

**STATEMENT OF BRETT P. GIROIR, MD
TO THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON THE SUBJECT OF THE
"INDEPENDENT ASSESSMENT OF THE HEALTH CARE
DELIVERY SYSTEMS AND MANAGEMENT PROCESSES
OF THE DEPARTMENT OF VETERANS AFFAIRS"**

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Chairman Miller, Ranking Member Brown, and Members of the committee, thank you for the opportunity to provide testimony regarding the Independent Assessments required by Section 201 of the Veterans Choice Act. My name is Dr. Brett Giroir; I am currently Senior Fellow at the Health Policy Institute of the Texas Medical Center in Houston, Texas, and the founding CEO of Health Science and Biosecurity Partners. I am a critical care physician by training, and have previously served in several leadership roles in Texas and nationally, including service as the CEO of the Texas A&M Health Science Center, Director of the Science Office at DARPA (Defense Advanced Research Projects Agency), and Director of the Texas Task Force on Infectious Disease Preparedness and Response. I am honored to appear before you today as Chair of the Blue Ribbon Panel created by the MITRE Corporation to provide support, oversight, and guidance for this independent assessment.

The Blue Ribbon Panel was composed of sixteen distinguished and outspoken experts whose names and brief biographies are listed in Appendix Q of the Integrated Report. Among the Blue Ribbon Panelists were the former CEOs of Kaiser Permanente, Geisinger, and HealthCare Partners; the Physician-In-Chief of Massachusetts General Hospital; a former Surgeon General of the Army; the world's leading academic authority on organizational change; the President and CEO of the National Quality Forum; the former Executive VP of United Health; a former Vice Chief of the US Army; the Webb Professor of Health Innovation at Arizona State University; the President and CEO of the Texas Medical Center; the former President and Chief Executive Officer of the California HealthCare Foundation; the Dean of the Jefferson College of Nursing; a Board Member of national Patient-Centered Outcomes Research Institute; and former Director of Medicare and Medicaid Services. More important than these objective qualifications is that each Blue Ribbon Panel member shared a deep commitment to our Veterans; and nearly all shared personal or family experiences interacting with the Veterans Health System.

Although not specifically required by the Choice Act, the independent Blue Ribbon Panel was fully involved from the onset of the assessment, with complete access to raw data, subcontractor project teams, subject matter experts, and MITRE senior management. We reviewed thousands of pages of data and drafts, engaged in numerous conference calls, and spent four 2-day sessions in highly interactive meetings at MITRE headquarters. We facilitated data collection, provided frequent and candid feedback, and worked collaboratively with MITRE to develop final priorities and recommendations while maintaining our Panel's full independence. Ultimately, as indicated by our

letter included in the Preface of the Integrated Report, the Blue Ribbon Panel members unanimously endorsed the Integrated Report and its findings and recommendations.

As the Members of the Committee have read, the Report contains numerous near-term operational recommendations, few of which were unexpected. For example, enhanced physician productivity – a key component to enhancing access for Veterans - will require more exam rooms, increased clinical support staff, improved patient scheduling, and greater authority granted to clinic directors for overall resourcing.

But more importantly, the Report also offers recommendations to solve deeper root-cause issues that have persistently plagued the VHA, and have prevented the successful implementation of reforms that were already suggested by the 137 previous VHA assessments. As MITRE has already testified, these root-cause issues are the basis of four overarching recommendations in the areas of Governance, Leadership, Operations, and Data and Tools that must be solved using an integrated systems approach. Addressing each of these four overarching recommendations is essential before any long term, sustained improvements in access, patient experience, and quality of care can be realized.

Indeed, even the example I just gave of improving physician productivity appears straightforward, but would require reform of unnecessarily bureaucratic clinical staff hiring processes, which take three times as long as the private sector; empowerment of VA medical center leadership to flex resources to meet dynamic patient access needs; commitment to a modern electronic scheduling system that transparently indicates appointment availability to both schedulers and patients alike; and overhaul of the facilities construction and leasing processes that now cost twice as much as the private sector but proceed at a pace that is two- to three-fold more slowly.

I will briefly describe these four overarching areas in more detail from the perspective of the Blue Ribbon Panel. This perspective was recently highlighted in a lead article appearing on September 30, 2015, in the *New England Journal of Medicine*, entitled “Reforming the Veterans Health Administration: Beyond Palliation of Symptoms.”

First, the VHA must establish a governance model that is representative, expert, relatively insulated from direct political interactions, and empowered with the necessary authority to improve quality, patient experience, personnel management, data validity, and cost-effectiveness. One of the most

urgent strategic priorities is to determine and clearly communicate the future mission of the VHA, and for Congress to align resources and authorities to meet that specific mission. As background, in 2014, 9.1 million of 21.6 million U.S. Veterans were enrolled in the VHA. Of these, only 5.8 million were actual VHA patients; and on average, these patients relied on VHA for less than 50% of their health care services. Much of that reliance was driven by a lack of health insurance — a driver that is now diminishing due to federal and various state initiatives.

These demographic data combined with access challenges suggest reconsideration of whether the VHA should aim to be *the* comprehensive provider for all Veterans' health needs — or whether the VHA should evolve into more focused centers providing specialized care, while utilizing non-VHA health care networks for the majority of Veterans' health care needs. Either paradigm could be highly beneficial to Veterans, as long as demand and resources are prospectively aligned, and there is a consolidation of current programs to simplify access to non-VHA providers. Under any future allocation scenario, however, the Panel believes there must be a region-by-region evaluation of Veterans' current and predicted health care needs in the context of both VHA and non-VHA health care capabilities. This evaluation may result in the elimination of some VHA inpatient beds, expansion of VHA or non-VHA outpatient or community resources, an increasing emphasis on non-VHA providers, or some combination of adjustments to assure access to high quality and cost-effective care.

Second, the VHA is currently experiencing a crisis in leadership because of an organizational environment that is perceived as disempowering, frustrating, and occasionally toxic. The VHA scored in the bottom quartile on every measure of organizational health assessed in the Report. VHA leaders believe that they are accountable for quality and patient satisfaction, but have little authority or flexibility to achieve their objectives. Risk aversion and mistrust within the VHA further inhibit innovation and demoralize otherwise passionate and committed professionals. Compensation for administrators is frequently 70% below that in the private sector. As a result, at the time of our assessment, 39% of senior leadership teams at VHA medical centers had at least one vacancy; and 43% of network directors had “acting director” status. Sixteen percent of VHA medical centers lack a permanent director. Moreover, more than two thirds of network directors, nurse executives, and chiefs of staff are eligible for retirement, as are 47% of medical center directors.

The solution, we believe, is multidimensional but starts with immediate changes in practice that will ultimately change culture to one that is Veteran-centric and committed to continuous improvement.

The VHA must push decision rights, authority, and responsibilities down to the lowest appropriate administrative level. The VHA must increase the appeal of senior leadership positions by pursuing regulatory or legislative changes that create new classifications for VHA leaders, and develop a robust leadership training and succession plan that nurtures future leaders in an environment that values honest assessments.

Third, the VHA must develop a patient-centered operations model that balances local autonomy with appropriate standardization, and shares best practices for high quality health care, patient experience, and cost-effectiveness throughout the VHA national system. The VHA Central Office's recent growth (by more than 160%) has not improved performance. In fact, the VHA scores in the bottom quartile in 35 of 37 management practices as compared with peers assessed for the Report. We recommend a shift in VHA focus from central bureaucracy to supporting clinicians and administrators in the field, and a clear articulation of what decision authority resides at each level of the organization. Performance metrics should be meaningful to the Veterans, simple to understand, objective, and numerically much fewer. Most importantly, a systematic approach is needed for identifying and disseminating best practices. The Report highlights many examples of leading VHA regional and site-based practices, for example a number of innovative programs from VISN 4 that have significantly improved patient flow, enhanced staff engagement, enabled review of quality in real time, and instituted novel collaborative partnerships with regional academic centers to ensure availability of inpatient beds.

Fourth, the VHA lacks fundamental enterprise systems and data tools that are required to achieve high-quality care and patient satisfaction in a cost effective manner. Once cutting edge, the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record (EHR) has been stagnant for a decade, and clinicians are frustrated with the lack of integration and mobility and feature deficits as compared with commercial systems. Moreover, the existence of approximately 130 different variations of VistA impedes system changes and dramatically inflates costs. Indeed, 85% of the VHA's FY16 Information Technology budget is allocated to maintenance of the current systems, with scarce remaining funding for IT and software improvements or replacements. Furthermore, VistA's lack of interoperability with Department of Defense systems introduces unacceptable risk into transitions of care, both for highly complex care such as PTSD, TBI, and severe traumatic injuries, but also routine health care of patients with chronic medical conditions.

VHA systems for patient scheduling, staff hiring, supply-chain management, billing, and claims payment are stagnant, lack automation, and have more limited capabilities than their private-sector equivalents. During our study period, the Panel has witnessed that data aggregation across the VHA is highly problematic, requiring enormous manual efforts by highly skilled teams, and data validity is still often impossible to verify.

Veterans consistently complain about the lack of patient-centered navigational tools that are generally available in most non-VHA integrated health systems. We believe that the VHA must provide these fundamental tools to clinicians, local administrators, and to Veterans. Moreover, the VHA should immediately perform a comprehensive evaluation of whether it should continue high-cost custom development and maintenance of VistA, or implement a commercial EHR and associated business and management systems.

Finally, on behalf of the Panel, I would like to express our appreciation to the hundreds of experts who contributed to this Report, and to the literally thousands of contributing Veterans and VHA employees who believed that this Report would become a roadmap to achieve the highest quality of care for Veterans, at a cost we can afford, and in a culture that would be the envy of any health care system in the nation. I would also like to express our gratitude to this Congressional Committee for your support of Veterans and our Panel, and for the opportunity to answer any questions related to our assessments and recommendations.