultural Transformation Efforts in VA and VHA), but the efforts are not systematic, integrated, or broadly deployed.[276] The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these

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[264] Employee Engagement Handbook: a guide for frontline leaders to measure and drive engagement. MyVA: Putting Veterans First. U.S. Department of Veterans Affairs, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Vol 19, Summer 2013. 4-5, accessed January 25, 2016, www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

[265] Employee Engagement Handbook: a guide for frontline leaders to measure and drive engagement. MyVA: Putting Veterans First. U.S. Department of Veterans Affairs. P4. Ramsel, Dee. December 2015. Improving VHA's Culture. A presentation before the National Leadership Council, Veterans Health Administration. P 7-9. Federal Employee Viewpoint Survey Results: Employees Influencing Change. U.S. Office of Personnel Management Planning and Policy Analysis. WWW.OPM.GOV/FEVS. P6

[266] Ramsel, Dee. December 2015. Improving VHA's Culture. A presentation before the National Leadership Council, Veterans Health Administration, 7-9

[267] The MITRE Corporation, *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.

[268] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 44, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[269]The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 47, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf

[270] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 46, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[271] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 46, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[272] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 49-51, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[273] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 53 and 60, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[274] U.S. Office of Personnel Management Planning and Policy Analysis, *Federal Employee Viewpoint Survey Results: Employees Influencing Change,* accessed May 16, 2016, WWW.OPM.GOV/FEVS. P47

[275] U.S. Office of Personnel Management Planning and Policy Analysis, *Federal Employee Viewpoint Survey Results: Employees Influencing Change,* 51, accessed May 16, 2016, WWW.OPM.GOV/FEVS. P47

[276] Ramsel, Dee. December 2015. *Improving VHA's Culture. A Presentation Before the National Leadership Council*, Veterans Health Administration, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

efforts and has no requirements on the VHACO program offices to participate in the efforts.[277] 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.[278]

Table X - Cultural Transformation Efforts in VA and VHA[279]

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

VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.[280] This cultural transformation needs to occur at all levels of the organization (VA, VHACO, VISN, VAMC, and CBOC). 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

[277] See www.ethics.va.gov/integratedethics/elc.asp; www.qualityandsafety.va.gov/stoptheline/stoptheline.asp; Veterans Health Administration Center for Organizational Development, accessed May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. MyVA, Department of Veterans Affairs, Employee Engagement Handbook: a guide for frontline leaders to measure and drive engagement, September 28, 2015.
[278] Ramsel, Dee. December 2015. Improving VHA's Culture. A presentation before the National Leadership Council, Veterans Health Administration.p13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, 11/20/2015.
[279] Ramsel, Dee. December 2015. Improving VHA's Culture. A presentation before the National Leadership Council, Veterans Health Administration.29-31
[280] 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

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 USH 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 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 their own efforts that are not part of this new model going forward and align their 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 USH 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 at each facility to act as a local champion for cultural transformation 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 doesn't 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 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 thirty six 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 X, Page Y.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the USH with long term responsibility for creating, executing, and tracking the cultural transformation.
- Align front line 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 Agency Administrative Changes

- None required.

Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applies 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 do use is not specific to health care or benchmarked to the private sector. VHA also does not use the 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 the Department, the goal of implementing an effective leadership management system in VHA.
- That VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- That VHA adopt and implement a comprehensive system for leadership development and management.

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.[281]

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.[282] Indeed, the most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.[283] 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.[284] Investing in new supervisors and emerging leaders is critically important because employees report that when they quit a job they leave their supervisors and not their organization.[285] 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.[286]

[281] US Marine Corps Sustaining the Transformation. Foreward. Department of the Navy. Washington, DC. 28 June 1999. MCRP-6-11D http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf
[282] Jim Collins, Good to Great. Chapter on Level 5 Leadership. Fred Kiel, Return on Character.
[283] Deloitte University Press. Global Human Capital Trends 2014: Engaging the 21st Century Workforce. P25 http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf
[284] Deloitte University Press. Global Human Capital Trends 2014: Engaging the 21st Century Workforce. P3 http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf
[285] http://www.forbes.com/sites#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3
[286] Veterans Health Administration VHA Workforce Planning Report 2015. P21-23. http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015 percent20VHA percent20Workforce percent20Report.pdf

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.[287] Staff who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.[288] 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.[289] The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others. [290] An effective leadership system develops leaders at all levels, from front line supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."[291], [292]

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.[293] 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 for future roles.[294] 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

[287] Office of Policy and Evaluation Perspectives, US Merit Systems Protection Board. June 1998. Federal Supervisors and Strategic Human Resources Management. http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT

[288]Office of Policy and Evaluation Perspectives, US Merit Systems Protection Board. June 1998. Federal Supervisors and Strategic Human Resources Management. http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT;. Sherry Heffner, Sean Kennedy, Josh Brand, Peter Walsh. 2011. Develop Your Leaders, Transform Your Organization. Harvard Business Publishing. http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title

[289] Sherry Heffner, Sean Kennedy, Josh Brand, Peter Walsh. 2011. Develop Your Leaders, Transform Your Organization. Harvard Business Publishing.
http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.; Dominique Jones December 7, 2015. Creating and Retaining Great Leaders. http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419 ; Lydia Dishman February 2, 2016. The One Leadership Skill That Impacts Overall Success. Fast Company. http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success

[290] Fred Kiel. April 7, 2015. Return on Character: The Real Reason Leaders and Their Companies Win. Harvard Business Review Press. Lydia Dishman February 2, 2016. The One Leadership Skill That Impacts Overall Success. Fast Company. http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success; Sherry Heffner, Sean Kennedy, Josh Brand, Peter Walsh. 2011. Develop Your Leaders, Transform Your Organization. Harvard Business Publishing.
http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title

[291] Sherry Heffner, Sean Kennedy, Josh Brand, Peter Walsh. 2011. Develop Your Leaders, Transform Your Organization. Harvard Business Publishing.
http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title

[292] U.S. Marine Corps Sustaining the Transformation. Department of the Navy. Washington, DC. 28 June 1999. MCRP-6-11D
http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf

[293] 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.

[294] 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.

and training because the training programs are not coordinated.[295] As a result, VHA does not have a robust pipeline of young leaders ready to take on higher level responsibilities.[296]

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*.

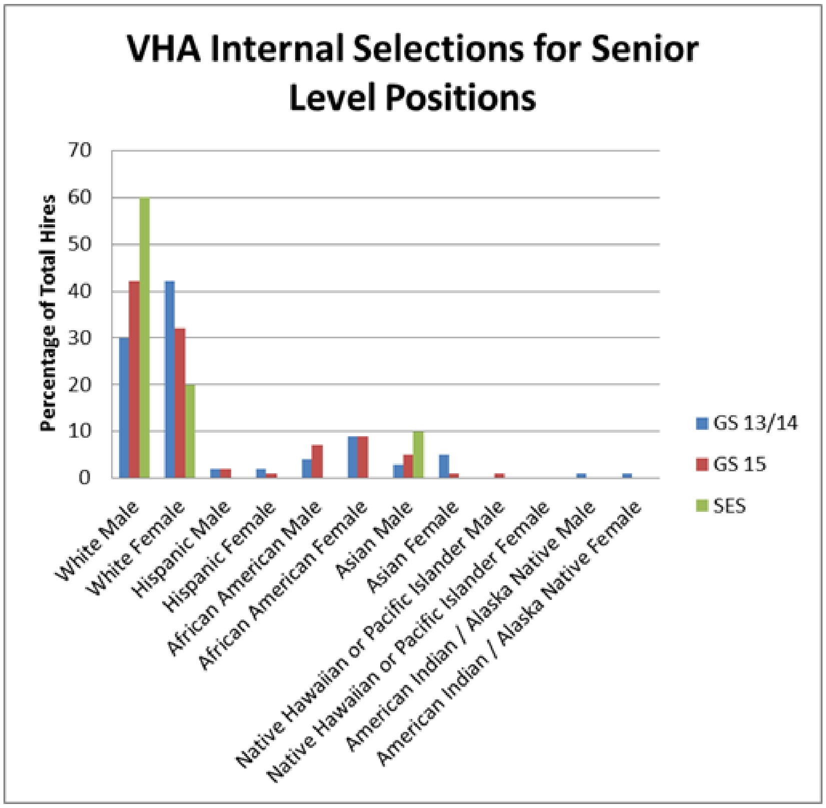
Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.[297] Having a cogent competency model is a prerequisite to a coherent strategy.[298] Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.[299] 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.[300]

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.[301] 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 position requirements, performance management, and training content.[302] The plan mentions

[295] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 38, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[296] 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.
[299] The American College of Healthcare Executives, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. Joint Medical Executive Skills Program, Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. National Center for Healthcare Leadership, accessed May 16, 2016 http://www.nchl.org/static.asp?path=2852,3238.
[299] The American College of Healthcare Executives, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. Joint Medical Executive Skills Program, Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. National Center for Healthcare Leadership, accessed May 16, 2016 http://www.nchl.org/static.asp?path=2852,3238.
[299] The American College of Healthcare Executives, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. Joint Medical Executive Skills Program, Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. National Center for Healthcare Leadership, accessed May 16, 2016 http://www.nchl.org/static.asp?path=2852,3238.
[300] The American College of Healthcare Executives, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. Joint Medical Executive Skills Program, Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. National Center for Healthcare Leadership, accessed May 16, 2016 http://www.nchl.org/static.asp?path=2852,3238.
[307] https://www.shrm.org/publications/hrmagazine/editorialcontent/2015/010215/pages/010215-hiring.aspx accessed April 8, 2016 **PROBLEM WITH FOOTNOTES 414-420. Need to delete them and reinsert, BUT cannot access this URL. Membership to SHRM required.**
[307] https://www.shrm.org/publications/hrmagazine/editorialcontent/2015/010215/pages/010215-hiring.aspx accessed April 8, 2016 **PROBLEM WITH FOOTNOTES 414-420. Need to delete them and reinsert, BUT cannot access this URL. Membership to SHRM required.**

coordination with VA Learning University but provides no detail.[303] 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.[304]

Figure XX



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.[305] As a result, field senior executives may lack extensive outside experience and first-hand knowledge of alternative management methods.[306] Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.[307] 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.[308]

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307 https://www.shrm.org/publications/hrmagazine/editorialcontent/2015/010215/pages/010215-hiring.aspx accessed April 8, 2016 **PROBLEM WITH FOOTNOTES 414-420. Need to delete them and reinsert, BUT cannot access this URL. Membership to SHRM required.**
307 https://www.shrm.org/publications/hrmagazine/editorialcontent/2015/010215/pages/010215-hiring.aspx accessed April 8, 2016 **PROBLEM WITH FOOTNOTES 414-420. Need to delete them and reinsert, BUT cannot access this URL. Membership to SHRM required.**
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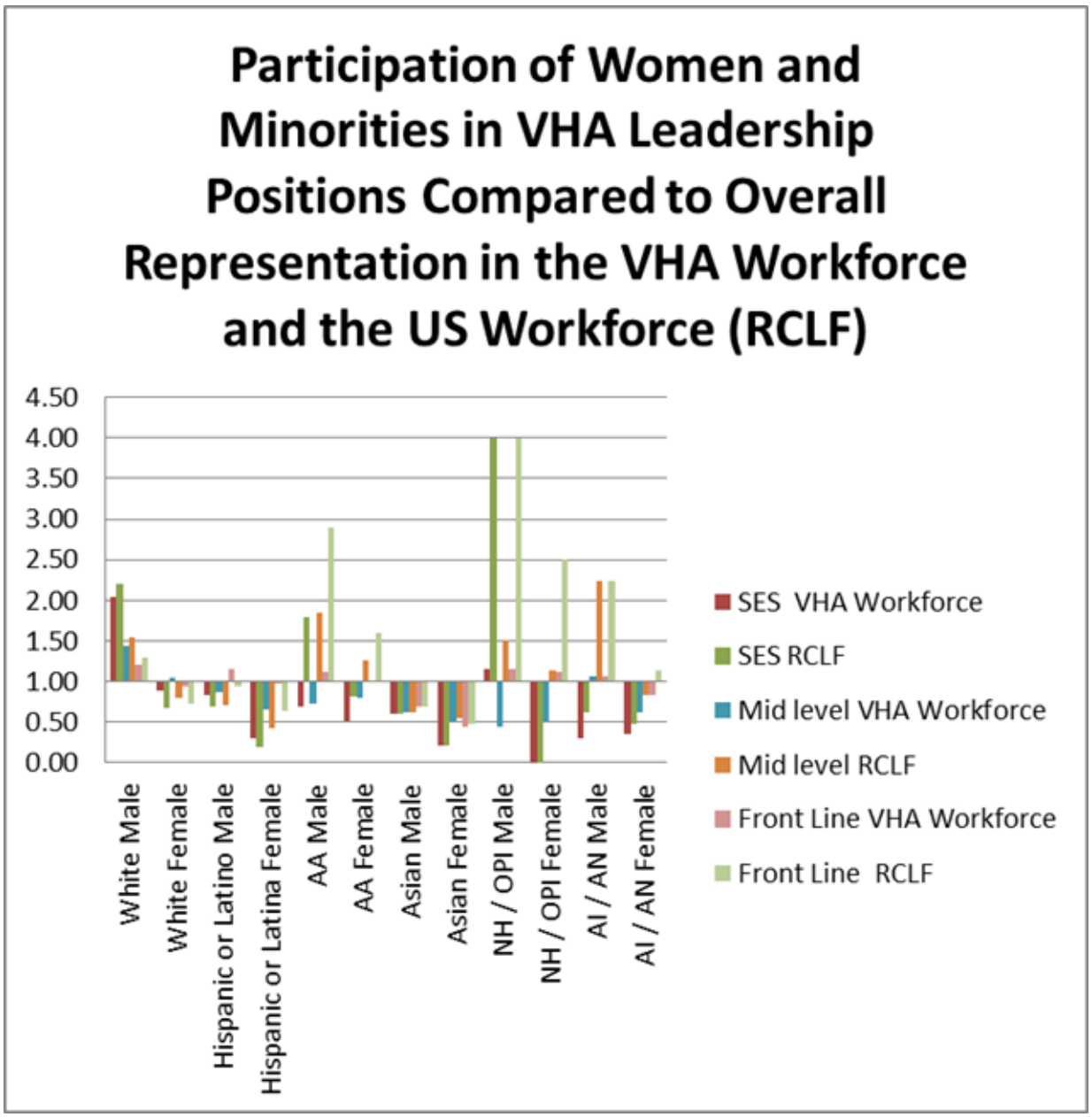
307 https://www.shrm.org/publications/hrmagazine/editorialcontent/2015/010215/pages/010215-hiring.aspx accessed April 8, 2016 **PROBLEM WITH FOOTNOTES 414-420. Need to delete them and reinsert, BUT cannot access this URL. Membership to SHRM required.**
308 Personal communications / public statement of Nancy Schlichting Commission on Care Meeting, March 22, 2016.

Table XXX

	TCF (2015)	GHATP (2014)	Facility LEAD (2015)	VISN/CO LEAD (2015)	HCLDP (2015)	VHA Workforce
White Male	34.82% (78)	30.43% (14)	19.14% (160)	22.04% (69)	41.26% (151)	23.17%
White Female	15.63% (35)	28.26% (13)	40.91% (342)	40.58% (127)	39.34% (144)	36.10%
African American Male	14.73% (33)	8.7% (4)	7.89% (66)	7.67% (24)	3.83% (14)	8.88%
African American Female	18.75% (42)	15.22% (7)	21.53% (180)	15.97% (50)	6.28% (23)	14.92%
Hispanic/Latino Male	4.46% (10)	4.35% (2)	2.75% (23)	3.51% (11)	1.37% (5)	3.10%
Hispanic/Latina Female	3.13% (7)	2.17% (1)	3.47% (29)	3.19% (10)	1.09% (4)	3.74%
Asian Male	4.02% (9)	2.17% (1)	1.08% (9)	0.64% (2)	1.91% (7)	2.93%
Asian Female	2.23% (5)	8.7% (4)	1.91% (16)	4.15% (13)	3.28% (12)	4.92%
Native Hawaiian/Pacific Islander Male	0.00% (0)	0.00% (0)	0.36% (3)	0.00% (0)	0.00% (0)	0.14%
Native Hawaiian/Pacific Islander Female	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.18%
American Indian/Alaska Native Male	1.79% (4)	0.00% (0)	0.12% (1)	0.64% (2)	0.82% (3)	0.55%
American Indian/Alaska Native Female	0.00% (0)	0.00% (0)	0.84% (7)	1.28% (4)	0.82% (3)	0.91%

Figure XXX



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.[309] 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 (SES).[310] Furthermore, white men are allowing minority women to shoulder the relative biggest burden of formal mentoring within the organization.[311] VHA also has the lowest representation

[309] VHA Healthcare Talent Management, Workforce Management & Consulting Office. 2015. VHA Workforce Planning Report 2015. P94
[310] Under Secretary for Health, Veterans Health Administration, Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, November 23, 2015, Attachment A (no page numbers in the report).
[311] Under Secretary for Health, Veterans Health Administration, Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, November 23, 2015, Attachment B (no page numbers in the report).

of veterans among its staff (31 percent) compared to VBA (52 percent) and NCA (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees[312] Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.[313]

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.[314]

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 be confounded to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without a 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 USH 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, the Department of Veterans Affairs 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 must 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 OMB's ongoing review of the department's management objectives. Executive leaders must 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 USH and senior executives must keep in mind that their role is not to manage crises or to oversee a process or to manage up. Rather, their role is to lead their people. Their time and attention must reflect that priority.

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[312] Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

[313] Data provided for employees in VHA as of 9/30/2015. Provided by VHA Health Care Talent Management Office, March 8, 2016.

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Leadership Model

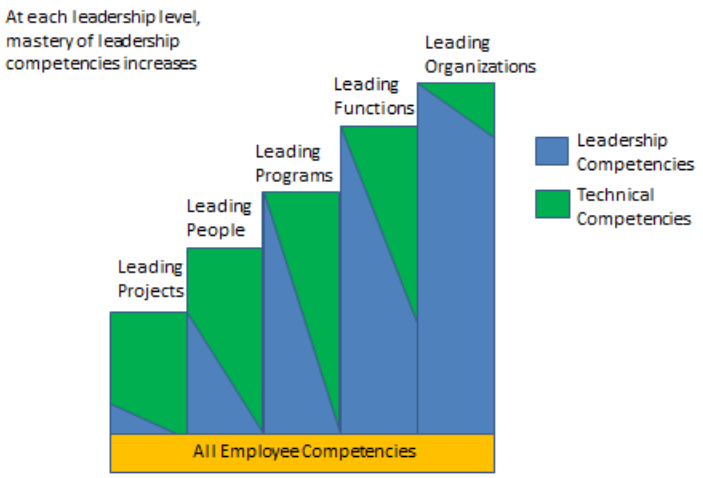
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one, benchmarked health care competency model. Currently, VHA is subject to OPM executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high potential staff to follow and they don't 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 ways of being 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 VHACO program executive should fit into the competency model.
- This 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, a self-assessment, and a supervisory review process. 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 XXX



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 __ for descriptions of such training material.) VHA should look for opportunities to partner with DoD 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 systems of care, 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 establish a masters degree level training program to develop the health care management skills that physician executives require to lead a medical facility. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run this program 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 this program would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for participating.

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. This means 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, this means that 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. 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 pre-certified 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 mid-career 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 mid-career 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. (See Appendix __ for a description of these initiatives.) Finally, the current GHAPT 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 USH and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding process 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 USH 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 VAMC and 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 CMO, 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 GHAPT, MTF, and private-sector fellow pools, clarifying application of merit system principles, including veterans preferences.
- Establish VA-specific veterans preference for recruitment and retention.
- Establish Intergovernmental Personnel Act authority for VHA to include the 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 thirty six 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 X, Page Y.

- Fun and 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 leaders at all levels that re-enforces 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 preferences in executive development.

Other Department and Agency Administrative Changes

- None required.

Transform organizational structures and management processes to promote decision-making at the lowest level of the organization, eliminate waste and redundancy, promote innovation, and foster 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 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 patient driven care.
- That VHA clarify and define the roles and responsibilities of the VISNs, facilities, and re-organized VHA program offices in relation to one another, pushing decision making down to the lowest executive level and ensuring policies, budget, and tools support this change.
- That VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.
- That VHA establish a transformation office, reporting to the USH with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large scale changes outlined throughout this report.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.[315] 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."[316] 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."[317] In an organization the size of VHA, with a budget of $69 billion,[318] more than 300,000 employees, and more than 1,000 sites of care,[319] strong leadership systems are essential.

In the last successful reorganization of VHA in 1995,[320] the organizational design and functional roles of the leadership system were organized into the VISNs, responsible for operations;[321]

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[315] Baldridge Performance Excellence Program. 2015. *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, 50. http://www.nist.gov/baldridge. James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't.* (NY, Harper Collins, 2001) 17-64.
[316] Baldridge Performance Excellence Program. 2015. *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, 50. http://www.nist.gov/baldridge
[317] Baldridge Performance Excellence Program. 2015. *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, 50. http://www.nist.gov/baldridge
[318] Accessed 3/10/2016, http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf
[319] Accessed 2/5/2016, http://www.va.gov/health/aboutVHA.asp
[320] Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berret-Koehler Publishers, Inc., 2012), 54.
[321] 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.

VHACO program offices, responsible for policy, guidelines, and outcomes;[322] the National Leadership Board (made up of VISN directors and all program office leaders), responsible for collective, fact based decision making; the Friday Hotline call to communicate leadership priorities and decisions directly to VAMC leadership; and a negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics[323] supported by centralized functions that benefit from economies of scale.[324] As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.[325] 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."[326] The *Independent Assessment Report* included the following findings about VHA operating model:[327]

- VHACO has grown rapidly since 2009 and fails to coordinate, integrate, or prioritize the policies it directs the VISNs and VAMCs to follow.
- 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 by 21 percent since 2009.[328] The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new offices and new staff infrastructure to support it.[329] 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.

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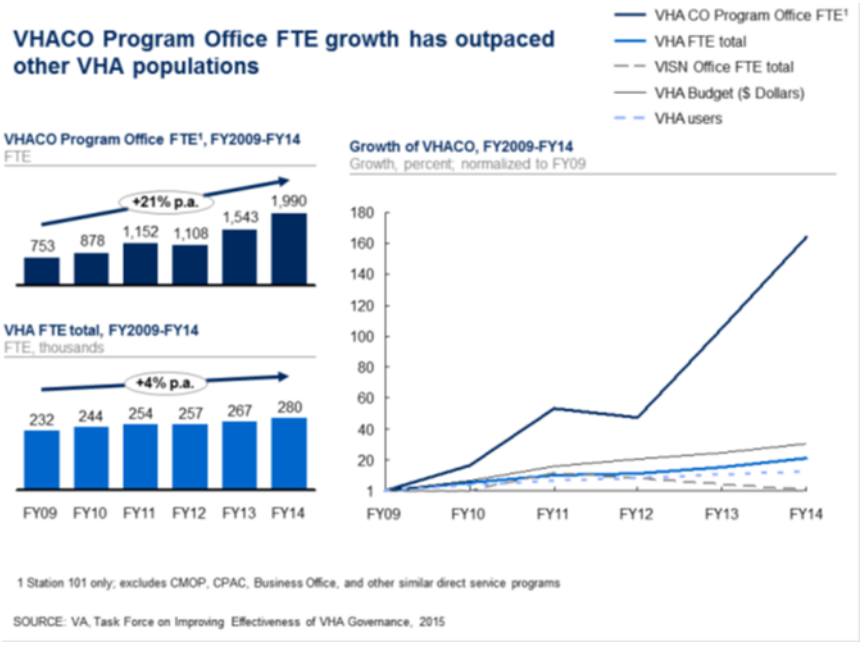
[322] Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 54. Kenneth Kizer and Ashish Jha, "Restoring Trust in VA Health Care,"*New England Journal of Medicine*, 371, (2014): 295-297.
[323] Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72
[324] Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, Vision for Change: A Plan to Restructure the Veterans Health Administration, 1995, 33
[325]Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, Vision for Change: A Plan to Restructure the Veterans Health Administration, 1995, 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. The report has no page numbers. 1996.
[326] 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
[327] 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
[328] 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
[329] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 96-99, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf

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.[330]

Figure XXX – Growth in VHACO Staff[331]



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. [332] In FY2015, specific purpose funds were spread across more than 450 line items,[333] 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. Because VA lacks adequate management systems and data analytic capabilities to track expenditures in real time[334] (and report them to Congress and central office), the only means available to hold the medical centers accountable was to fund the priority initiatives as separate allocations 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

[330] 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.
[331] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 98, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf
[332] 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
[333] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 107, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf
[334] 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

authority, prioritization, and long-term support."[335] VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:[336]

- 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, and where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can 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 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.

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

[336] Baldridge Performance Excellence Program. 2015. *2015-2016 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care).* Gaithersburg, MD: US Department of Commerce, National Institute of Standards and Technology, 50, 34, 7. http://www.nist.gov/baldridge.

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. VISN are critical players in the feedback loop between service delivery and VHACO to identify bad 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 USH 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. Specific-purpose funds must no longer be used to direct obligations at facilities. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by an effective financial management data systems and fully trained staff and leadership who understand how to use such a system.

To support the leaders, program offices, and the field in this transformation, the USH 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 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 USH, 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 USH 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.

Implementation

Legislative Changes

- Gain agreement from Congress for a return to three appropriation lines only: medical care and administration, construction, and research.

VA Administrative Changes

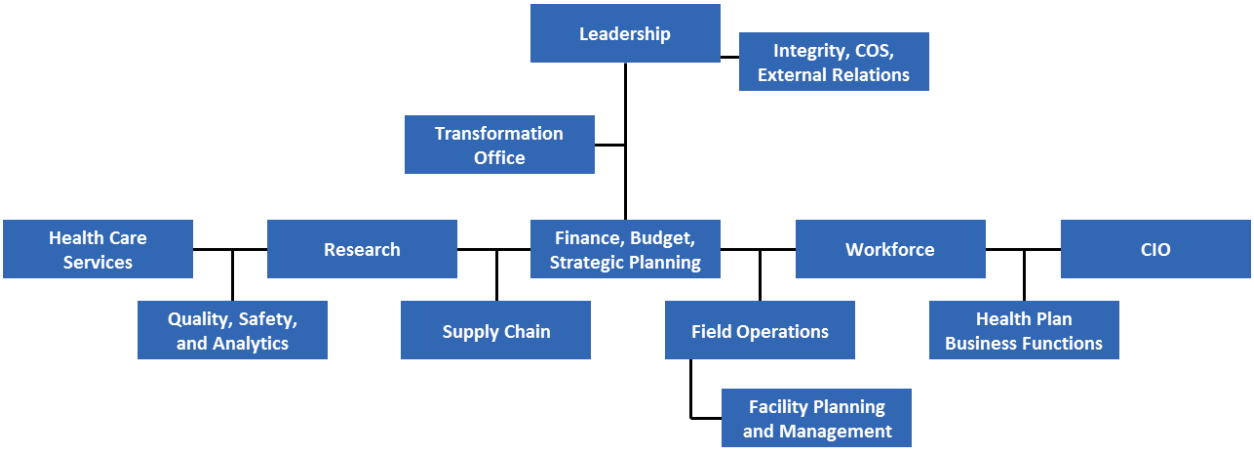
The following administrative changes are a priority over the next thirty six months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix X, Page Y.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure (see org chart, figure xx).
- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- To support clinical delivery, create innovative organizational structures 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.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA.
- 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 Agency Administrative Changes

- None required.

Figure XXX. Proposed VHA Organizational Chart[337]



[337] 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.

Streamline and focus performance measurement in VHA using core metrics that are identical to those used in the private sector and establish a 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 . . .

Organizational Performance Measurement

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

Workforce Performance Management System

- That VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- That the USH and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- That 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.[338] 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.[339] Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support health care delivery and the achievement of action plans.[340] Although there is a relationship

[338] Baldridge Performance Excellence Program. 2015. *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, p16. http://www.nist.gov/baldridge.
[339] Baldridge Performance Excellence Program. 2015. *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, p20. http://www.nist.gov/baldridge.
[340] Baldridge Performance Excellence Program. 2015. *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, p20. http://www.nist.gov/baldridge.

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.[341] 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.[342] ACHE and other leading practitioners[343] 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 management system must also make meaningful distinctions among individuals[344] and promote high performance through rewards, recognition, and incentive practices.[345] 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.[346] 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.[347]

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, including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.[348]

Distinct from performance measurement, the performance management process[349] 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*

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[341] "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.
[342] "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.
[343] "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. NeuroLeadership Institute's "Reengineering Performance Management: How Companies are Evolving Beyond Ratings" webinar, scheduled on January 14th, 12-1, slide # 21 – give slide to Jennifer for records
[344]OPM. Performance Management. Performance Management Cycle. Implementing FCAT-M Performance Management Competencies: Differentiating Performance. https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/
[345] Baldridge Performance Excellence Program. 2015. *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, p20. http://www.nist.gov/baldridge.
[346] Office of Personnel Management. Proficiency Levels for Leadership Competencies. 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
[347] The MITRE Corporation, *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
[348] Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.
[349] The MITRE Corporation, *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.

noted that currently, "Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards."[350] Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,[351] metrics are hard to track in real time and lack the detail required for individual performance assessment,[352]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. [353] The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.[354]

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 work group (absent for a number of years) comprised of leaders from the field and VHACO to provide oversight and direction to the performance measurement process.[355] 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.[356] 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).[357] It is critical that these aspirations become policy.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.[358] 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's) Hospital Compare website.[359] 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,

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[350] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 82, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[351] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 82, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[352] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 84, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[353] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 84, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[354] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 87, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
355 David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).
356 Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.
357 Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.
358 For example, accessed 4/21/2016, https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation
[359] VA Health Care, Quality of Care, Medical Center Performance Search (MCPS), Accessed May 16, 2016, http://www.va.gov/qualityofcare/apps/mcps-app.asp .

surgical complication measures, and health care related infection measures, survey data of patient experiences, and other measures required of hospitals participating in Medicare.[360] Dr. 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."[361]

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.[362] 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. 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.

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,[363] although more streamlined than 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.[364] The commission was informed that Corporate Senior Executive Management Office has implemented a new online performance management data tool that

360 Title XVIII of the Social Security Act 42 U.S.C. 1395 et seq. http://www.va.gov/qualityofcare/apps/mcps-app.asp accessed 4/21/2016.
361 Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014
362Baldridge Performance Excellence Program. 2015. 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, 16, accessed March 1, 2016, http://www.nist.gov/baldridge.
363 Veterans Health Administration, Draft Fiscal Year 2016 Performance Plan Template, Network Directors and Medical Center Director, November 20, 2015.
364 Baldridge Performance Excellence Program. 2015. *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, 20, accessed March 1, 2016, http://www.nist.gov/baldridge.

allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.[365] 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 requires a cohesive, integrated performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes accountability to key organizational outcomes but also assesses organizational and professional objectives. A new performance management system must be free of OPM standards and instead be benchmarked to the private sector[366] and consistent with the new leadership competency model (See page x of this report).Congress required DoD to establish independent standards for the Commanders of Military Treatment Facilities and should consider doing the same for VHA.[367] 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

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[365] The MITRE Corporation, *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.

[366] The American College of Healthcare Executives, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. National Center for Healthcare Leadership, accessed May 16, 2016 http://www.nchl.org/static.asp?path=2852,3238.

[367] 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."

provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The USH must 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.[368] 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 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.

Implementation

Legislative Change

- Obtain legislative relief from the requirement to use the OPM ECQ system of competencies and ratings and tied to new Title 38 pay authority for health care leaders. (See page xxx.)

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 X, Page Y.

- 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.

[368] Toby Cosgrove, statement during Commission on Care public meeting, March 22, 2016.

Cultural Competence and Health Equity

Foster cultural and military competence among VHA leadership, clinicians, staff , and community providers to promote cultural sensitivity, eliminate health care disparities, and improve veteran health outcomes.

This recommendation writeup will be provided in a separate email.

Workforce

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

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.

The Commission Recommends . . .

- That Congress create a new alternative personnel system under Title 38 authority to simplify human capital management in VHA, increase fairness for employees, and improve flexibility to respond to market conditions.
- That 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, non-discrimination, due process) through simplified, sensible processes that work for managers and employees.
  - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
  - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
  - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
  - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
  - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
  - Grandfathers current employees with respect to pay and benefits.
- That VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Background

During the 1990s, Congress passed the Government Performance and Results Act[369] 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,[370] yet one essential component of modernizing the management of federal programs is still missing: reform of human capital management.[371]

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

The Civil Service Act was initially passed in 1883 and revised in 1978.[372] 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."[373] 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.[374]

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."[375] This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.[376] 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.[377] "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."[378]

The Partnership for Public Service is not alone in calling for reform. GAO continues to point to human capital management as a high-risk area across government.[379] The Department of

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[371] United States General Accounting 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. United States General Accounting 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

[372] The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

[373] Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.

[374] Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18. NB: 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.

[375] Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.

[376] Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.

[377] Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.

[378]Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.

[379] U.S. Government Accountability Office, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce US Postal Service and the Census, Committee on Oversight and Government*

Defense (DoD) has proposed walking away from the Title 5 civil service system to support modernization of human capital management,[380] President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service, [381] and Congress is considering whether the time is right for civil service reform.[382]

VHA currently uses four different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and all other employees not part of the other *excepted service* systems (positions and agencies that are not required to use OPM's competitive hiring practices),[383] Title 38 for physician and dentists,[384] Title 38 Hybrid for allied health professionals,[385] and Title 38 7306 for other technical personnel required in the office of the USH.[386] Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.[387] Currently, about two-thirds of VHA employees serve in Title 38/Hybrid occupations.[388]

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 FBI, NIH, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and NASA.[389] In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also enacted 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

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Reform, House of Representatives, Statement of Robert Goldenkoff, GAO-14-723T, Washington, DC, 2014. http://www.gao.gov/assets/670/664772.pdf.

[380] "Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System," Jared Serbu, accessed April 8, 2016, http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/.

[381] "Obama's Budget Touts Progress Within Federal Workforce, but Offers it Nothing New," Eric Katz, 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.

[381] "Brace Yourselves: Congress Preps Civil Service Reform," Andy Medici, accessed April 8, 2016, http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/

[382] "Brace Yourselves: Congress Preps Civil Service Reform," Andy Medici, accessed April 8, 2016, http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/.

[383] Government Organization and Employees, 5 U.S.C.

[384] Subchapter I – Appointments, 38 U.S.C. §§ 7401-7404.

[385] "Master Agreement between the Department of Veterans Affairs and the American Federation of Government Employees: 2011," Department of Veterans Affairs, accessed April 12, 2016, http://www.va.gov/lmr/docs/agreements/afge/master_agreement_between_dva_and_afge-fin_march_2011.pdf.

[386] Administrative Provisions for Section 7405 and 7406 Appointments, 38 U.S.C. § 7307.

[387] "VA Publications," Department of Veterans Affairs, accessed April 12, 2016, http://www1.va.gov/vapubs/search_action.cfm?dType=2.

[388] Joleen Clark, Jack Hetrick, and Donna Schroeder, Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, *Alternative Personnel System* (2014) (unpublished)

[389] U.S. Government Accountability Office, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, http://www.gao.gov/assets/80/79968.pdf.

approach to human resources is a critical organizational priority in 2016.[390] According to a report from Deloitte, "HR is redesigning almost everything it does—from recruiting to performance management to onboarding to reward systems" to learning and development.[391] Younger workers are driving many of these changes with expectations for meaningful work, learning opportunities, and career progression.[392] 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).[393] 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.[394]

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.[395] VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.[396] This problem occurs in the face of acknowledged national shortages of physicians[397] and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.[398] 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.[399] Medical center directors do not receive the support they need from

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[390] "Global Human Capital Trends 2016: The New Organization: Difference by Design," Deloitte University Press, accessed April 12, 2016, http://www2.deloitte.com/us/en/pages/human-capital/articles/introduction-human-capital-trends.html?id=us:2ps:3gl:confidence:eng:cons:111215:em:dup1179:kMa1DIAd:881105247:99897190749:b:Human_Capital_Trends:Human_Capital_Trends_BMM:nb.

[391] "Global Human Capital Trends 2016: The New Organization: Difference by Design," Deloitte University Press, accessed April 12, 2016, http://www2.deloitte.com/us/en/pages/human-capital/articles/introduction-human-capital-trends.html?id=us:2ps:3gl:confidence:eng:cons:111215:em:dup1179:kMa1DIAd:881105247:99897190749:b:Human_Capital_Trends:Human_Capital_Trends_BMM:nb.

[392] "Global Human Capital Trends 2016: The New Organization: Difference by Design," Deloitte University Press, accessed April 12, 2016, http://www2.deloitte.com/us/en/pages/human-capital/articles/introduction-human-capital-trends.html?id=us:2ps:3gl:confidence:eng:cons:111215:em:dup1179:kMa1DIAd:881105247:99897190749:b:Human_Capital_Trends:Human_Capital_Trends_BMM:nb.

[393] Partnership for Public Service, *Building the Enterprise: A New Civil Service* Framework, accessed April 12, 2016, https://ourpublicservice.org/publications/download.php?id=18.

[394] Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015,* 9 and 13.

[395] "VA Struggles to Fill Medical Center Positions in Arizona, Across Nation," Danika Worthington, 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.

[396] Joleen Clark, Jack Hetrick, and Donna Schroeder, Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, *Alternative Personnel System* (2014) (unpublished)

[397] 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.

[398]"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/.

[399] The MITRE Corporation, *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.

HR to accomplish hiring, disciplining, and planning for succession of employees.[400] 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.[401] In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.[402]

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.[403] 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.[404] 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).[405] 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.[406]

The general schedule system has also been identified as a barrier to career advancement.[407] Clerical staff members in particular often cannot advance in pay and responsibility without

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[400] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vii, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf

[401] Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13.

[402] MyVA, Putting Veterans First, MyVA Advisory Committee (MVAC): Meeting #4, February 1-2, 2016, 103.

[403] 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 April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[404] Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014 (unpublished).

[405] Veterans Health Administration Veterans Health Administration Leading Access Scheduling Initiative – People. Assessment of Hiring Barriers. VHA Classification Workgroup. 2014 (unpublished).

[406] The MITRE Corporation, *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.

[407] The MITRE Corporation, *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.
The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 99, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

leaving their positions and moving into a different job series. [408] 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.[409]

The hiring process in VHA is acknowledged to be too long.[410] "HR is expected to fill a position within 60 calendar days… but process requirements, even if perfectly executed, take about 49 to 62 days" Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.[411]

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."[412] 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.[413]

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA's workforce.[414] 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 healthcare organization.*[415]

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[408] "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/.
[409] Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).
[410] 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 April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[411] The MITRE Corporation, *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 .
[412] 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.
[413] 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.
[414] 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 April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[415] Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report* (unpublished). August 2014.

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite 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.[416] 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 by up to $310,000 and on average, $74,631. The only specialties where VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry."[417] 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.[418] 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.[419] VHA can offer up to a maximum of $60,000 for 2 years ($30,000 per year), yet most states offer much more: $80,000 in Arizona and Arkansas, $90,000 in Colorado, $100,000 in Georgia and Alabama, and $190,000 in California.[420]

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 under Title 38. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.[421] Title 38 currently prohibits VA physicians from receiving fee-basis compensation, or overtime, from the same VA in which they are salaried, although they can receive additional pay from another VA facility. These restrictions can make it hard to meet policy requirements for night and weekend schedules[422] without reducing staffing on inpatient

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[416] 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.
[417] 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)*, 40, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.
[418] Increases in Rates of Basic Pay, 38 U.S.C. § 7455.
[419] Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report* (unpublished). August 2014.
[420] "Physician Loan Repayment Guide," Jimmy Karnezis, accessed April 13, 2016, https://www.credible.com/blog/physician-loan-repayment-guide/.
[421] 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.
[422] 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).

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.

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 it is power structure."[423] 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.[424] 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.[425]

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.[426] 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.[427] Currently HR professionals in VA are largely focused on compliance with a complex set of rules[428] 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

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[423]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

[424] Veteran's Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, Presented to the National Leadership Committee March 22, 2016.

[425] MyVA, Putting Veterans First, MyVA Advisory Committee (MVAC): Meeting #4, February 1-2, 2016, 103

[426] [426] 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 April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[427] 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.

[428] 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.

- allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job
- allow flexibility in the processes used to hire staff including direct hiring when needed
- 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, that governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector. (See Appendix E, Summary of Legislative Actions.)
- Update student loan reimbursement limits to be competitive with state programs and establish a median to use in states with no loan repayment program. These amounts

should be considered a maximum, but local recruitment conditions should determine if a lower amount can be used to meet recruitment and retention goals.

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 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 other conditions or requirements on the management of the new alternative personnel system. This includes no limitations on pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

- The Merit System Protection Board should continue to provide access to VHA employees to the appeal process for terminations, but the rules used to adjudicate each case are based on the new regulatory standards established by VHA for the new alternative personnel system.

Require top 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 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 an equal member of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends . . .

- That VHA hire a chief talent manager.
- That VA and VHA prioritize the transformation of human capital management with adequate attention, funding and continuity of vision from executive leaders.
- That VA align HR functions and processes to be consistent with best practice standards of high performing health care systems.

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."[429] Human capital management, although often viewed as a cost, must be viewed as an investment in business success.[430] 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.[431]

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 Veterans." [432] Governance and responsibility for human capital management is fragmented and complicated.[433] Medical center directors appear to be largely on their own in addressing human

[429] United States General Accounting Office, Office of the Comptroller General. Human Capital: A Self Assessment Checklist for Agency Leaders. September 2000, Version 1. GAO/OCG-00-14G. 3.
[430] United States General Accounting Office, Office of the Comptroller General. Human Capital: A Self Assessment Checklist for Agency Leaders. September 2000, Version 1. GAO/OCG-00-14G. 2
[431] United States General Accounting Office. Management of VA: Improved Human Resource Planning Needed to Achieve Goals. March 1993. GAO/HRD-93-10. Executive Summary, accessed March 1, 2016, www.gao.gov/products/HRD-93-10
[432] 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.
[433] 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.

capital management needs, without competent and timely assistance to support disciplinary actions, hiring employees, and planning for succession.[434] Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.[435] 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.[436] Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.[437] Insufficient resources are devoted to training,[438] leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and customer service-focused.[439] 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."[440]

Some progress has been made in updating human capital management functions. The Department of Veterans Affairs is in the process of implementing new talent management software to provide better process management and analytics.[441] HRA has also started a new HR Academy.[442] The academy is intended to demonstrate alignment between training resources and competency requirements[443] and to describe the experience needed to advance to the next position level in human resources.[444] VA also instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of performance outcomes;[445] however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work. [446] Although some new systems have been purchased, life cycle funding for them is not guaranteed by OIT 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

[434] 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.
[435] 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.
[436] 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.
[437] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 61, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[438] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 67, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[439] 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.
[440] 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.
[441] 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.
[442] 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.
[443] Accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUsereIDPChecklist.pdf
[444] Accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.
[445] 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.
[446]The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 24 and 110, accessed January, 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf

initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation. [447]

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 excepted personnel system under Title 38.[448] (See page X.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support human capital management at the department 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.[449]

Top leadership, including the SECVA, DEPSECVA, and USH, 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 USH must hire an executive to lead the human capital management function who has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested or chart – page X)

The SECVA, DEPSECVA, and USH must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have been elicited to inform the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the USH for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

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

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[447] 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

[449] Citation needed

[449] Citation needed

- need for a chief of talent manaement
- 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[450]
- funding and FTEE staffing for human capital functions that meet private-sector benchmark standards for healthcare
- 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

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 processes 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

[450] U.S General Accounting Office, Office of the Comptroller General. Human Capital: A Self Assessment Checklist for Agency Leaders. September 2000, Version 1. GAO/OCG-00-14G., 34

support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VA 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 the GAO is launching a comprehensive audit of human capital management functions in VA[451] to be delivered to Congress in September 2016. The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VA.

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 X, Page Y.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, and 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.
- HRA and OIT 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.
- Develop and implement an effective progressive discipline process for all staffing authorities.

[451]Ms. Frieda Stenzel, lead investigator 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.

CONTRACTING AND SUPPLY CHAIN

Problem

Four major business areas related to contracting are key in providing veterans' health care: establishing contractual relationships with non-VA providers, purchasing supplies and services from vendors, executing contracts for developing and operating IT systems, and building and leasing medical facilities. Because so many varied authorities affect contracting each one of these areas vital to providing quality health care in a timely fashion can be affected. Managing the supply chain is particularly vital in that supply chain management has become a discriminating factor in compairing health care delivery systems. That said, the VHA supply chain has a confusing structure, lacks appropriate leadership, relies on out-of-date technology, is hampered by unnecessary requirements and procedures, and lacks the ability to modernize to maximize cost efficiencies. Without a plan to address contracting and supply chain issues, transforming veterans' health care will be challenging.

Analysis

VHA needs to create a more flexible and responsive approach to business functions if it is to successfully create integrated networks of community providers and to maintain a physical plant appropriate for providing needed service not purchased in the community. To achieve that goal, VHA will need to transform its contracting support and culture across the organization. In addition to addressing broad contracting issues, VHA needs to streamline its supply chain to take advantage of contracts and bulk purchasing of medical supplies and equipment to maximize efficiency and minimize cost, using the pharmacy program as a model supply chain system.

Recommendations

Transform contracting support and culture to create a more flexible and responsive approach to business functions across VHA.

Problem

Like the IT and HR service domains, effective contracting[453] is essential to a successful transformation of the VA health care system. Contracting services supporting VA entail a large, elaborate business domain that touches almost all activities directly or indirectly across VHA. Together, VA and VHA have 28 entities involved in aspects of contracting in some way, which complicates the contracting process unnecessarily.

Background

Although extensive contracting takes place within entities of VHA, the contract entities within VA Central Office (VACO) also play a substantial role on behalf of VHA, especially in IT development and facilities construction.

Figure ____ depicts the organizational framework (as of July, 2015) for contracting activity across VA. There are four contracting entities within VA—the Strategic Acquisition Center (SAC) and the Technology Acquisition Center (TAC) that sit within Office of Administrative Operations (OAO), and the National Acquisition Center (NAC) and Denver Acquisition and Logistics Center (DALC) that sit within the Office Acquisition, Logistics and Construction (OALC). There are 24 contracting entities within VHA for the medical supply chain—21 network contracting offices (NCOs) that establish contracts for each VISN and three service area organizations (SAOs) that establish contracts on behalf of multiple VISNs. The SAOs are geographically aligned to the western, central, and eastern regions of the

The Commission Recommends . . .

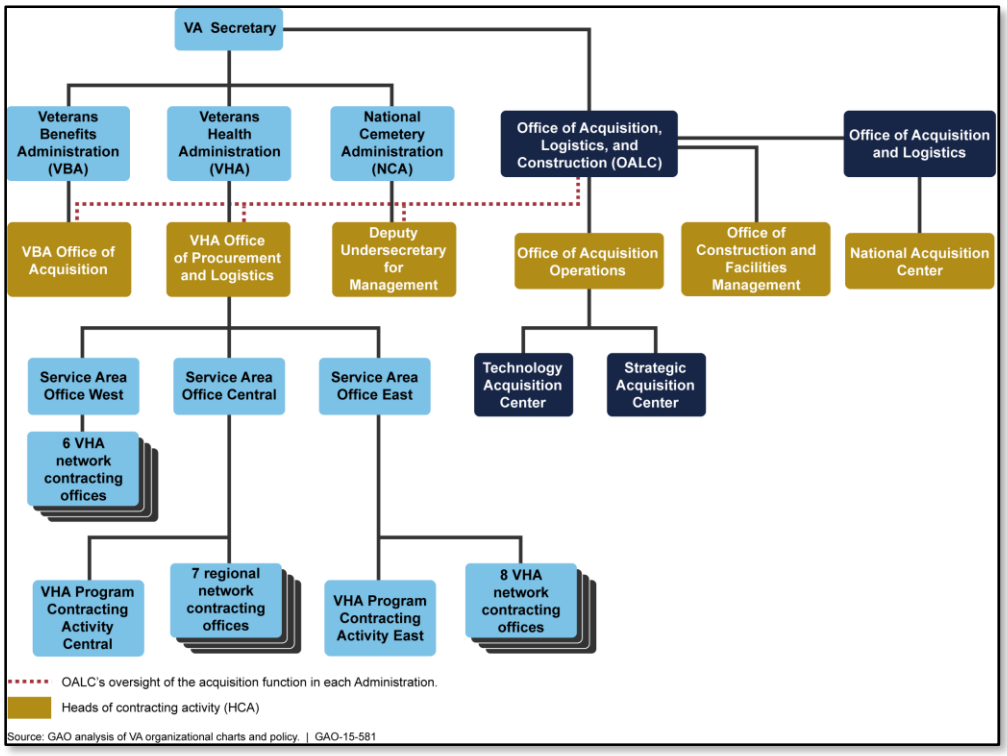
- That Congress establish a single statutory authority to replace conflicting care-contracting requirements before establishing VHA's integrated care networks.
- That VA transform and consolidate its entire medical supply chain organization by consolidating into one integrated supply chain organization that manages all VA contracting and logistical management of clinical supplies and medical devices.
- That VHA establish robust performance management of supply and device procurement that is focused on Veteran outcomes.
- That VHA streamline, standardize, and integrate key supply chain management processes by automating wherever possible, linking inventory management systems to ordering systems, and driving greater use of electronic order entry.
- That VHA expedite product selection and standardization in key categories, rationalize contracting requirements when possible, and provide VAMC-level staff with access to contracting status.
- That VA systematically identify, collect data from, and propagate innovations departmentwide.
- That VA transform the contracting organization to align contracting and contract modification approval processes to a fast-paced environment.[452]
- That VA align the incentives for contractors to improve project management within the bounds of government regulation.
- That VA consider increasing warrants (authority to obligate funds) on site for faster decision making: Increase skill requirements and warrant levels for SREs. Adequately staff projects to ensure contract compliance and rapid response.

[452] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 128, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

[453] The Commission uses the word "contracting" to mean any form of procurement, contracting or purchasing provided in support of veterans health care by VHA.

country.[454] Overall, these 28 entities employ about _____ personnel managing $_____ in contracts annually.[455] [We need some metrics that will give the reader an appreciation for the scale of VA contracting.]

Figure XX. Title



All contracting offices are generally required by VA policy to use the department's electronic contract management system (eCMS) when making awards. Information from this system feeds into the government's federal procurement database. Within VA, eCMS is intended to act as a repository for all contract actions and their supporting documentation, and data are used by VA to provide oversight of its contracting. There are, however, deficiencies in eCMS that hamper effective management and oversight of VA contracting (see p. # for details).

There are four major business areas supported by contracting important to veterans health care:

- establishing contractual relationships between VHA and non-VA providers of health care
- purchasing supplies and services from vendors to support the delivery of health care to veterans

[454] (IA J- pg IX) McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* IX, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[455] Citation needed.

- executing large contracts to facilitate the development and operations of IT systems throughout VHA
- building and leasing medical facilities to serve veterans

The four major business areas listed above each involve major contracting issues in need of substantial reform.[456] What follows are some of the major findings scattered throughout the *Independent Assessment Report* (the 12 volumes) and several GAO and VA OIG reports that address contracting, and major conclusions drawn from those findings, along with a set of key recommendations.

Contracting for Purchased Care

A critical component of efforts to transform health care for enrolled veterans is the expansion of purchased care through integrated community networks of VA and non-VA providers across the nation. Depending on what is included, from 10 to 15 percent of VHA's health care budget is dedicated to purchased care.[457] VHA has embarked on a path that entails greater use of non-VA providers, including a mix of military, other government, university, nonprofit, and for-profit providers.

Although the Commissioners have differing views on the extent of purchased care VHA should undertake, all favor accelerated and broadened purchased care effort using integrated community care networks of VA and non-VA providers.

Regardless of scale, in each instance some form of a contractual agreement must be in place to secure the relationship between VHA (or its third party administrators) and non-VA providers. The Federal Acquisition Regulation (FAR) and the VA Acquisition Regulation (VAAR) provide the foundation for contracting with most providers.

VHA has in place a wide variety of contract vehicles to serve veterans health care needs under multiple purchased care programs. For example, the Patient-Centered Community Care (PC3) program[458] relationships with Health Net and TriWest represent one form of such contracting: large-scale, cost-type contracts with the government contractor as third party administrators (TPAs) to purchase an indefinite amount of care for many veterans on an indefinite delivery

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[456] Contracting issues for IT systems is not addressed in this section, but instead is covered as part of the overall review of IT systems in _____ of the Final Report.

[457] IA C p. A-1 These figures range from $5.6 billion to $8.5 billion in FY 2014. [can we get more recent figures?] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities),* A-1, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

[458] Patient-Centered Community Care (PC3) program and the Veterans Choice Program (VCP) are the two most prominent purchased care programs in place now. Established several years ago, the PC3 program is substantially larger, managing 21.3 million purchased care appointments in FY 2015. In contrast, the VCP established in 2014 created over 3 million authorizations for purchased care over the 12-month span February 1, 2015 through January 31, 2016. Nationally, VA completed more than 57.36 million appointments from March 1, 2015, through February 29, 2016. These statistics are cited in an article in the May 2016 issue of ACCESS, a VHA monthly publication on community care topics. VA Undersecretary for Health, Dr. David Shulkin "*VA's top health care official lists progress made, initiatives to open access to care for Veterans*"

schedule over a period of years. TPAs can use agreements instead of formal contracts with providers who are willing to join the network or provide care on a case-by-case basis.

In September 2013, VA awarded Health Net and TriWest PC3 contracts totaling about $5.1 billion and about $4.4 billion, respectively. VA stated that PC3 contracts would replace costly individual authorizations by standardizing rates through contractual agreements, providing services to veterans when and where they needed them, and ensuring VA received medical documentation of the contracted care.[459]

The contractors had an approximate 7-month implementation period from October 2013 through April 2014 to establish their provider networks in six geographic regions spanning all 21 of VA's VISNs.[460] VHA reports that it has an extensive community provider network of more than 257,000 providers through the PC3 and Choice programs.[461]

Alternatively, a local VA medical center might purchase a specific medical service for a specific veteran at a local non-VA facility via a purchase order under the FAR micropurchase threshold, with very streamlined requirements for making that purchase under FAR.[462] Particularly noteworthy is VAAR Section 873.104, which establishes that contracts for services with provider institutions that are formally affiliated with VA (for example, academic medical centers) may be entered into on a sole-source basis and without publication and written justification requirements.[463]

These contracting alternatives highlight the fact that VA procurement for purchased care is complex. Beyond the technical requirements of FAR and VAAR that contribute to the complexity of purchased care, the multiplicity of VA contractual alternatives adds to the complication. In an effort to simplify and standardize the administration of these programs, VHA has proposed in the FY 2017-18 president's budget submission to consolidate them into a single program and appropriation termed *medical community care*.[464]

An important consideration in expanding purchased care is defining the scope of care that should be provided outside VHA to a veteran who is otherwise qualified. Under the VACAA, an enrolled veteran who qualifies for purchased care (based on distance, wait times, etc.) may seek outside services to complete an episode of care. Evolving clinical practices and standards in the broader health care community are establishing episodes of care as the coherent unit of

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[459] Veterans Administration, Office of Inspector General, Office of Audits and Evaluations, *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy*, September 29, 2015, 15-00718-507, 17.
[460] Veterans Administration, Office of Inspector General, Office of Audits and Evaluations, *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy*, September 29, 2015 15-00718-507, 16.
[461] May 2016 issue of ACCESS, a VHA monthly publication on community care topics. VA Undersecretary for Health, Dr. David Shulkin "*VA's top health care official lists progress made, initiatives to open access to care for Veterans.*"
[462] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities),* 101, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.
[463] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities),* 100, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.
[464] For an explanation of VA's proposed consolidation see: Department of Veterans Affairs, Volume II Medical Programs and Information Technology Programs, Congressional Submission, FY 2017 Funding and FY 2018 Advance Appropriations, 165-170.

care for treating patients. These episodes are typically comprised of diagnosis-related groups (DRGs)[465] that make up the *products* that providers use to seek reimbursement for care delivered. As the health care marketplace matures, future contracting may use well-defined episode-of-care standards, along with bundled payment arrangements and associated performance measures. VHA has begun to explore this approach, but the current contract vehicles remain largely fee-for-service arrangements paying non-VA providers based on transaction volume using Medicare rates (sometimes with discounts or premiums to these rates).

Analysis

The findings identified in this section are organized around the four major business areas that are supported in some manner by contracting services. There are instances in which similar findings occur in two or more business areas. Where practical, these overlapping findings share a common conclusion and recommendation covered in the next two sections.

Crosscutting Findings

The *Independent Assessment Report's* analysis showed that there are several areas of overlap between VA and VHA overall, between national and regional contracting organizations, and between the four VA-level contracting organizations, particularly the NAC and SAC. Senior leaders in VA's and VHA's supply chain organizations who were interviewed unanimously said that the current organizational structure is too complex and should be simplified. Several interviewees described tension among some of the groups involved in supply chain management. Others described a vacuum of ownership and accountability because of the organization's siloed and fragmented structure as well as lack of clarity on roles and responsibilities.[466] The various GAO, VA OIG, and the independent assessment reports the Commission examined make frequent reference to the overly complex organizational structure of contracting in VA and VHA, noting that this structure impedes rapid, effective decision making and diffuses responsibility. Whether valid or not, business units across VHA prefer to avoid engaging the various responsible contracting entities because of their reputation as overly complex and slow to respond.

eCMS is a critical IT system that documents and tracks contracting activity across VA. The VA inspector general has found serious problems with the completeness of documentation in eCMS. Its 2014 report indicated that contracting officers did not consistently include a complete history of contract actions in eCMS. These findings echoed those in an earlier, 2009 report, which indicted that eCMS was not used effectively and that procurement information was

[465] Diagnosis-related group (DRG) is a system to classify hospital cases into one of originally 467 groups that represent the "products" that a hospital provides. One example of a "product" is an appendectomy. The system was developed in anticipation of convincing Congress to use it for reimbursement, to replace "cost based" reimbursement that had been used up to that point. DRGs may be further grouped into Major Diagnostic Categories (MDCs). DRGs are also standard practice for establishing reimbursements for other Medicare related reimbursements such as to home healthcare providers. For more details on the origins of the DRG system, see: John S. Hughes, Jeffrey Lichtenstein, and Robert B. Fetter, *Procedure codes: Potential modifiers of diagnosis-related groups.* Health Care Financing Review/Fall 1990/Votume ll. Number 1. Accessed June 1, 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191135dl.pdf

[466] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* IX, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

incomplete. In that report, the inspector general recommended that VA implement an oversight program to ensure that all procurement actions were recorded in eCMS. In response to prior inspector general findings, VA has committed to making guidance, training, and system changes to improve eCMS.[467]

Another area that affects the process for awarding contracts and exercising effective oversight of contractors during the post-award phase is the extent and nature of training VA contracting personnel receive. This area is especially pertinent in contracting for clinical care by non-VA providers. The GAO and the VA OIG have authored several reports examining contractor performance of non-VA providers and foound that inadequate training of contractor personnel, combined with IT systems ill suited to tracking contractor performance, undermine efforts to select and manage non-VA providers of care and the TPA contractors that establish and manage these care networks.[468]

Federal acquisition regulation, quality assurance surveillance plans (QASPs) enable the Government to perform contract quality assurance at such times and places as necessary to determine whether procured supplies or services conform to contract requirements.[469] Too often these QASPs suffer from a lack of data to gauge the performance of contractors in ways that would identify and resolve deficiencies. Moreover, poorly developed and executed QASPs are of little use in deciding on future contract awards for these same contractors.

Contracting for Purchased Care

Interviews with VA officials and experts indicated that contracts that VA negotiates directly with providers (not PC3 or Choice Program agreements) may take months to put in place and therefore reduce VA's ability to respond to local needs in a timely way and discourage non-VA providers from contracting with VA. One VA expert commented:

> *In previous work I've done in interfacing with private facilities who've had to work with VA, a common refrain was that they would rather do the work for free than to deal with the painful VA contracting processes that typically take many months and is very resource intensive; it took more resources to execute a contract than just do the work and take care of the Veterans themselves.*[470]

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[467] Veterans Administration, Office of Inspector General, Office of Audits and Evaluations, Review of Patient-Centered Community Care (PC3) Provider Network Adequacy, September 29, 2015 15-00718-507, 16.
[468] For examples see: GAO-15-581 and GAO-15-654T, and the VA OIG report on PC3 performance. Also VA OIG report on audit of support service contacts in VHA November 19, 2014 12-02576-30
[469] For an assessment of QASP deficiencies in supporting the PC3 contracting efforts see: Veterans Administration, Office of Inspector General, Office of Audits and Evaluations, *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy*, 11, September 29, 2015 15-00718-507.
[470] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* 126, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

As part of VA's FY 2016 president's budget, VA asked Congress for legislative changes to the current contracting rules to streamline the process of purchasing care when other options are not available.[471]

In February 2016, testimony before the House Committee on Veterans Affairs' Subcommittee on Health, a VA OIG official described a series of problems in the execution of the PC3 contracts:

> *In our July 2015, Review of Allegations of Delays in Care Caused by Patient-Centered Community Care (PC3) Issues, we examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling [scheduling without first consulting with the veteran]. We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submit timely authorizations, and Health Net and TriWest schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. The then Interim Under Secretary for Health agreed with our recommendations to ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements.* [472]

In May 2016, the VA OIG issued a report on the PC3 community care program and estimated that of the $3.9 billion expended in FY 2015 on community care, $2.1 billion, or 55 percent, of payments for care from non-VA providers used contracts that were not in compliance with the FAR. In response, VHA noted that efforts were underway to correct deficiencies resulting from noncompliance with the FAR. VHA indicated that it could not invalidate or halt payments under these contracts as doing so would jeopardize the delivery of care to millions of veterans. VHA said a legislative proposal has been submitted for congressional consideration that would allow these VA-initiated Veteran care agreements to authorize non-VA medical services. In October 2015, VHA issued a hierarchy of care memorandum that directed purchased care programs to utilize federal acquisition compliant contracts such as the Choice Program as a top priority.[473]

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[471] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* 126, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

[472] Statement of Gary K. Abe, Deputy Assistant Inspector General, Department of Veterans Affairs before the Subcommittee on Health, Committee on Veterans Affairs, US House of Representatives, "Choice Consolidation: Improving VA Community Care Billing and Reimbursement", February 11, 2016, 1.

[473] VA Office of the Inspector General, Office of Audits and Evaluations, *Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2015*, May 12, 2016, 3. (note: The cover page on the OIG document incorrectly used May 12, 2015. This date was corrected in subsequent pages of the document to May 12, 2016.)

Although VHA PC3 health care service purchases had increased to about $34.1 million by the end of the second quarter of FY 2015, PC3 purchases still constituted less than 5 percent of VHA's approximate $730.4 million non-VA care provider expenditures during this period.[474]

In another report released in November 2015, VA Office of Business Oversight, Management Quality Assurance Service examined a statistically representative sample of 190 non-VA care out-patient claims from among 7,080 payments and estimated that 22 percent of this universe were at risk for improper payments. Payment errors were generally the result of (a) incorrect billed charges, (b) non-receipt of medical documentation, (c) missing veteran VACAA eligibility information, and (d) missing explanation of benefits for non-service-connected care of veterans with other health insurance.[475] The Commission noted that although this is a very small sample with a 25 percent margin of error around the mean payment error estimate (22 percent), the evidence may be symptomatic of a more pervasive and systemic problem in processing payments for non-VA provided care, especially when complex treatment protocols are required over extended periods of time involving multiple providers.

Purchasing Supplies and Services

The performance of VA's contracting organization does not meet customers' expectations, so frontline staff have developed workarounds: Ninety-one of 122 interviewees we spoke to regarding contracting for clinical supplies and medical devices, including contracting leadership, expressed concerns about the proliferation of VA contracting organizations or their ability to collectively meet performance needs of the organization. When the assessment team asked clinicians, logistics staff, and facility administrators to identify three areas they would most like to improve, speed and responsiveness of contracting was almost always one of their recommendations.[476]

As a result of the ongoing contracting challenges, frontline staff members reported they had developed two interrelated workarounds to avoid using contracting. First, they try to buy the majority of their clinical supplies and devices on VA-issued purchase cards because doing so gives them more autonomy to choose the products they want and to buy through their preferred channel (for example, directly from a manufacturer or through a local distributor). Second, they try to ensure that any orders placed (regardless of payment mechanism) are below the $3,000 micropurchase threshold that would trigger involvement of contracting. As a result, approximately 98 percent of VA's purchases of clinical supplies are made on purchase cards, which accounts for around 75 percent of VA's spend on that category.[477] Ninety-seven percent of VA's clinical supplies and prosthetics purchase orders are below $3,000, although this only

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[474] Veterans Administration, Office of Inspector General, Office of Audits and Evaluations, *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy*, September 29, 2015 15-00718-507, 11.
[475] Purchased Care Review: Nationwide Review of Veterans Access, Choice, and Accountability Act Payments. Department of Veterans Affairs, Office of Business Oversight, Management Quality Assurance Service 15-04-PCD-SP-002 Report Issue Date: November 12, 2015.
[476] 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.
[477] VA Congressional budget submission. Volume II - Medical programs and information technology programs. (VA, FY2014a).

accounts for 59 percent of the total spend for those categories.[478] Data also confirmed that a disproportionately high number (two to three times the expected number) of purchase orders for clinical supplies are within $500 of the micro-purchase threshold ($2,500 to 3,000).[479]

Use of purchase cards is encouraged in Federal Acquisition Regulations (FAR), partly because their use reduces the need for contracting to make multiple small-value awards. Their use limits VA's ability to ensure compliance with government contracting regulations, however, because purchase card holders are responsible for identifying appropriately priced goods and contracted vendors, and VA's current systems do not support these tasks with integrated catalogs and controls. This practice likely leads to higher-than-necessary prices paid for goods.[480]

Purchase card purchasing processes are also inefficient when compared with modern alternatives, such as electronic order transmission and funds transfer. Purchase card holders are required to maintain appropriate documentation and to reconcile purchases. Electronic ordering and payment can automate reconciliations, reduce errors, and also enable automatic reordering based on utilization forecasting. [481]

The *Independent Assessment Report* analysis 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 receive the first response from contracting requesting, for example, additional information or paperwork.[482]

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes regarding ordering 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 was also indicated by providers as an issue pertaining to equipment availability.[483]

VHA customer surveys show that communication from contracting is another area for improvement. Of all the dimensions assessed in surveys of contracting users (included on all

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[478] VA Congressional budget submission. Volume II - Medical programs and information technology programs. (VA, FY2014a); and *Pending wait time using create date for new patients and desired date for established patients.* Retrieved June 8, 2015, from http://www.va.gov./health/docs/pending_access_data_using_cd_and_dd_11202014.pdf (VA, FY2014c).
[479] VA Congressional budget submission. Volume II - Medical programs and information technology programs. (VA, FY 2014a).
[480] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* XI, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[481] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* XI, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[482] 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.
[483] 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.

email communications by contracting), communication received from contracting officials scored lowest by customers (3.3 average NCO score out of 5, ranging from 2.7 to 4.0 for overall communication effectiveness and 2.8 to 3.8 for status updates).[484] Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care. [485]

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.[486]

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.[487] Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.[488]

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VA's supply purchasing systems are not integrated 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, VA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not

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[484] 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.

[485] 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.

[486] (VHA Assistant Deputy Under Secretary for Health Administrative Operations, 2014) 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.

[487] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* XII, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

[488] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* XII, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.[489]

VA's fragmented inventory management systems and processes also create challenges. VA's current inventory management does not have a feedback loop that links inventory to product utilization, contracting, ordering, and vice versa. This lacking information prevents optimal utilization of the medical/surgical prime vendor (MSPV) 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.[490]

There are pockets of good performance and innovation in VA that could be replicated across its supply chain: the *Independent Assessment Report* noted that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VA'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 VA.[491]

Additionally, contracting and other supporting entities should be accountable and equipped to support a fast-paced project environment and facilitate the needs of construction projects and leases.[492]

Contracting to Build, Renovate, and Lease Medical Facilities

The *Independent Assessment Report* indicated that VA leasing contracts are typically favorable to VA, but are often not enforced**. A**lthough VA does an excellent job negotiating tenant-favorable terms while typically remaining within benchmark rental rates, these favorable terms are often not enforced. When VHA staff identify concerns about the quality of a facility, contracting staff may not enforce these terms with lessors, given skill and capacity constraints.[493]

Given the varied reporting structures, there are different views in the organization on who is the overall project owner (for example, project manager, senior resident engineer, contracting officer) and who is accountable in the different project phases (for example, design, construction, activation). Based on CFM manuals, project managers are effectively responsible

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[489] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* XII, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[490] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* XII, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[491] 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 June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[492] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* VIII, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[493] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 161, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

for overall project goals; however, they lack formal authority over the other key figures in project teams (for example, resident engineers and contracting officers) and, according to interviews, they do not feel empowered for fast and effective decision making.[494]

With respect to facilities renovation and construction, the *Independent Assessment Report* indicated there are not consistent staffing guidelines for major projects that consider size or complexity of projects. There is not a clear policy that sets project staffing guidelines for major projects. Currently, there is not visibility on how critical project factors such as volume or project technical complexity are factored in to design project teams. It has also been shared during VA stakeholder and expert interviews that VA project staffing levels are substantially below other major agencies' (such as USACE, NAVFAC), especially in the resident engineer and contracting side. In some projects, the relationship of construction and facilities maintenance (CFM) staff to contractor is greater than 1:10, and project managers could oversee portfolios of approximately $1 billion. This situation limits the ability of CFM staff to address all issues identified in the field, thereby impacting project execution timelines.[495]

The contracting organizations are overwhelmed and burdened by complex approvals and struggle to effectively manage construction and leasing contracts. Interactions between the contracting organizations and their customers (for example, VAMCs) are reported as ineffective by both parties.[496] CFM contracting officers (COs) manage contracts for major construction and leases, and all other construction, leasing, and maintenance contracts are executed by VHA network contract offices (NCOs) which are aligned with, but do not report to, VISNs. Both of these organizations face challenges, including heavy workload, a lack of training for the complexities of construction and leasing contracts, and lack of integrated involvement of the contractor and customer throughout the process. Some interviewees cited that COs cover double the contract volume as counterparts in the government, have not been effectively trained to cover the complexities of construction and leasing contracts, and due to the low approval authority given to most COs must pass leases through high levels of oversight that delay programs.[497]

The *Independent Assessment Report* did highlight some promising initiatives that could serve as best practices across VHA in renovation and construction contracting:

- Alabama VAMC: The local team created an online tracker system with electronic signatures to monitor different approvals and contributions to requests for information (RFIs) and contracting packages. The system allowed the organization to have visibility

[494] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 119, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[495] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 119, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[496] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 21, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[497] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 21, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

on bottlenecks and have performance dialogues on how to optimize response times and time to approvals.[498]

- VISN 4: This VISN takes a long-term strategic approach to the implementation of its nonrecurring maintenance (NRM) program by using a rolling plan to strategically prioritize projects VISN-wide across fiscal years. With this system, the capital team can develop contracting packages in advance of the next fiscal year, using the historical funding levels to predict the volume of projects that will be funded in the coming fiscal year. This practice enables projects to be ready for award during the first quarter of the fiscal year, increasing the likelihood that projects will be completed as scheduled. As a result, VISN 4 is a leader in the amount of funds obligated for NRM projects, though it should be noted that this has not improved the VISN's construction execution timelines.[499]

In contracting, compliance often trumps performance. Successful compliance does not always lead to successful outcomes. Effective performance often takes a back seat to compliance with the terms and conditions established in the contract.

VA/VHA lacks integrated support services teams comprised of multiple functions (IT, contracting, HR, etc.) focused on the same outcomes. Each function has its own reporting chain with too few opportunities to engage in cross-functional decision-making and performance assessment. Contracting processes are bureaucratic and slow, which can delay veterans' access to care. Purchasing processes are cumbersome, which has driven VHA staff to workarounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given lack of data, which likely leads to avoidable expense for the VA.[500]

The IT systems that support virtually all facets of contracting lack interchanges that allow data in one system to be passed to others for efficient monitoring of contractor performance and accurate payments for services provided.

Training across the contracting domain is often lacking or misguided to serve the needs of personnel responsible to competing, selecting, and monitoring contractor performance.

Implementation

Legislative Changes

- Establish a single statutory authority to replace conflicting care-contracting requirements as a prerequisite to establishing VHA's integrated care networks. Congress should establish a single statutory framework that enables VHA to create provider

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[498] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 140, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[499] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 140, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[500] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* V, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

networks and replace current contract-care authorities to bring the salient features of VHA's existing purchased-care programs—the traditional program, PC3, Access Received Closer To Home (Project ARCH) pilot, and the Choice Program—into a single program.

VA Administrative Changes

- Transformand consolidate its entire medical supply chain organization by consolidating into one integrated supply chain organization that manages all VA contracting and logistical management of clinical supplies and medical devices.

- Establish robust performance management of supply and device procurement that is focused on veteran outcomes.

- Streamline, standardize, and integrate key supply chain management processes by automating wherever possible, linking inventory management systems to ordering systems, and driving greater use of electronic order entry.

- Expedite product selection and standardization in key categories, rationalize contracting requirements when possible, and provide VAMC-level staff with access to contracting status.

- Systematically identify, collect data from, and propagate innovations across the organization.

- Transform the contracting organization to align contracting and contract modifications approvals processes to a fast-paced environment.[501] This would include conducting an effort to map and streamline major processes and systems within the contracting organization (for example, approval processes for contract modifications, response for RFIs) to increase agility of the decision-making process and alleviate current workload levels.

- Align the incentives for contractors to improve project management within the bounds of government regulation. Contracts will need to be enhanced to align incentives for shared benefit to VA and VA's contractors when capabilities are delivered ahead of schedule, and under cost. Alternatively, VA contracts may need to be more flexible if capabilities need to be extended either beyond the original period of performance or via increased mission scope based on positive user feedback.[502]

- Consider increasing warrants (authority to obligate funds) on site for faster decision making: Increase skill requirements and warrant levels for SREs. For example, other

[501] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 128, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.
[502] 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-14, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

delivery organizations required all SREs to have professional engineering licenses and Level 2 contracting warrant to reduce workload for contracting officers.

- Adequately staff projects to ensure contract compliance and rapid response.

Other Department and Agency Administrative Changes

- None required.

Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive discriminator 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 Supply Chain Chief Operating Officer (COO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- That VA and VHA re-organize all procurement and logistics operations for VHA under the Supply Chain COO 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 which includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- That 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 healthcare.
- That 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.

Background

Health syustems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize savings, while maintaining quality services.[503] This effort includes examining the supply chain for ways to save money.[504] 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.[505] 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 from the tens to hundreds of millions of dollars.[506] 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.[507]

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[503] 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.

[504] "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/.

[505] 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.

[506] "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.

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.[508] 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.[509]

VHA has a successful internal model of aggressive supply chain management tht 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 manage pharmaceutical supplies, logistics, and prescribing.[510] 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.[511] 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, VISN-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.[512] PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical

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"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.

[507] 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.

[508] "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.

[509] "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.

[510] 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.

[511] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 20, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

[512] VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

leaders across the system are helping drive PBM policy and practices.[513] As a result, 90 percent of purchases are acquired through Pharmaceutical Prime Vendor contracts. [514]

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).[515] The use of the 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.[516] Eighty percent of prescriptions in VHA are filled through the CMOP,[517] which has been recognized by JD Power and Associates 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 Script and Walgreens on line.[518] Customer service, veteran satisfaction, and patient safety delivered through team based care are a hallmark of the mission of PBM,[519] and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

Analysis

There is disparity in quality between VHA's supply chain for clinical supplies, medical devices and related services as 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."*[520]

The problems are systemic. The organizational structure is chaotic, contracting operations aren't aligned to business functions, and processes are poorly constructed, lacking

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[513] 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.
[514] 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.
[515] 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.
[516] "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.
[517] 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.
[518] "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.
[519] "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/index.asp.
[520] 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.

standardization across the organization. Information technology infrastructure is inadequate and it lacks appropriate interoperability between IT systems. Finally, VHA is unable to produce high-quality data on supply chain utilization and doesn't effectively manage the process using the insights such data could provide.[521]

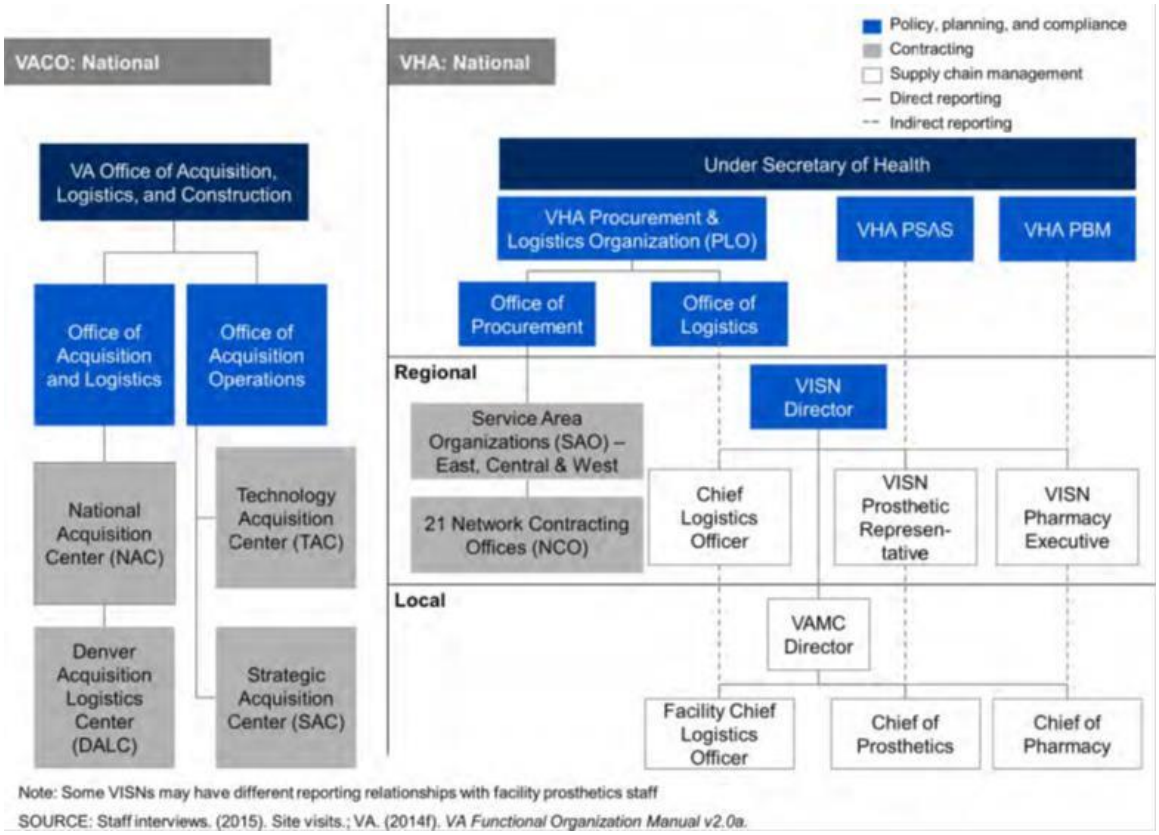
Leadership and Organizational Structure and Function

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 Supply Chain COO, and personnel are aligned along product categories to develop and utilize deep expertise in the products and suppliers they manage.[522] In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.[523] 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).[524] Procurement personnel within VHA's regional contracting and 19 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.[525] To further complicate the management picture, clinical supplies are managed by the logistics organization while medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)[526] (See figure X). In most health care organizations, the Supply Chain COO and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.[527] 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,

[521] 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.
[522] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 57-58, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[523] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* ix, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[524] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 96-97, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[525] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 47-50, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[526] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 58, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[527] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 58, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

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."[528]

Figure XO. Title.[529]



The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Front line staff members indicate the time it takes to procure simple items through contracting (one to three 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.[530] 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, [531] findings borne out by low customer satisfaction scores given to these organizations.[532]

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[528] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 55, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[529] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 49, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[530] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 67, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[531] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 68, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

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 complicated, bureaucratic system filled with redundancies.[533] These broken processes serve as a precursor for catastrophic systems failures.[534]

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA Supply Chain Chief Operating Officer (COO), 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 COO 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 Supply Chain COO 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."[535] VHA did not have a means to determine what supplies should be standardized and no feedback loop to administrators and staff to assess whether standards were being used when they did exist.[536] As a result, limited product standardization has been achieved across VHA. This, despite VHA establishment of national Standardization User Groups in 2001 responsible for identifying items for standardization based on national procurement data.[537] To date, however, national product standardization has been achieved in only a limited number of categories.[538] 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

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[532] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[533] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 47-50, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[534] Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.
[535] 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.
[536] 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.
[537] VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.
[538] 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.

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."[539] Under this 2011 policy, the establishment of VISN oversight committees was also required in order to provide accountability and feedback to the local committees, but these were apparently never established.[540]

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), has begun to make progress on clinician alignment to accomplish value based purchasing decisions on medical and surgical supplies. The 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. [541]

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. The VERC has started this process, however, they require further funding and leadership support to fully implement a clinician driven sourcing process. Current and future leaders of VA and VHA must ensure that the VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from the VHA Supply Chain COO.

Information Technology, Data Standards, and Analytics

VHA "current information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing are major impediments to effective supply chain management."[542] 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.[543] "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

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[539] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 82, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[540] 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.
[541] Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.
[542] 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.
[543] 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.

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."[544]

The VERC is working on reducing the more than 130 versions of VISTA in place across the country so that the same data sets can be tracked and reported.[545] Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names 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.[546]

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 can't occur without a seamless information technology infrastructure. With a current IT system where 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 the VHA Supply Chain COO with support from the VERC, must be fully integrated with planning and procurement within OIT and fully financed to accomplish these important goals.

Policy and Procedures

Ninety eight percent of all clinical supplies are acquired using purchase cards[547] and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.[548] This isn't a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete [549] However, 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.[550] It can also be illegal, as the use of purchase card often means orders must be split to remain under the $3,000 purchase

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[544] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 60, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[545] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 60, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[546] Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.
[547] 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.
[548] 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.
[549] 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 December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[550] 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.

card limit.[551] 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.[552] Indeed, the private sector trend in healthcare has been for hospitals and health care systems to form alliances in "group purchasing organizations" to achieve the scale that VHA naturally enjoys.[553]Weaknesses in logistic management have been recognized in VHA for some time and still remain.[554] For instance, a review of logistics business practices at seventeen VHA medical facilities in 2014 found that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of non-compliance ranged from 53-88 percent depending on the business metrics examined.[555]

Finally, VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the government wide regulations to promote simplified purchasing procedures.[556]

The 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) 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.[557] 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.[558] As of April 2016, an estimated $24.4 million in supply chain costs had already been avoided since January..[559]

The establishment of a new medical/surgical prime vendor 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. But in order 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 re-worked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the

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[551] 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.
[552] 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.
[553] 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.
[554] 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.
[555] U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.
[556] Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.
[557] Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.
[558] Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.
[559] Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

organization. Finally each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the 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 the VHA Supply Chain COO.

Talent Management

VA is unable to hire good talent to manage its supply chain: in 2014, 20-30 percent of logistics positions were unfilled, and 20 percent of medical supply aid jobs were vacant.[560] The causes were identified as lengthy time to hire, no internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.[561] Examples of recent downgrades include Supply Technician, Mail Manager, Administrative Officer, and Materials Handler.[562] "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 VA's recruitment and retention challenges."[563]

To begin to address talent management issues, the 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."[564] The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.[565]

As noted elsewhere in this report, the application of the more than sixty-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery organization. Health care supply chain management is a recognized field of study and

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[560] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* xiii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[561] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* xiii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[562] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 87, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[563] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 88, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[564] "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, http://www.acquisitionacademy.va.gov/schools/scm/message.asp.
[565] "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.

a valued component of the leadership teams of the highest performing health care organizations. In order for VHA to compete for top leadership talent in this field and front line staff, logistics and procurement personnel must be included in the new excepted personnel system we envision to be developed under Title 38 for VHA.

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, the VHA Supply Chain Chief Operating Officer (COO), 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 the VHA Supply Chain COO and with support from the VERC.

- Reconcile the VAAR with the 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 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.

ELIGIBILITY

Problem

Once former service members are determined to have veteran status, the primary driver in determining who receives health care services is priority groupings. As VHA works to improve access, choice, and quality through integrated community networks, it is likely that more veterans will want to receive at least some of their health care from the VHA system. Because increased use will necessarily mean increased cost, VHA will have to consider various mechanisms that can be used to control costs and keep the system sustainable.

Analysis

Although VHA must maintain its commitment to making the health care of veterans with service-connected disabilities and financial difficulties its top priority, eligibility is one of the key mechansisms that can be adjusted to control cost. Congress has not reevalutated the eligibility system in several decades, and much has changed in both veterans' health care and health care in general in that time. The Commission recommends that Congress appoint a body to deeply examine the eligibility system and consider what changes can and should be made to reflect the current and projected future state of health care and how changes to eligilbility might factor in to creating a system that is both more veteran-centric and sustainable. There are two eligibility issues that should be addressed independent of such a working group.

For some former service members who fall in the category of other-than-honorable (OTH) discharge (and therefore are not considered veterans), there may be cause to provide them veterans status, at least for health care. VHA should investigate the possibility of providing access to VHA health care for those OTH former service members who meet certain criteria and likely were discharged because of behaviors prompted or exacerbated by service-rated incidents.

One way to offset increased costs of providing greater access and choice is creating new revenue streams. There is already a history within VHA of serving certain nonveterans (i.e., certain family members of veterans). VHA should use pilot programs to evaluate the feasibility of expanding its provision of nonveteran care as a tool for increasing its workload in areas where that is needed and a mechanism for generating direct income.

Addressing these eligibility-related recommendations should allow VHA to provide quality care to those who deserve and need it most, while creating a strong foundation for long-term sustainability.

Recommendations

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

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.

The Commission Recommends . . .

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

Individuals who are dismissed from military services with an other-than-honorable discharge, in some cases, may be dismissed because of actions that resulted from health conditions (such as TBI, PTSD, or substance use) caused by or exasserbated by their service. By current 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-connected 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,[566] 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.[567] The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), other-than-honorable (OTH), bad conduct (adjudicated by a general court or special court-martial), and dishonorable.[568]

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.[569] VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to include service members who receive an OTH discharge as a result of any of the following conditions: (1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or spying, (3) an offense involving moral turpitude,

[566] 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.
[567] Veterans Benefits, 38 U.S.C. § 101(2).
[568] 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.
[569] Certain Bars to Benefits, 38 U.S.C. § 5303(a).

(4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.[570]

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.[571] Benefits may be granted based on a prior period of other than dishonorable service for individuals with two or more periods of service.[572]

Former service members with OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.[573] 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; however, VA regulation bars the individual from receiving benefits.[574]

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments where 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.[575]

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.[576] Many have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.[577] 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

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[570] Characters of Discharge, 38 C.F.R. 3.12(d).
[571] Certain Bars to Benefits, 38 U.S.C. § 5303(b).
[572] 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.
[573] Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).
[574] Certain Bars to Benefits, 38 U.S.C. § 5303(a).
Characters of Discharge, 38 C.F.R. 3.12(d).
[575] 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, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[576] 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): 13, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[577] 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): 13, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

"moral turpitude,"[578] and "willful and persistent misconduct."[579] Neither of those two regulatory terms, which originated in 1944,[580] is defined; neither provides criteria or examples of what is or is not covered. Both are ambiguous and susceptible of subjective judgment,[581] with great potential for different VA regional offices reaching different outcomes on the same facts.[582] VA officials have acknowledged that these terms are broad and imprecise,[583] and advocates have documented the resultant disparities in VA adjudicative decisions.[584]

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[585]—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.*[586]

The VA's Office of General Counsel, in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters of the types of behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

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[578] Characters of Discharge, 38 C.F.R. 3.12(d).
[579] Characters of Discharge, 38 C.F.R. 3.12(d).
[580] 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): 160-192, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[581] 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): 164, 186, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[582] 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): 10, 172, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
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.
[583] 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, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[584] 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): 68-70, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[585] Characters of Discharge, 38 C.F.R. 3.12(b).
[586] Determinations of Insanity, 38 C.F.R. 3.354(a).

> *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."*[587]

As understood by the VA Office of General Counsel at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,[588] 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, post-traumatic stress disorder (PTSD). Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,[589] impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).[590] Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.[591] 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 Marine 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.[592]

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[587] Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, http://www.va.gov/ogc/opinions/1997precedentopinions.asp.

[588] 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.

[589] 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.

[590] 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.

[591] 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.

[592] 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.

- Tim, a Marine 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 of his discharge.

- Tom, a combat infantryman in first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family, but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.[593]

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,[594] depression,[595] homelessness,[596] premature mortality,[597] and suicide.[598] Access to VA health care is vital to successful reintegration of combat-traumatized veterans into societybecause it provides "the only reservoir of combat PTSD expertise."[599]

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,[600] yet many former service members are reluctant to seek treatment for

[593] 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.

[594] 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.

[595] 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.

[596] 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.

[597] 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.sciencedirect.com/science/article/pii/S1047279705001109.

[598] 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

[599] 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. https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

[600] Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12. http://www.ncbi.nlm.nih.gov/pubmed/10761674

behavioral health problems.[601] 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.[602]

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 member needed treatment for their conditions when they are able to establish their health problems were incurred in service.[603] 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."[604] 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 of those. This approach would allow VA to provide meaningful access to treatment without delay to those likely to be granted eligibility. VA should also revise its regulations, at least for health care purposes, by recognizing that the severe punishment of characterizing a person's service as "dishonorable" is not justified 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 CFR § 17.34 to provide for tentative eligibility determinations applicable to certain individuals with OTH discharges.

- Amend of 38 CFR § 3.12(d) to provide for recognition of circumstances that show, for purposes of health care eligibility, that service was not dishonorable.

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[601] 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.

[602] 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.

[603] Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

[604] Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Other Departments and Agencies

- None required.

Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to hold out the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.[605] Congress and VA leadership must work to identify who VHA will serve, and what services it will provide.[606]

The Commission Recommends . . .

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

Background

VHA's core mission is to care for the veteran 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.[607]

- The World War Veterans Act of 1924, which established the Veterans Bureau[608] (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.[609]

- 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.[610]

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[605] 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.
[606] 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.
[607] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.
[608] The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.
[609] World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).
[610] 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).[611]

- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,[612] 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.[613]

- 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.[614]

- 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.[615]

Veterans' eligibility laws 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,[616] 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 1950's hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.[617] It essentially provided that all veterans are eligible for VA hospital care and *medical services*.[618]

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[611] Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).
[612] Pub. L. No. 91-500.
[613] S. Rep. No. 91-481.
[614] Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).
[615] 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.
[616] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).
[617] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).
[618] 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 might be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement in the law to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.[619] 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.[620] 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 put forth 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.[621] The act also required the SECVA to manage the enrollment system such that care is timely and of acceptable quality.[622] That requirement remains in law.

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.[623] Although law and VA regulation require a system of annual patient enrollment,[624] VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria 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.[625]

In 2014, Congress funded 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.[626]

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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.

[619] Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4)

[620] 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.

[621] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

[622] Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

[623] H. Rep. No. 104-690, 16.

[624] 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."

[625] Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

[626] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

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[627] 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.[628] Post-9/11- era veterans are enrolling for VA care at historically high levels.[629]

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though those with higher incomes are not eligible to enroll.[630] 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 statutory service-connected enrollment priority has little practical significance.[631] Future budget constraints could result in more restrictive enrollment criteria[632] 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.[633] All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll for VHA care and without time limitation.[634] 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[635] or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.[636] 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

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Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

[627] Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File,* (Dec. 31, 2015).

[628] 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), http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx.

[629] 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.

[630] 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.

[631] 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.

[632] Enrollment, 38 C.F.R. 17.36(c)(1).

[633] 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). https://www.govtrack.us/congress/bills/114/hr203/text

[634] Readjustment Counseling Service, 38 U.S.C. § 7309.

[635] 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.

[636] 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, http://doi.org/10.1056/NEJMoa1101388.

be considered a risk factor for coronary heart disease,[637] it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.[638]

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 based on the presumption that they were exposed to particular toxic substances.[639] 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 base.[640]

Congress has made only limited provision for VA to cover care for family members of certain veterans,[641] but with research suggesting that long combat deployments can take a psychological toll on family members,[642] 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 PTSD in military personnel are associated with psychological problems for the spouse.[643] Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.[644]

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

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[637] 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): http://doi.org/10.1161/CIRCULATIONAHA.113.005407.

[638] Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, http://doi.org/10.1161/CIRCULATIONAHA.114.009286.

[639] Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

[640] Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

[641] Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

[642] 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. 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.

[643] 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

[644] Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058–1066, 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, http://doi.org/10.1542/peds.2009-1180.

raise new questions for policymakers.[645] VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.[646] Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.[647] Given that VHA serves large numbers who are poor or near-poor and have chronic medical conditions and behavioral health problems,[648] 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.[649]

ver time Congress has expanded VA health care eligibility to ever-wider 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 less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.[650]

Substantial changes have occurred since Congress last comprehensively examined eligibility for VA care. Those changes merit a reexamination of VA health care eligibility.[651] 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[652] as calling for it to make recommendations on this fundamental issue of congressional policy. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected-disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- None required.

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[645] Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association,* 307, no. 8 (2012): 789-790, http://doi.org/doi:10.1001/jama.2012.196.
[646] 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.
[647] "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, http://explore.va.gov/health-care-affordable-care-act?show=all.
[648] Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association,* 307, no. 8 (2012): 789-790, http://doi.org/doi:10.1001/jama.2012.196.
[649] "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/.
[650] 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.
[651] 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.
[652] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

VA Administrative Changes

- SECVA should amend 38 CFR, 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 Agencies

- None required.

Develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans to purchase VA care in areas where increasing the volume of patients will improve the quality and cost-effectiveness of care.

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 three main factors: (a) the overall decline in the size of veterans population, (b) the outmigration of veterans away from some parts of the country, such as the 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.

The Commission Recommends . . .

- That Congress authorize VHA to establish pilot programs that will allow veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.
- That Congress allow VHA to receive reimbursement from patients who wish to purchase VA care using their Medicare entitlement.
- That VHA improve its third-party billing and collections activities so they correspond with those of private-sector delivery systems.
- That collections under the demonstrations be retained at the VHA delivery sites and not subject to offset.
- That pilots would be tested in conjunction with the growth of the high-performance, integrated delivery networks.

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.[653]

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. Towards that end, VHA should 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

[653] 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.

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.

Background

Current Nonveteran Access to VHA Care

Though not widely known, VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of $1.9 billion in 2015,[654] or 3.6 percent of total VHA obligations.[655]

By far the largest subgroup within the nonveteran patient population comprises 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 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 utilized 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.[656]

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.[657] 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

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[654] Allocation Resource Center, information provided to Commission on Care, December 8, 2015.
[655] 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.
[656] Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S. Code § 1782.
[657] 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.

- 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
- providing a *public option* for health care to a wider range of veterans as well as non-veterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans health care

Appendix ___ details a proposed set of seven pilot programs. These programs would experiment with allowing nonveteran spouses and veterans who are currently ineligible for health care (because of income and lack of service connection) access to VHA care under fee-for-service models or within accountable health care organizations at selected sites across the system. Highlighted below are key characteristics of the pilots:

- All participants would have to bring either public or private health insurance coverage to VHA.
- Prospective participating sites would need to certify that they are in compliance with VHA access guidelines for enrolled veterans.
- For sites selected to serve as accountable health care organization pilots, VHA-delivered care would be provided whenever possible, but VHA would be authorized to subcontract with its private-sector partners (those included in its integrated delivery networks) to provide care that is unavailable or inaccessible at VHA in the same manner as it provides care to enrolled veterans.
- VHA would determine the appropriate benefits package and plan design to correspond with participants' health care coverage.
- Participating VHA facilities will be able to retain any *profit* associated with treatment of new users without offset.

Implementation

Legislative Changes

- Authorize Medicare (Parts A, B, C, and D) to reimburse VHA to optimize the feasibility of these pilots. (This authorization is not strictly necessary for the programs' success.)
- Authorize VHA to treat nonveteran spouses who are not eligible for CHAMPVA at VHA pilot sites.
- Authorize VHA to collect and retain payment from third-party payers for the care of ineligible veterans and nonveteran spouses.

VA Administrative Changes:

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

Other Agency Administrative Changes

- None required.

CONCLUSION PLACEHOLDER, IF NEEDED

APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

[Intro: yet to be provided from economists.]

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. 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, among 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 the VA. 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.

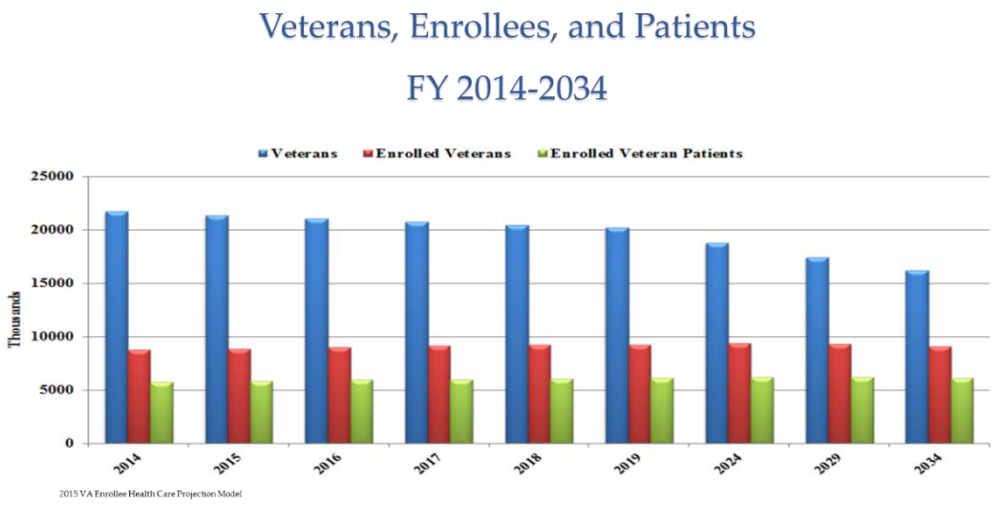
Utilization

Utilization depends on enrollment, reliance, and characteristics of the health care system such as medical technology and practice patterns. Here we focused on enrollment and reliance. Both enrollment and reliance have a multiplicative effect on utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent. If reliance doubles, costs will double. Thus it is important to carefully consider the effect of any policy change on both enrollment and reliance.

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, the numbers of enrollees and patients are projected to remain relatively stable over the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, a veteran is considered continuously enrolled until death.

This enrollment trend is not set in stone. Enrollment rates assume 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 patients while easing access to care would likely increase enrollment and patients. Changes to other health insurance policies outside of VA can also effect enrollment and patients (for example changes to the Affordable Care Act).



Reliance

On average, enrolled veterans who used VA at least once during the year,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 impact reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost sharing levels, and characteristics of other insurance options. Any policy that effects 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 the care was provided. We used unit cost projections from 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 a service is provided in a VA facility, in the community at historic Care in the Community rates, or in the community at Medicare allowable rates. Therefore, any policy that affects the balance of how much care is provided in VA facilities and how much care is provided in the community, will have an effect on the total cost of care. If care is provided in the community, the rate of provider reimbursement will also affect costs.

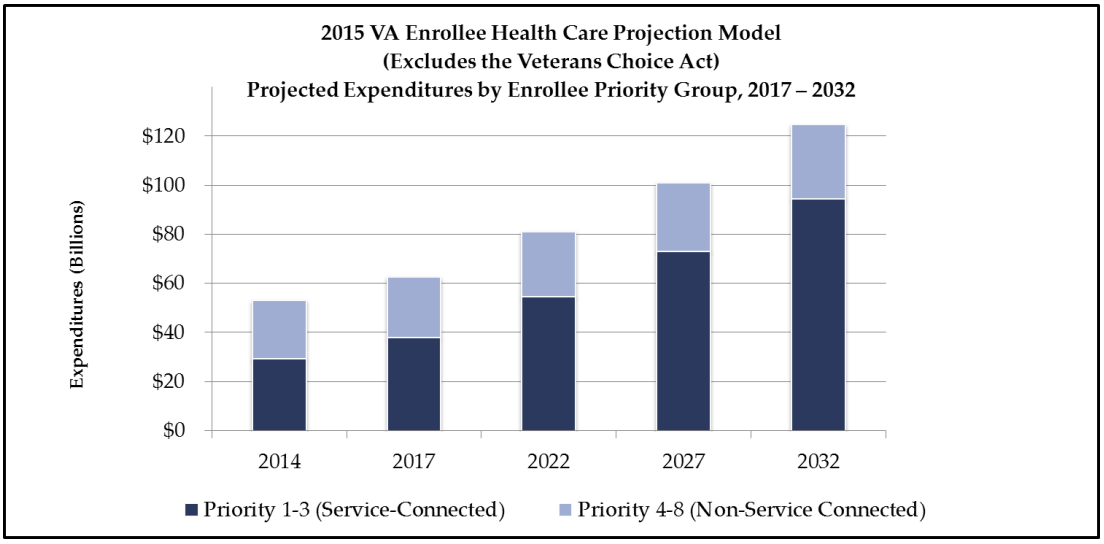
Baseline Cost Projections

The baseline cost projections show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, projected inflation rates, and other factors.

The projections reflect current policy with regard to enrollment eligibility and the VA health care benefit, with the exception of The Choice Act. The Choice Act expanded access to care in the community for enrolled Veterans who met certain criteria, and we assume a continuation of this policy in the baseline.

The projections are based on assumptions about inflation and how changes in health care practice are expected to affect the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as the economic recession, can occur and change projected demand for VA health care over this time period. The projections do not include requirements for several activities/programs (because they are not projected by the VA Enrollee Health Care Projection Model), including building, 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 dollars in 2014 to 125 billion dollars 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 healthcare. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees being adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees are expected to increase their reliance to reflect the significantly higher reliance of enrollees in the service-connected Priorities 1-3. This effect can be seen in the significantly higher expenditure requirements for enrollees in priorities 1-3 on the slide.



These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. Health care utilization is assumed to 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. While we do 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. These limitations were highlighted in a 2008 RAND review of the EHCPM and are particularly important for analyzing policy changes such as expanded community care.[658] In light of the types of policy choices that are likely to be considered 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 first present results for three main scenarios for expanding access to providers outside of the VA. These scenarios expand community care for different categories of care and vary by whether referrals are required to receive specialty care. Second, we briefly summarize some of the other scenarios that were examined. Finally, we estimate costs for two other policies that are discussed in this report: (1) expanding the use of Nurse Navigators to help patients coordinate their care in the VA and in the community; and (2) expanding eligibility to all Veterans with an Other than Honorable discharge until the adjudication process is complete to determine whether they will remain eligible.

Community Delivered Services Networks

At least initially, all care currently being provided by the VA would continue to be provided by the 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, mid-level practitioners and therapists, and hospitals and clinics) that are vetted by the VA. CDS will be focused on tertiary and quaternary care, and may include primary care, depending on the option. CDS will not include special emphasis care and some types of specialty care that are provided in a unique fashion by the VHA. The network of CDS providers will be coordinated by the VA and would vary by community. In order 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 of the VA.

Technical Assumptions

We base our estimates on utilization and unit cost data and projections for 78 Health Service Categories (HSC) that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, utilization and unit costs are projected 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 Care in the Community (CITC) will continue to be offered and utilized at baseline levels.[659] For both the baseline and the scenario

[658] Katherine M. Harris, James P. Galasso, and Christine Eibner, *Review and Evaluation of the Enrollee Health Care Projection Model*, accessed June 1, 2016, http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG596.pdf.
[659] CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

estimates, we assume that the current Choice Program continues for veterans living more than 40 miles away from a VA medical care facility or facing excessive travel burdens. All effects are phased in over the first 5 years.

Both CDS networks and CITC are priced at Medicare Allowable rates by matching Medicare fee schedule data to VA HSCs.[660] 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 roughly 10 percent of care in 2014, form our proxy for the fixed 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 non-recurring maintenance, so these costs are also implicitly assumed to be fixed.

Improving access, choice and/or quality of services is likely to induce greater reliance and enrollment in the VA system. While reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these 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 the 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. 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 being 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.[661]

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[660] 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 in an HSC, Medicare amounts were estimated.

[661] Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," accessed June 1, 2016, https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9924/12-18-keyissues.pdf.

There are a number of caveats associated with our estimates. The estimates do not include savings and costs of reducing or repurposing infrastructure, or impacts on VA's teaching, research and emergency preparedness missions. Medicare Allowable rates are assumed to be 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 be representative of future rates. Shifting care into CDS networks does not impact the unit cost of care that remains in VA facilities. Other than equipment and national overhead, the costs of care shifting out of VA facilities is phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for Option 1, and the same as existing enrollees in Options 2 and 3.[662] 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.

Sample Cost Models

Option 1

Option 1 would expand community care. At least initially, all care currently being provided by the VA would continue to be provided by the 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, mid-level practitioners and therapists and hospitals and clinics) that are vetted by the VA. CDS will include primary and standard specialty care. It will not include special emphasis care (care that is uniquely provided in the VA).[663] The care eligible for CDS networks comprised 68 percent of total modeled expenditures in 2014. Receiving CDS eligible care in or out of the VA does not requires a referral.

Option 1 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. While 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 [664], 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.

Willard G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review,* 77, no. 3, (1987): 251–277, http://www.jstor.org/stable/1804094.

[662] Assumptions based on previous analysis by VHA and Milliman.

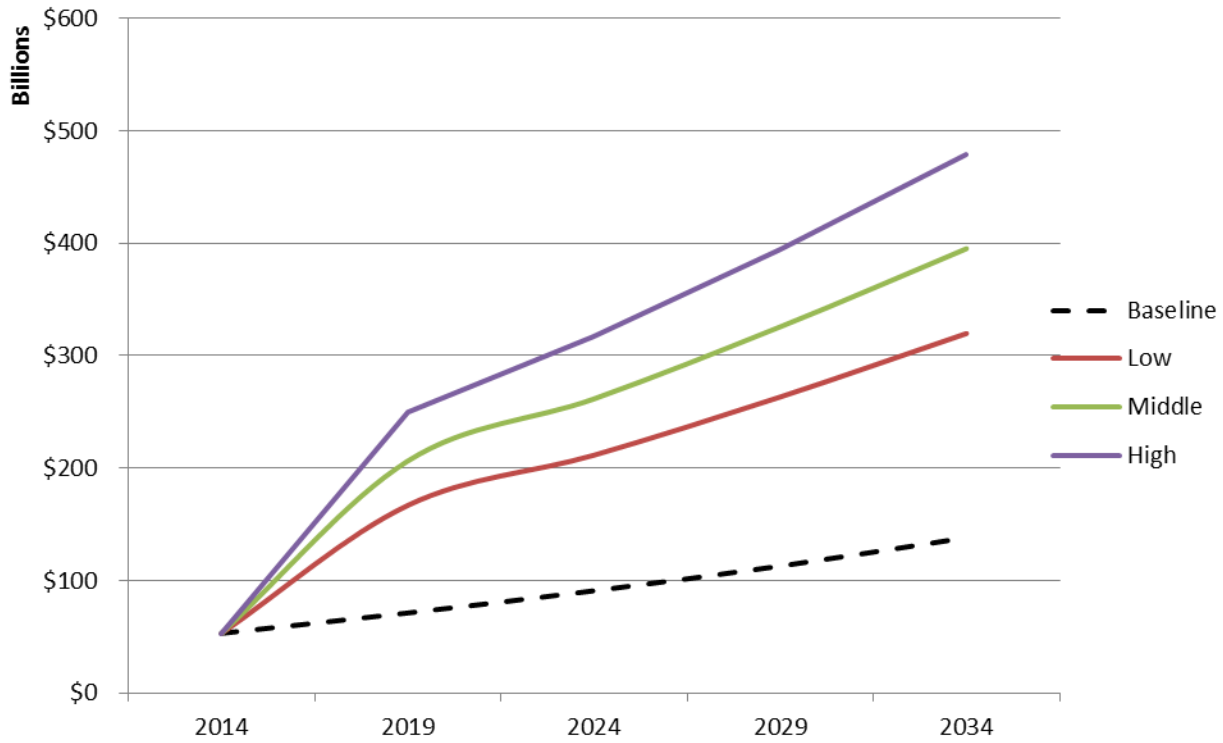
[663] Special emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis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

[664] 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): 723-744, http://doi.org/10.1111/j.1475-6773.2005.00382.x. 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, http://doi.org/10.1002/pam.20024.

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 rates of 80, 90, and 100 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 2. In 2019, when effects are fully phased-in, estimated costs range from $167 to $250 billion, with a middle estimate of $206 billion. This compares to a baseline projection of $71 billion. While estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario and relative to Options 2 and 3 below.

Figure 2. Projected Costs of CDS Option 1



Option 2

Option 2 would again expand community care for certain types of care, but in Option 2 care provided in CDS networks will be focused on tertiary and quaternary care. They will not include primary care, special emphasis care, and some types of specialty care. This network of providers will be coordinated and vetted by the VA and would vary by community, and like in Option 1, receiving CDS eligible care in or out of the VA does not requires a referral.

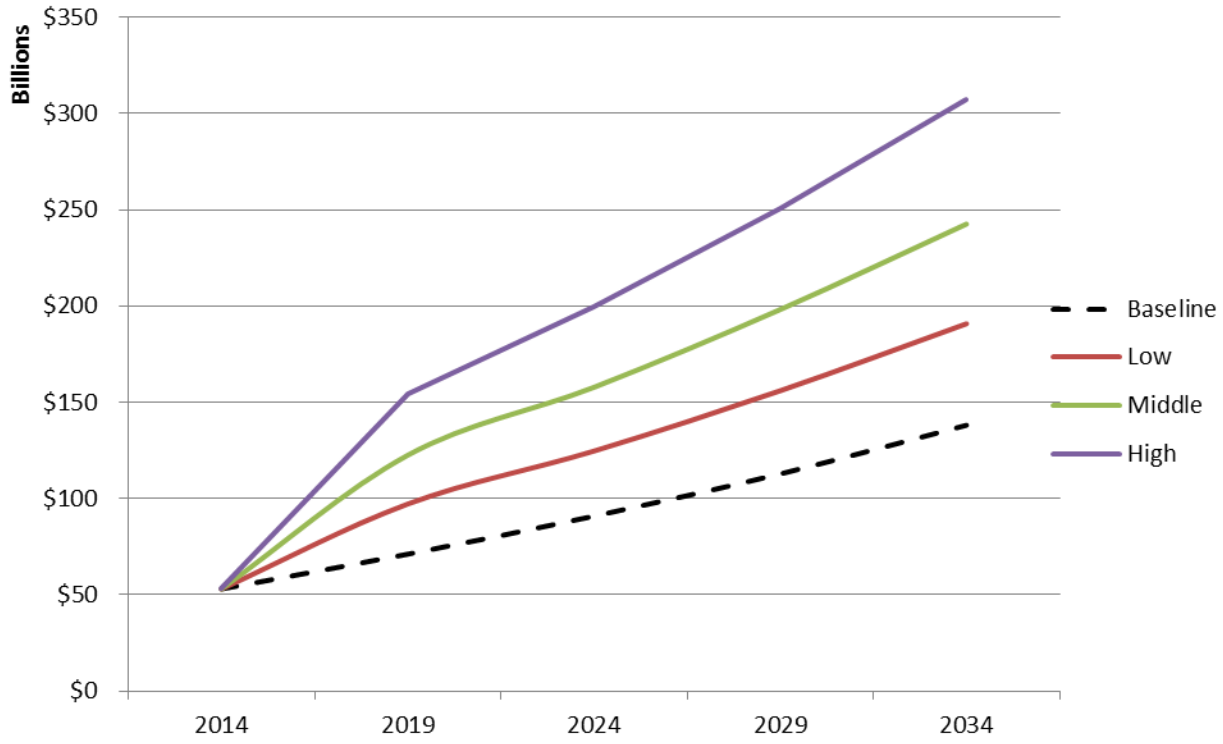
This option differs from Option 1 in that veterans must consult their VHA primary care physician before seeking community care, and most but not all specialty care is available through the CDS networks. Some specialty care, all primary care, and all special emphasis care is only provided in the VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek care in CDS networks is entirely up to the veteran. The care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

Although not as generous as Option 1, Option 2 is still very attractive relative to the current system. Some patients must consult with VHA primary care providers, yet they do not need referrals before seeking care that is eligible for CDS networks, regardless of whether the CDS-eligible care is ultimately provided within the VA or in the community.

We expect reliance increases to be high for CDS-eligible care, but somewhat lower than in Option 1. We expect enrollment increases to be lower than Option 1 both because of the requirement for VHA primary care consultations and because inpatient and primary care are no longer eligible for CDS networks. We model reliance rates of 60, 80, and 100 percent; enrollment increases of 5, 10, and 20 percent; 50 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

Estimates are displayed in figure 3. In 2019, the baseline projection is $71 billion. Option 2 estimates range from $97 to $154 billion, with a middle estimate of $122 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

FigureXX. Projected Costs of CDS Option 2



Option 3

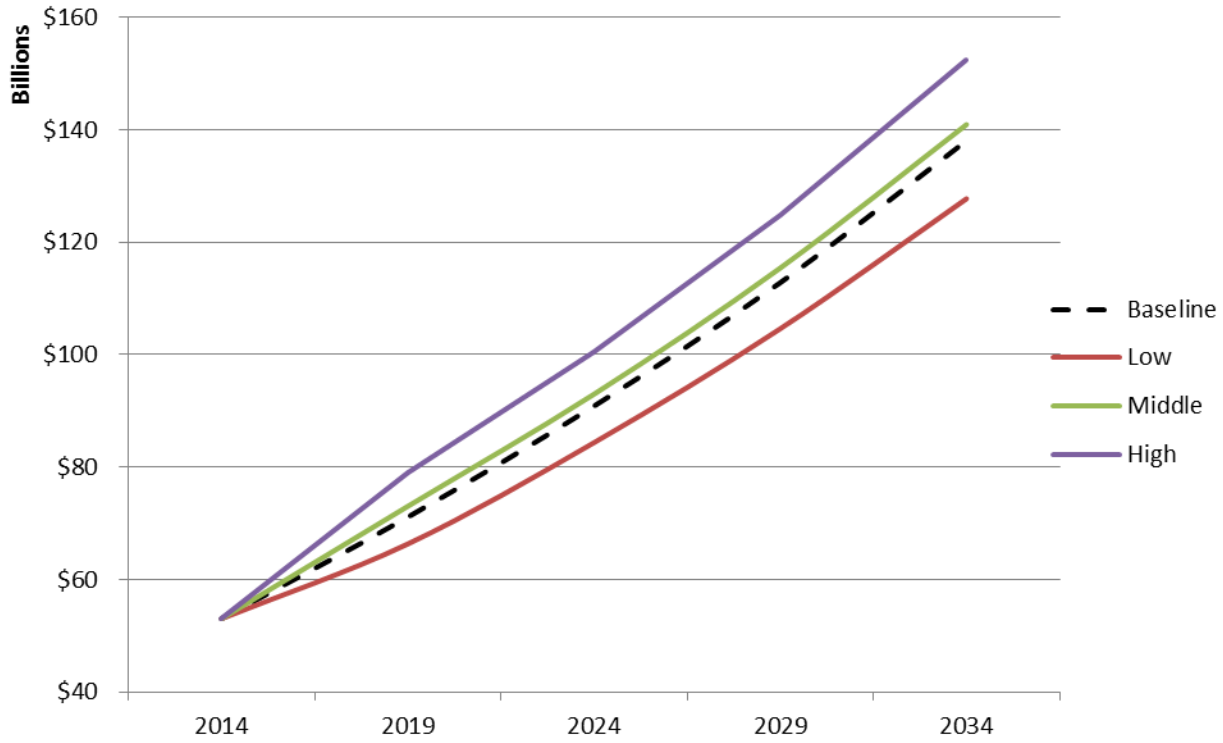
Option 3 is similar to Option 2 above. The only difference is that a referral is required from a VHA primary care provider. The patient can no longer unilaterally choose to receive specialty care in CDS networks. We predict that this change would dramatically reduce the cost of this option relative to Options 1 and 2. Use of specialty care in the VA currently requires a referral, so Option 3 makes no change in terms of gatekeeping the access to specialty care. The advantage of Option 3 over the baseline focuses squarely on the CDS networks, which we assume are robust and expand choice to additional providers.

We assume that 50 percent of eligible care shifts from VA facilities to CDS networks. We model increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 41, and 51 percent. These reliance increases are applied only to CDS care, not CDS-eligible care that is provided in VA facilities, because the referral requirement for care in VA facilities does not change. We model enrollment increases of 0, 5, and 10 percent. These increases are substantial, but far lower than Options 1 and 2. While the choice of providers is expanded and wait times are potentially reduced, the requirements for access to specialty care remain the same as in the current system. Finally, in response to a reduction in cost sharing for newly entering veterans who are treated in CDS networks, we assume a 20 percent utilization increase for new demand in CDS networks.

Figure 4 displays estimates for Option 3. Estimates range from $66 to $79 billion in 2019, with a middle estimate of $73 billion. The middle estimate is very close to the baseline projection of

$71 billion. While reliance and enrollment increases push VA budgetary costs up, these effects are offset by the switch from VA unit costs to Medicare Allowable rates for CDS networks and CITC.

Figure XX. Projected Costs of CDS Option 3



Other Modeled Scenarios

We also modeled a number of other scenarios including a scenario for which all standard specialty care moved to the community, a scenario for which veterans could choose between VA care and an insurance plan with a substantial cost sharing, and a scenario for which eligibility for VA care is extended to all Priority 8 veterans. aLthough details of those estimates are not shown here, they informed the policies and estimating strategies of the options above.

Additional Cost Factors

Nurse Navigators

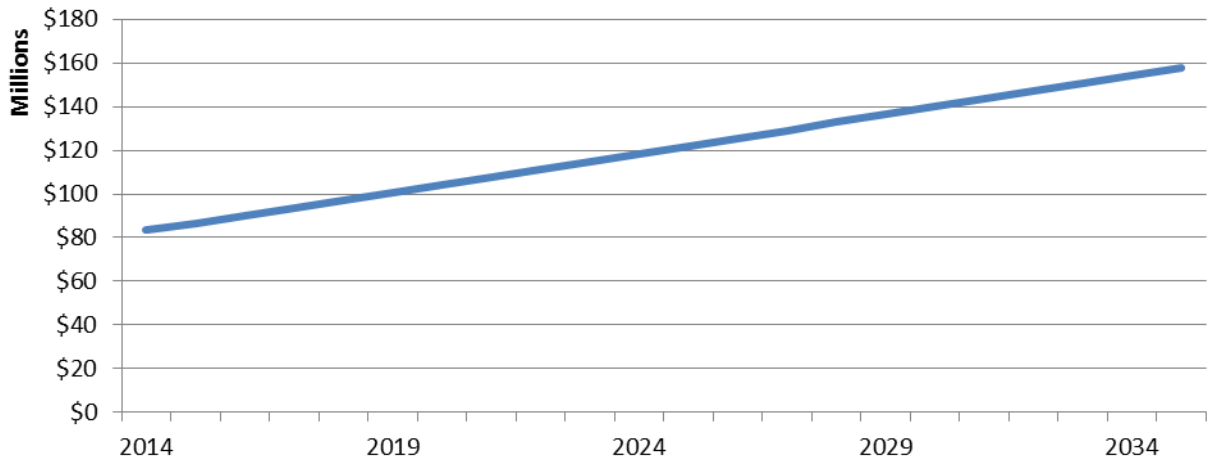
VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special emphasis PACTs such as those for spinal cord injury and disorders (SCI&D), 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, a RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1200 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 1 additional RN care manager per 5 panels would be necessary to handle a substantial increase community care such as that associated with the CDS scenarios.[665] 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 FY14) 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.

FigureXX. Cost of Hiring Additional RN Care Managers



Other than Honorable Discharges

We also consider a policy where those with an "Other than Honorable" (OTH) discharge are made presumptively 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 was due to behavior associated with a mental health condition that

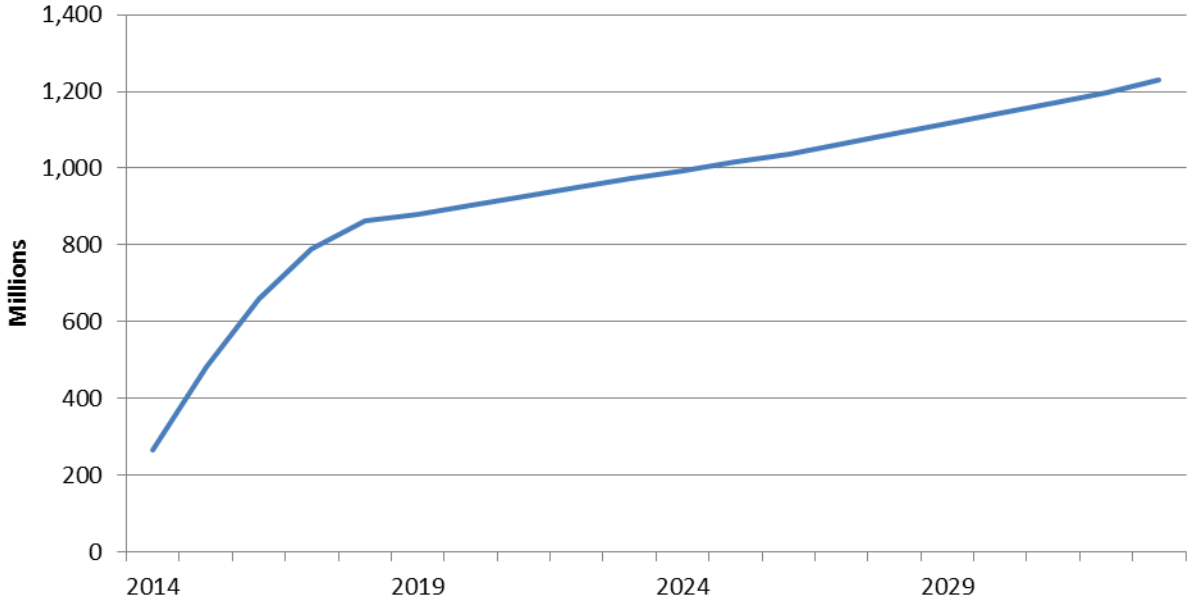
[665] These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

was 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 made 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. Over a period of five 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 over the first five years as they become aware of the new rules. It increases to 52 percent, which is the enrollment rate 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 dollars in 2014 to 1.23 billion dollars in 2033. Fully phased-in, the cost is 864 million dollars in 2019. The shape of the cost curve reflects increasing enrollment over 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 over 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 over the projection window.

Figure XX. Projected Costs of Covering Veterans with Other than Honorable 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 Option 3, which provides increased community care that is reimbursed at Medicare Allowable rates but maintains referrals for specialty care, does not significantly increase costs. However, Option 1 and to a lesser degree Option 2, which eliminate the need for referrals for standard specialty care, lead to much higher costs. We find that the costs of introducing expanded Nurse Navigators/Care Coordinators and making those with OTH discharge presumptively eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table X –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/DepSEC or USH depending on level	Now (0-6 ms)
Assess cultural transformation models and decide on a single model	Chartered SE Team	Now (0-6 ms)
Create an execution strategy for cultural transformation	Chartered SE Team	Now (0-6 ms)
Develop communication strategy and materials and release	Chartered SE Team	Near (18 ms)
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 ms)
Establish leadership standards for behaviors and actions	Chartered SE Team Subcommittee	Near (6-9 ms)
Publicize the standard	Chartered SE Team Subcommittee / USH /HTM	Near (12 ms)
Develop assessment tools	SE Subcommittee / NCOD, NCEHC, HTM	Near (12-24 ms)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions	HTM/USH	Near (12-36 ms)
Provide coaching to the standard	(Current HCM office responsible)	Near (24 ms)
Collect standards, training, support materials into a living curriculum for leaders	EES/HTM	Near (24 ms)
Modify VA Directive 5021 (Employee/Management Relations)[666] 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 ms)

[666] Employee Management Relations, VA Directive 5021 (2002).

Action	Responsible	Timeline
That VHA align front line staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation	Chartered SE Team	Near (9 ms)
Establish behavioral expectations / requirements for staff	Subcommittee	Near (9-18 ms)
Develop hiring tools against the staff standard	Subcommittee	Near (18-36 ms)
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 ms)
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 ms)

Action	Responsible	Timeline
Establish program office and VAMC standards and strategy for execution		
Establish subcommittee to develop VAMC and PO execution standards	Chartered SE Team	Near (18 ms)
Establish execution strategy and policy requirements	Chartered SE Team Subcommittee /NCEHC / NCOD	Near (18-36 ms)
Develop consolidated, meaningful metrics with input from experts and field users		
Assign responsibility for metric development	Chartered SE Team / USH	Near (6 ms)
Develop and test metrics	Organizational Excellence	Near (6-18 ms)
Deploy metrics	Chartered SE Team / USH / (policy owner)	Near (18ms)
Identify outliers and intervene	SE Team / USH / (policy owner)	Near (24 ms)

Table X –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 ms)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018	VHA OPP and USH	Now (3 ms)
Adopt VHA leadership management goal and submit to OMB / White House	VA OPP and SECVA	Now (3 ms)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management / NLC leadership subcommittee of the HR committee	Now (4 ms)
Include yearly targets in the performance plan of the USH and SES members.	VHA NLC subcommittee on performance planning	Now (4 ms)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	USH	Now - ongoing
Schedule regular meetings with VHACO an field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	USH	Now - ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA	USH / ask NLC executive committee to develop and implement a plan	Now (6 ms)
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 ms)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 ms)

Action	Responsible	Timeline
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 ms)
Assess existing training against the model and identify gaps	EES	Near (18 ms)
Develop and implement a plan to fill these gaps	EES / reporting to NLC to ensure funding	Near (plan 20 ms – fill gaps 36 ms depending on$)
Assess opportunities to share additional leadership training with DoD and create a plan to implement it	HEC / JEC	Near (9 ms)
Develop and fund a face-to-face training to fulfill competencies for critical career positions	EES	Near (24 ms)
Develop a masters level training program for clinical leaders in partnership with academic medicine	EES / Academic Affiliations	Near (36 ms)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations	EES / Academic Affiliations	Near (18 ms)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 ms)
Establish a coaching program	HTM / EES	Near (18 ms)
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 ms)
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 ms)
Create interview questions incorporating competencies for all key positions	HTM	Near (12 ms)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 ms)
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 ms)
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 ms)

Action	Responsible	Timeline
Establish an IDIQ, PBA or similar contract for executive recruitment	Human Capital Management	Now (6 ms)
Establish requirement in policy for all ECF, SES / SES eqv to complete IDP	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF	Human Capital Management / DoD Coordination	Now (6 ms)
Expand GHAPT program	EES	Now (6 ms)
Establish a plan for developing and managing the candidate pool	NLC subcommittee for leadership	Now (6 ms)
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 ms)
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 ms)
Establish and fund assistant level positions in all key career development tracks	USH	Now (18 ms)

Table X – 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 X	USH	Now (1 ms)
Prepare an initial RIF for offices eliminated	VHA Human Capital Management	Now (3 ms)
Engage the VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office / VERC	Near (3 ms – 12 ms)
Each program office in collaboration with the VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings	Transformation Office / PO / USH	Near (3 ms – 12 ms)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices	Transformation Office / USH	Now (1 ms)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO	Transformation Office / EES	Now (1 ms)
Develop training curriculum to support VHACO staff in developing the skills and competencies required	Transformation office / EES	Near (18 ms)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out	Transformation Office / USH	Now (1ms)
Modify in-service training and implement in on-boarding process for new VHACO employees	Transformation Office / EES	Now (6 ms)
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 ms)
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 ms)
Require the basic competencies in functional statements as a basis for hiring and promotion	Transformation Office / Each PO	Near (18 ms)
X-cutting: 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 ms)

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 / USH	Now (1 ms)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN	Transformation Office / EES	Now (1 ms)
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 ms)
Modify in-service training and implement in on-boarding process for new VISN employees	Transformation Office / EES	Now (6 ms)
Draft basic competencies for VISN staff (e.g. quality improvement, coaching, effective communication, change leadership, data analytics)	Transformation Office / HCM	Near (12 ms)
Require the basic competencies in functional statements as a basis for hiring and promotion	Transformation Office / Each PO	Near (18 ms)
X-cutting: Gain agreement from Congress to institute three appropriation lines only: Medical, Major Construction, Research	USH/ SECVA / OMB	Near (12 ms)
Eliminate segregation of specific purpose funds to the VISNs and facilities	USH / Office of Finance	Now (6 ms)
X-cutting: Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending	OIT / Office of Finance	Future (36 ms)
X-cutting: Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out	Finance / EES	TBD post procurement
X-cutting: 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
X-cutting: Delegate decisions in recruitment, retention and advancement (e.g. hiring bonus, retention bonus, market pay) for staffing to the facility	USH / HCM	Now (1 ms)
X-cutting: Delegate training and travel decisions	USH / EES / OAA	Now (1 ms)
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.	USH	Now (3 ms)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	USH / EES/ NLC	Now (6 ms)

Action	Responsible	Timeline
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	USH	Near (12 ms)
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	USH	Now (3 ms)
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	USH	Now (6ms)
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 ms – 6 ms)
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 (3ms - 6ms)
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 (3ms - 6ms)

Table X – 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[667], 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 ms)
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 ms)
Establish a mechanism to capture performance assessment outcomes and track and manage high potential staff	Human Capital Management / HRA	Now (3 ms)
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 / USH / Sec / OMB	Now (3 ms)
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 ms)
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 (3ms)
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	USH	Now (3ms)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation	Human Capital Management / USH	Now (12 ms)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance	Supervisors	Near (12 ms)

[667] ACHE and National Center for Healthcare Leadership

Table X – 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/DepSEC	Now (0-6ms)
Engage HR and change management experts to develop a benchmark human capital management plan for VA	HRA	Now (0-6ms)
Circulate new human capital plan for feedback and finalize	HRA with input from VHA, Congress, OPM, OMB, SECVA/DepSEC, USH	Now (6ms)
That VA and VHA leaders make transformation of Human Capital management a priority. (Leadership) 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/DepSEC and USH, as applicable	Near (9ms)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12ms – 30ms)
Create an HR IT technology plan	HRA & OIT	Near (9ms)
Establish meaningful measures and risk indicators for VA human capital management	HRA	Future (24 ms)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders	HRA, DepSEC, USH as appropriate	Near (18 ms)
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 ms)
Managers, supervisors and HR professionals complete training	SECVA/DepSEC and USH (HTM office)	Near (12 ms)
Train HR staff to be coaches in progressive discipline	HRA	Now (6 ms -12 ms)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process	HRA	Near (12 ms)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process	SECVA/DepSEC, USH	Near (12 ms)

APPENDIX C: BUILDING THE FIRST LINK TO THE FORCE OF THE FUTURE

Based on DoD Fact Sheet,
http://www.defense.gov/Portals/1/features/2015/0315_force-of-the-future/documents/FotF_Fact_Sheet_-_FINAL_11.18.pdf
Building the First Link to the Force of the Future

On his first day in office, Secretary Carter announced his goal to build the Force of the Future in order for the Department of Defense to maintain our competitive edge in bringing in top talent to serve the nation. The Acting Under Secretary of Defense for Personnel and Readiness, Brad Carson, was assigned to undertake a comprehensive review of the Department's civilian and military personnel systems.

The review occurred from April to August, and included over 150 subject matter experts from the Military Services, scholars, and researchers. A core research and writing team from the Personnel and Readiness office reviewed over 100 studies and commission reports related to civilian and military personnel management, talent management, and private sector human resources practices.

The review focused on ways in which the Department could increase permeability of personnel and ideas between the public and private sector, increase recruiting results and outcomes for the Department, and emphasize talent management and retention to ensure that the quality of today's current force would translate to a "Force of the Future."

The review produced a document in excess of 150 pages and included 29 reform proposals that captured almost 80 individual reform initiatives. After receiving the document for his review, the Secretary of Defense directed the Deputy Secretary of Defense and Vice Chairman of the Joint Chiefs of Staff to oversee a principal level working group to evaluate all the reform initiatives against the backdrop of force readiness and maintaining an all-volunteer Joint Force. That Working Group has recommended an initial tranche of over 20 reform initiatives, focused on permeability, recruitment, and retention.

Improve and Enhance College Internship Programs. The Department will create a centralized process to better manage its vast array of internship opportunities to increase the likelihood of interns receiving full time placement in the Department of Defense. With more young Americans pursuing internships today, it is imperative that we are leveraging this talent pool to attract future talent to the civilian workforces as many other agencies have done. The USD (P&R) will work with the Military Services to develop more robust mechanisms to transition successful and promising interns from temporary to permanent employees. Additionally, since many college students do not realize what kinds of civilian job opportunities DoD offers, USD (P&R) will also work to improve DoD's on-campus presence.

Establish the Defense Digital Service (DDS). Working closely with the White House lead United States Digital Services (USDS), DoD will establish the Defense Digital Service (DDS). DDS will be composed of a small team of talented engineers and digital experts, brought in to DoD on a temporary basis from the private sector to work with senior leaders to improve the

Department's technological agility and solve its most complex IT problems. Chris Lynch, a well-respected tech entrepreneur, will lead this organization starting today.

Launch Entrepreneur-in-Residence Program

DoD will launch an Entrepreneur-in-Residence (EIR) Pilot Program to embed up to three entrepreneurs in different parts of the Department to work on special projects sponsored by senior leaders. The goal of the EIR program is to align the attitude, expertise, experience, and professional networks of successful entrepreneurs against the mission and challenges facing large, complex, bureaucratic organizations. The EIR program is designed to unleash the powerful advantages of an entrepreneurial mindset such as creativity, urgency, independence, and calculated risk-taking into organizational cultures and/or against a specific problem. The new EIRs will be paired with a senior leader project sponsor from among the Military Services and Office of the Secretary of Defense to spearhead an entrepreneurial approach to tackling a specific DoD challenge. The EIRs will also participate in educational and mentorship programs that will contribute to a culture of innovation and entrepreneurship in DoD.

Designate Chief Recruiting Officer

DoD will designate a Chief Recruiting Officer (CRO) within the Office of the Under Secretary of Defense for Personnel and Readiness to lead executive recruitment throughout the Department. The new CRO will essentially function as an executive headhunter, and work with leadership among the Military Services and Office of the Secretary of Defense to bring in highly qualified executives from the private sector to assist the Department in managing key portfolios and issue areas where private sector experience could be valuable.

Expand Secretary of Defense Corporate Fellows Program

DoD will expand and upgrade its Secretary of Defense Corporate Fellows Program, in terms of both attendance and scope, and rename it consistent with its expanded focus: Secretary of Defense Executive Fellows Program (SDEF). This program allows service-members to serve in top industrial institutions – including places like Microsoft, Amazon, SpaceX, and Accenture – and bring back what they learn to keep DoD on the cutting-edge. The program will also expand the fellowship mandate to include fellowships with state and local government to help prepare service-members for leadership at strategic levels. Finally, the program will now also include eligible senior non-commissioned officers, as well as commissioned officers. Where previously the fellowship was a one year billet it will now be two years enabling the fellows to apply what they have learned in the private sector to a commensurate activity within the Department.

Increase Size of the Career Intermission Program

DoD will pursue Congressional action to lift the pilot restrictions for the Career Intermission Program (CIP). The CIP allows service-members to take a sabbatical from military service for a few years while they are starting a family, exploring different career opportunities (such as time in the private sector), or getting a new degree. The program promises to not only give service-members increasing flexibility as they pursue their military careers, but also enables them to

bring new and innovative skills back to DoD. Many Service members are reluctant to use the program based on the current pilot status; elimination of pilot authority will provide maximum flexibility for Service members and the Secretaries of the Military Departments to expand the utility, participation, and duration of the CIP based on individual Service needs, and ensure that taking advantage of this opportunity does not harm chances for promotion.

Implement Web-Based Talent Management System

The Military Services will pilot web-based systems that help match the right knowledge, skills, and abilities of Service members with available assignments. These web-based platforms will provide an opportunity for Service members and gaining units to "shop around" and discover mutual matches that better satisfy all parties involved. These are roughly equivalent to a "LinkedIn"-style system, in which service members will populate an online database with information they believe is important, which would then be wedded to official personnel data. Commanders and Service members will be able to search for the right job, using data that has not currently been captured by the Department. The Military Services will closely monitor these new systems to ensure there is no degradation of readiness or dearth of talent in certain geographic locations.

Establish Office of People Analytics

The USD (P&R) will immediately establish the Office of People Analytics (OPA) to better harness the Department's big data capabilities in managing our talent. DoD has limited visibility into the characteristics of civilian and military personnel and lacks the ability to conduct comprehensive analysis on how policy or environmental changes will affect the performance or composition of the workforce. OPA is designed to serve in direct analytic support to the Military Services and the Office of the Secretary of Defense (OSD) to fix this gap and inform better personnel policies that attract, recruit, and retain high performers within/to DoD. OPA will be prepared to partner with the Military Services and OSD on questions pertaining to recruiting, hiring and retention, succession planning, training, and increased talent-based assignment matching throughout the Department.

Diversity Briefing

Senior leaders (Vice Chiefs and Under Secretaries) will begin receiving semiannual briefings on the racial and gender diversity within each branch, career field, and military occupational specialty. USD (P&R) will also supervise a study to identify the primary causes and anticipated impacts of the geographic and familial concentration of military recruits.

Doctoral-Level Program in Strategy

The USD (P&R), in conjunction with the Joint Staff and the Military Services, will establish a doctoral-level program in Strategy through the current Professional Military Education (PME) system. USD (P&R) will coordinate with Joint Staff and the Military Services to identify an initial location (likely National Defense University) for the program and to develop a fully accredited curriculum.

Center for Talent Development

DoD will establish a Center for Talent Development (CTD) to provide Department-wide guidance on talent development policy and strategy, offer world class professional

development opportunities to the civilian workforce, and serve as a repository of expertise on talent development.

Civilian Human Capital Innovation Laboratory

The Department will establish a Civilian Human Capital Innovation Laboratory (CHIL) to ensure DoD's human resources (HR) personnel remain at the forefront of human capital best practices. The CHIL's primary purpose is to continuously design, launch, and evaluate pilots, prototypes, and experiments aimed at formulating and testing concepts and practices that improve HR outcomes for DoD stakeholders, accelerate and simplify business processes, and reduce costs. Defense Innovation Network. DoD will establish a Department-wide Defense Innovation Network (DIN) for the purpose of identifying, connecting, empowering, and encouraging military and civilian personnel throughout the DoD workforce who are or aspire to be involved in innovation.

Active and Reserve Component Permeability. The Department will form a Task Force, chaired by the USD (P&R), to identify mechanisms that increase the speed and ease with which Service members can transition from the Active Component to the Reserve Component

APPENDIX D: PROPOSED PILOT PROJECTS FOR EVALUATING VA *BUY-IN* PROGRAM

As discussed on page # of this report, the Commission is recommending the development pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans to purchase VA care in selected areas. These pilots will specifically evaluate whether such a strategy will allow the VHA to optimize the quality and cost-effectiveness of its health care system by avoiding dangerously low volumes of routine and specialty care in certain sections of the country. The project will also evaluate whether such a strategy will provide new revenues needed to sustain 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 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: Fee For Service plan covering Spouses	Non-Veteran Spouses of Veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: Fee For Service plan covering veterans currently Ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: Fee For Service plan covering Spouses	Non-Veteran Spouses of Veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 3-8
Demonstration 4: Fee For Service 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

	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 5 and 6: Accountable Healthcare 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
Demonstrations 7 and 8: Accountable Healthcare 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 healthcare 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 projects affect over the overall quality of care, market structure, pricing, and range of health care options available to both veterans and non-veterans in the surrounding community?

APPENDIX E: 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 of 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.[668]

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, 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."[669] 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 Public Health Service 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.[670]

Under Hines' tenure, VA grew to 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.[671] 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.[672]

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[668] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 4.
[669] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (U.S. Department of Veterans Affairs, May 2014), 13-14.
[670] Id., 19.
[671] Id., 21.
[672] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 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 expose characterizing veterans' hospitals as backwaters of medicine, magnified the problems.[673]

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed head the agency, with its network of 97 hospitals, and a need for more.[674] Dr. Paul Magnuson, who served as VA's chief medical director 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.*[675]

With President Harry Truman's statement that "the VA 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.[676] 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,[677] 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.[678] By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.[679]

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 reverted to its pre-Bradley ways and remained that way for the next forty years,"[680] according to one account.

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[673] Not Your Father's VA, supra, 22.
[674] Id., 23-5.
[675] Quoting from Ring the Night Bell, in Not Your Father's VA, supra, 22.
[676] Need a citation for the quote.
[677] Not Your Father's VA, supra, 27.
[678] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 214.
[679] Not Your Father's VA, supra, 28.
[680] Id., 29.

By the early 1950s the veteran population had grown to more than 20 million.[681] VA was operating 162 hospitals, with an average census of more than 104,000 patients.[682] 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."[683] 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.[684] Critics called for reducing free medical care of nonservice-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 ability to pay.[685]

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.[686] 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) asserted 87,000 was sufficient.[687]

The expiration of the incumbent chief medical director's (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.[688] During Middleton's tenure, from 1955 to 1963, VA research funding grew from some $6 million to more than $30 million.[689] 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.[690] 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 of chemotherapy for tuberculosis.[691] Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to

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[681] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 254.
[682] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 254.
[683] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 254.
[684] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 253.
[685] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 253-4.
[686] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 256.
[687] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 258.
[688] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 262-3.
[689] Robinson Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 263-4.
[690] Stanley Zucker, et al., "Veterans Administration support for medical research: opinions of the endangered species of physician-scientists, *The FASEB Journal,* vol. 18, no. 13 (Oct. 2004), 1481-1486. http://www.fasebj.org/content/18/13/1481.long
[691] Id.

allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat PTSD.[692]

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).[693]

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.[694] Some 59 percent responded, and nearly two-thirds of respondents preferred VA.[695] 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.[696]

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 Commission also recommended that VA experiment with models for community-based integrated care.[697] The commission's recommendation for integrating the VA system into the nation's civilian health care program[698] provoked objection, particularly in Congress.[699] Hearings produced sharp rejections of the NAS findings and its call to end VA's role in providing health care to veterans.

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).[700] 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

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[692] Veterans Health Administration, "History of VA Research Accomplishments." http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf
[693] Id. 265-7.
[694] Id. 390.
[695] Id.
[696] Id.
[697] Statement of Dr. Saul Farber, in *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs,* H. Reps, 95th Cong., 1st Sess. (July 21, 1977), 3-4.
[698] J. William Hollingsworth, M.D., and Philip K. Bondy, M.D., "The Role of Veterans Affairs Hospitals in the Health Care System," N Eng J Med, vol. 322, No. 10 (June 28, 1990), 1851-1857 http://www.nejm.org/doi/full/10.1056/NEJM199006283222605
[699] See, *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs,* H. Reps, 95th Cong.,1st Sess. (July 21, 1977).
[700] *Not Your Father's VA, supra*, 30-31.

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. After years of debate, and opposition from administration offices and advisors, President Reagan, in 1988 signed legislation creating a Department of Veterans Affairs.[701] 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 with a $12 billion budget.[702]

Facing an aging veteran population[703] expected to overwhelm the system by 2010, the new secretary, Ed 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.[704] 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.[705]

Dr. Jim Holsinger, a new under secretary for health, 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, Ken 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.[706] 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.[707]

Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.[708] Among Brown's most important early acts was selecting Dr. Ken Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the post of under secretary for health.[709] With experience

[701] Id. 33-40.
[702] Id., 50.
[703] 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. GAO, VA Health Care: Improvements Needed in Nursing Home Planning, (June 1990). http://www.gao.gov/assets/150/149139.pdf.
[704] Id. 51.
[705] GAO, Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform, GAO/HEHS-95-14 (December 1994) http://archive.gao.gov/f0902a/153054.pdf
[706] Not Your Father's VA, supra, 53.
[707] Eric Schmitt, "Angry Veterans Groups Say They Made Bush Oust Agency's Head," New York Times (Sept. 29, 1992) http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html
[708] Not Your Father's VA, supra, 89.
[709] Id. 92.

heading the California department of public health, Kizer saw health care as a system and data as a tool to improve it.[710]

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, and integration of services and realigned payment policies.[711] 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."[712] At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.[713] 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 no outcomes and heightened productivity; and a culture that is committed to change.[714]

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 vertical 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 to the new network directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.[715] 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.[716] The central office structure would be marked by its *flatness*, foregoing a tiered hierarchy.[717]

The system Kizer and his team inherited was characterized by a multitude of problems.[718] 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.[719]

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[710] Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours*, (3rd ed., Berrett-Koehler Publishers, Inc. 2012) 50-51.
[711] Ashish Jha, M.D., et al., *Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care,* N Eng J Med, vol. 348 (May 29, 2003), 2218. http://www.nejm.org/doi/full/10.1056/NEJMsa021899#t=articleBackground
[712] Longman, 51.
[713] *Not Your Father's VA, supra*, 97-8.
[714] Id., 105
[715] Id., 110.
[716] Ashish Jha, What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation, Agency for Healthcare Research and Quality Patient Safety Network (Sept. 2006). https://psnet.ahrq.gov/perspectives/perspective/31
[717] Not Your Father's VA, supra, 111.
[718] Kenneth Kizer and R. Adams Dudley, Extreme Makeover: Transformation of the Veterans Health Care System, Annu. Rev. Public Health, vol. 30 (2009), 316.
[719] Id. 318-323.

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,[720] and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.[721]

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, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,[722] and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.[723] 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.[724]

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 thousand acute care beds, merged 52 medical centers into 25 multicampus 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.[725]

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 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."[726] 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.[727]

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

[720] VA in 2006 won the Harvard Innovations in Government Award for its VistA system. See Not Your Father's VA, supra 211.
[721] Not Your Father's VA, supra, 157-165.
[722] Kizer and Dudley, supra, 323.
[723] Not Your Father's VA, supra, 128-129.
[724] Kizer and Dudley, supra, 319-320.
[725] Id., 170.
[726] Id., 133-134.
[727] Id., 168-169.

to give VA a tool to align demand for care with its funding level.[728] 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.[729] 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."[730] 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 GAO 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.[731]

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.[732] As the then under secretary for health 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."[733]

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.[734] A cascade of other events muddied, and even blackened, VHA's reputation: accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center; failed software acquisitions;[735] 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 VA Medical Center represented a decisive turning point and set the stage once again for transforming veterans' health care.

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[728] H. Rept. 104-690 (July 18, 1996).
[729] *Not Your Father's VA*, supra, 193.
[730] Id. 194.
[731] *Not Your Father's VA*, supra, 195.
[732] *Not Your Father's VA*, supra, 196.
[733] Dr. Robert H. Roswell interview (2011) as quoted in *Not Your Father's VA*, supra, 196.
[734] See, Phillip Longman, "Best Care Anywhere," Washington Monthly, (Jan./Feb. 2005), http://www.washingtonmonthly.com/features/2005/0501.longman.html. Gilbert Gaul, "Revamped Veterans Health Care Now a Model," Washington Post (Aug. 22, 2005), http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html. Catherine Arnst, "The Best Medical Care in the U.S.", Business Week (July 16, 2006). http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot
[735] *Not Your Father's VA*, supra,

APPENDIX F: THE COMMISSION'S PROCESS [IN PROGRESS]

Commission Meetings

The Commission held public meetings …….. 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
VHA Leadership	Department of Veterans Affairs ▪ Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
September 21-22, 2015 (continued)	
Assessment Leadership	CMS Alliance to Modernize Healthcare ▪ 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, Network 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
October 19–20, 2015 (continued)	
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, Veterans Health Administration
December , 2015	
	▪ X
	▪
January , 2016	
	▪ X
	▪
February , 2016	
	▪ X
	▪
February 29 – March 1, 2016	
	▪ X
	▪
March , 2016	
	▪ X
	▪
April 18 – 19, 2016	
	▪ X
	▪
May 9 – 11, 2016	
	▪ X
	▪

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 X.

Table X – Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP
Health Care Alignment	▪ Demographics ▪ Healthcare Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance	▪ Blecker ▪ Gorman ▪ Khan ▪ McClenney ▪ Cosgrove ▪ Johnson ▪ Longman ▪ Selnick
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 X – Alignment Workgroup Process

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
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 (WG) was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The WG (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 WG 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 WG 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 WG 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 X – Health Care Operations Workgroup Process

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

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E= email review M= face-to-face meeting Date	Type	EXPERT INPUT S=met with staff W=met with workgroup F=full commission testimony Expert	Date	Type
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 WG 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 WG 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. The Commissioners are still deciding on the final recommendations and supporting content for each of the four topic areas and when this information is finalized, it will be presented to the full

commission for deliberation. A summary of the work completed on each topic is provided in the table below.

Table X – Data, Tools & Infrastructure Workgroup Process

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			
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 X – Leadership Workgroup Process

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

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 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	3/4/2016	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
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.[736] 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.[737] 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.[738]

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. [739] 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.[740]

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 VISNs. Additionally, all the commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

Table XX1 – 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 CBOC, (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, NC)
10	VA Health Care System	VA Ann Arbor Healthcare System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)

[736] 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.
[737] 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#.
[738] 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#.
[739] Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, http://vaww.ush.va.gov/.
[740] 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.

VISN	VISN Name	VA Facility
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Healthcare System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Healthcare Network	Greater Los Angeles Healthcare System (Los Angeles, CA) VA San Diego Healthcare 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 the 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.[741]

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.[742] 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 (PC3))

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 dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below:

[741] "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.
[742] Department of Veterans Affairs, VHA, Veterans Integrated Service Networks (VISN), accessed March 14, 2016 http://www.va.gov/directory/guide/division.asp?dnum=1

Strengths	Weaknesses	Opportunities	Threats
▪ VAMC 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 ▪ OPM 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 4000-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 health care that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

Another important source for the Commission to consider is 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 through VHA was not possible. 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 membership in open sessions with the Commission and in formal letters and other statements on their positions on issues directly to the Commission.

The feedback offered by veterans directly to the Commission's web site covers 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 which 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 the 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's reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."[743] The Commission reviewed the comments and confirmed the DAV's assessment.

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

[743] All we have is a printed copy. We need a source to cite that the public can review.

provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, the VA like most agencies encourages veterans and others to submit comments on a particular aspect of VA services and benefits.[744]

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 (ADUSH) 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.[745]

Survey of Healthcare Experiences of Patients (SHEP)[746]

The 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, the 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, 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 Choice Act. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

The VHA also established a Veteran Insights Panel composed of over 3,200 Veterans that are representative of users of VA health care.[747] VHA interacts with the panel through email

[744] Cite a source here. What about policies in which the FR requests comments?
[745] For results of the 2015 survey see:
[746] For more details on SHEP and VHA's recent initiatives to expand the scope of the program see: http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1

notification and a special access website (mobile device enabled). This 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)[748] concepts in a pilot to explore Veterans' experience with the VA through the eyes of 40 Veterans across a range of demographics and locations.[749] The pilot had two goals:

1. To test the usefulness and application of a human-centered design methodology within the context of the VA.
2. To better understand Veterans' experiences interacting with the 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 kinds of users within the set of 40 veterans engaged in the pilot. Each persona is an archetype based on commonalities we observed amongst 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 are 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, etc. 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.

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[747] http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1

[748] 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.

[749] *Toward a Veteran-centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report*, US Department of Veterans Affairs, Center for Innovation, July 2014. http://www.innovation.va.gov/hcd.asp

What follows are four distinct narrative vignettes (personas) intended to reflect the attitudes, needs and intentions of veterans as distilled from the 40 veterans extensively engaged in this

THE LIFER

I frequently use VA services and plan to continue doing so. I look to the VA to play a supporting, community building role in my life. I am grateful for my VA benefits, but I get frustrated when problems arise which break up the continuity of my care - like when my doctors change too frequently and when I can't transportation to VA facilities. Generally, I try to speak highly of the VA and want to contribute to making it work better for fellow Vets.

EXPECTATIONS

- That the VA cares and takes the time to understand my needs and story
- Cost of VA services won't rise
- That I can reach someone at the VA anytime I need anything

NEEDS

- I don't want to tell my story over and over, especially after using the VA for so long
- I want to know what's going on with my services and especially my benefits
- I'd like patient, nurturing healthcare

DESIGNING FOR THE LIFER

Allow me to pause and ask questions, and to have access to a VA professional to speak with frequently and in a timely manner. Include info about local Veteran support chapters in communications. Provide me with a single online tool or a call center where they can refill prescriptions, see test results, and maintain all aspects of the VA needs. Give high level of feedback loops so that I can be assured my request was submitted and is being handled.

THE TRANSACTIONAL

I joined the military largely based on the promise of a the opportunities it would afford me in life. I plan to use VA services to 'get my life on track' post-service. I tend to be in the younger generation of Vets (OIF, OFF, OND). I am often engaged in the Veteran community, see other Veterans as allies and I advocate in helping folks understand and use their benefits. But I will share my frustrations if I feel like the VA isn't helping me as promised.

EXPECTATIONS

- That the VA will deliver on it's promises and help me to access the me the benefits I've earned
- That the VA has benefits available to my family
- That it'll be a headache, and I'll have to figure it out on my own with the help of my network

NEEDS

- Accurate expectations
- Financial support at times, especially if I grow a family
- To feel like I am part of a community

DESIGNING FOR THE TRANSACTIONAL

Explain VA benefits and services comprehensively and early so that life plans can made upon quickly post-service. Include lists of phone numbers, websites, resources, and why they are relevant. Auto-enroll when it's possible.

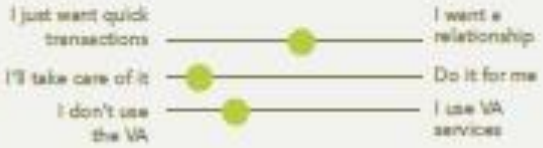
Present benefits as they relate to life events (school: GI Bill, employment: Job resources, family: home loan). Visualize processes, timelines and how I should be prepared.

pilot.

THE JUST-IN-CASE

I am proud of my service, but don't need the VA and plan on using it only as a backup. Mature and organized by nature, I have all of their papers in order with the VA and have a good idea of what I am eligible for.

I am grateful for the benefits available to me, but see working with the VA as a tradeoff for my time and will likely only lean on the VA as backup plan, to make sure my family is taken care of.



EXPECTATIONS

- That I'll likely never need VA benefits
- That the VA will be there for me if I need it
- That there are benefits available to my family
- Private benefits are of higher quality & greater ease

NEEDS

- Peace of mind
- To be assured that all documents are in line
- To easily get in touch with one person about one question

DESIGNING FOR THE JUST-IN-CASE

Offer straightforward information about VA benefits that is easy to then communicate to others. Clearly articulate what is available, when, and to whom involved in my life.

Establish an online portal or phone system where both Veteran and the VA can see that all of paperwork is up-to-date and notify me if something is missing.

THE INFREQUENT

I really don't think very much about the VA. I have used VA benefits in my lifetime, yet often years will go by between those interactions.

This might be because I live in a place where it's difficult to access VA services, because I am financially comfortable or because it seems like too much hassle. I tend to prefer quick interaction - a short phone call or a few clicks on a website.

EXPECTATIONS

- The VA is slow - like any bureaucracy
- The VA is for "other, injured Vets who need it more"
- Someone will tell me when and if I am eligible for something

NEEDS

- To be able to quickly navigate processes
- To be reminded every few years of how the VA might be able to help me

DESIGNING FOR THE INFREQUENT

Provide ways for me to learn about and access benefits both through third parties (i.e at the bank when securing a home loan).

I will most likely use VA services if I can a) see the value for my life and b) accomplish my goals in convenient, simple service interactions. Offer me easy-to-use websites and the ability to speak with someone.

Vantage Point: VA's Official Blog

In addition to surveys, focus groups and town-hall sessions, the VA instituted a blog on its web site and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Go to http://www.blogs.va.gov/VAntage/ 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.[750]

Veterans Views Gathered by Veterans Service Organizations (VSO)

Like VHA, the VSO's solicit input from their membership and other stakeholders on a variety of topics and issues relevant to **V**eterans. 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.

The DAV Veterans Pulse Survey (2015)

In mid-2015 the Disabled American Veterans (DAV) surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.[751] The survey includes questions on various aspects of veterans health care. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the US. 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.

VFW Our Care Veterans Survey (2015)

In the fall 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.[752] In response to the intensified debate over reform of veterans health care, the VFW launched a survey in the summer 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

[750] http://www.blogs.va.gov/VAntage/date/2016/04/
[751] The DAV Veterans Pulse Survey, Disabled American Veterans (DAV), November 11, 2015. 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.
[752] Our Care , A Report on Veterans' Health Care Options, Preferences and Expectations in Health care, September 22, 2015, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf

percent of those eligible reporting that they utilize VA health care.[753] 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.[754] While the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

The American Legion Survey of Patient Healthcare Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's PTSD/TBI programs, including alternative and complementary treatments.[755]

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI, PTSD and/or TBI and 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 healthcare 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 healthcare systems. [756]

Iraq and Afghanistan Veterans of America (IAVA) Member Survey (2015)

During the first half of CY 2015, 1,501 IAVA 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

[753] Our Care, A Report on Veterans' Health Care Options, Preferences and Expectations in Health care, September 22, 2015, p 4.
[754] http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/
[755] http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment
[756] http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf

insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA Choice program was also covered separately.[757]

The 2015 Wounded Warrior Project® (WWP) Alumni Survey

This web-enabled opt-in survey of 23,200 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.[758] This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-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.[759] Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual "conversations" with a pre-selected 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, the DAV reached out to veterans around the US and asked them to share their experiences with the VA health care system. As a result, the DAV received (as of April, 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from the VHA. The Commission was provided a copy of the report containing the verbatim text and is posted on the Commission's web site.[760] The Commission's review of the material showed that a majority of the veterans' comments were positive in nature. The DAV's own analysis concluded that 82 percent of the comments could be categorized as "Overall Positive Experiences."

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[757] http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/
[758] https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf
[759] Right to care: Voices of Swords to Plowshares' Veteran Community, Megan Zottarelli, Swords to Plowshares, Institute for Veterans Policy, undated briefing report. [This report does not appear to be available on its web site. We need to track down a reference we can cite for the report.]
[760] I am assuming we will receive an electronic version of this and will post it. Once we have it, we can create a proper citation for downloading a copy of the document.

Other Surveys on Veterans Issues

In addition to efforts by the 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 (CV_4A) survey of veterans health care (November, 2014)[761]

The CV_4A commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014. This was 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 health care; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

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.

[761] http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf

APPENDIX H: ADDITIONAL RESOURCES [IN PROGRESS]

Further Reading

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.

Military 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 – all 3.1 million of them. 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

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.

- Issue Introduction (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf)
- Did You Know? Moral Injury (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#page=2)
- Practical Pastoral Tips: Getting Started with Moral Injury (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#page=3)
- A Story for Reflection: The Betrayal (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#page=4)
- Research: Moral Injury (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#nameddest=Research)
- A Community Success Story (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#page=5)
- Your Story Matters (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#page=6)
- Moral Injury Readings for Clergy (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#nameddest=Readings)
- VA Resources for Veterans, Family Members and Friends, and Communities (http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December2015.pdf#page=8)

Swords to Plowshares Combat to Community Training

Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by our Institute for Veteran Policy team with the purpose of

educating the community to address the challenges veterans face re-integrating and the unique skill sets they acquire in service. The training is developed for law enforcement, first responders, 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 Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans.
- Our training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase your 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 internal to VA. Versions of these trainings should be made available to community providers through an alternative to TMS which allows these outside providers to access the training.

Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)

This online course, sponsored by Department of Veterans Affairs and Department of Defense, aims to help you understand the role that military culture plays in the lives of those you serve. This 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: Treatment Resources, Prevention & Treatment (VA 19335)

The final 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 Culture Training for Health Care Professionals - Organization and Roles (VA 19332)

This online course opens with an overview of the differences between the explicit and implicit features of military culture and proceeds to describe 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 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 are presented by experts in their field 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 the 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 you better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using mobile devices. The course brochure and evaluation are only accessible through a VA Networked device.

Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)

This online course offers the learner an explanation on 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.

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APPENDIX I: ENABLING LEGISLATION

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:

(I) 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)(E), 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:

(I) 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:

(I) 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.

(C) 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.

APPENDIX J:
COMPOSITION OF THE COMMISSION
[IN PROGRESS]

APPENDIX K:
SUMMARY OF LEGISLATIVE ACTIONS
[IN PROGRESS]

APPENDIX L: ACRONYM LIST [IN PROGRESS]

ACRONYM	DEFINITION
ACA	Affordable Care Act
CDS	Community Delivered Services
CITC	Care in the Community
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
EHCPM	Enrollee Health Care Projection Model
EHR	Electronic Health Record
FY	Fiscal Year
GAO	Government Accountability Office
GUI	Graphic User Interface
HR	Human Resources
HSC	Health Service Category
IT	Information Technology
MTF	Military Treatment Facility
NVTC	Northern Virginia Technology Council
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care

ACRONYM	DEFINITION
PTSD	Post-Traumatic Stress Disorder
SECVA	Secretary, Department of Veterans Affairs
SES	Senior Executive Service
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACO	VA Central Office
VERC	Veterans Engineering Resource Center
VHA	Veterans Health Administration
VHACO	VHA Central Office
VSO	Veterans Service Organization