STATEMENT FOR THE RECORD

OF

PARALYZED VETERANS OF AMERICA

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

"FROM TUMULT TO TRANSFORMATION: THE COMMISSION ON CARE

AND THE FUTURE OF THE VA HEALTHCARE SYSTEM"

SEPTEMBER 7, 2016

Chairman Miller, Ranking Member Takano, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to express our views on the Commission on Care's Final Report. We appreciate the Committee's continued commitment to thoroughly examining the best way forward for comprehensive reform in the delivery of veterans health care.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

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

PVA supports the creation of fully integrated health care networks with the Department of Veterans Affairs (VA) maintaining responsibility for all care coordination. This part of the recommendation is consistent with the proposal that PVA along with our partners in *The Independent Budget* (IB)—DAV and VFW—put forward late last year. We also support eliminating the 30-day and 40-mile standards for access established as part of the Choice program. The IB offered a similar recommendation last year suggesting that access to care and when and where to seek service should be a clinically-based decision determined by the veteran and his or her provider, not an arbitrary access standard. Despite our support for the concept of creating fully integrated health care networks, we have some significant concerns with other aspects of the Commission's recommendation.

We are first, and foremost, concerned with the Commission's recommendation for "choice." The report proposes that veterans should have unrestricted choice for any primary care provider within their newly-constructed network. In order to access specialty care (outside of VA's specialized services), veterans would be required to get a referral from their designated primary care provider.

The Commission does not, however, discuss what the boundaries should be in establishing the networks. The breadth of the networks is limited only by the Commission's assumption that the networks will be "tightly managed" by VA and that primary care providers wishing to participate will meet certain quality standards. Together these two parameters do not establish a clear picture as to what extent VA may efficiently dilute its capacity to deliver care in favor of outsourcing to the private sector.

These networks must be developed and structured in a way that preserves VA's capacity to deliver high-quality care while specifically preserving its core competencies and specialized services. Without a critical mass of patients, VA cannot sustain the very infrastructure that supports and makes VA specialized services world-class. Providing veterans unfettered choice as to their provider jeopardizes this baseline of patients. A better proposal is found in VA's Plan to Consolidate Community Care Programs, which rests on a principle of using community resources to supplement service gaps and better realign VA resources. This sets a natural boundary that would prevent the networks from expanding to a harmful and unmitigated degree. Ultimately, the Commission failed to articulate what constitutes a "tightly managed" network, and it admittedly did not contemplate "[r]eductions in the volume of care within VA facilities, and potentially adverse effects [on] quality . . . ."[1] The result we are left with is lip service paid to preserving VA's specialized services.

In addition to VA specialized services, there is insufficient discussion regarding care coordination within these networks. The recommendation suggests that care coordination take place through all primary care providers, but VA would assume overall responsibility for care coordination of all enrolled veterans. There is no delineation, though, as to exactly where VA and community providers hold responsibility. The recommendation is conflicting and could ultimately lead to finger pointing instead of well-coordinated care for veterans being served in the community. We would again point to VA's Plan to Consolidate Community Care Programs.[2] VA's proposal would administer care-coordination based on the intensity of coordination needed. This method offers the functionality and flexibility needed to ensure that patients with complex cases receive adequate attention and resources. It also tailors the level of care coordination to each individual patient's complexity and needs, regardless of whether the patient receives care in VA facilities or in the community.

We are further concerned with the report's consideration of funding for the new health care delivery system. It does not clearly reconcile how VA currently determines its appropriations

[1] Commission on Care, *Final Report*, June 30, 2016, p. 32 (hereafter "Report").
[2] Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, pp. 21-25, http://www.va.gov/opa/publications/va_community_care_report_11_03_2015.pdf.

needs through the Enrollee Health Care Projection Model (EHCPM) with how it will have to determine its appropriations needs through the new system with local leadership input.

The report also considers cost-sharing, particularly for veterans with non-service connected disabilities. The cost-sharing opportunity would be used to expand options for choice, but it would likely come with increased costs for Priority Group 4 (non-service connected catastrophically disabled) who do not currently have a cost for their care. This proposal is contemplated within the larger context of determining priority of service. The report recommends priority be given to service-connected disabled veterans and those with low incomes, but it does not properly consider the relationship of Priority Group 4 veterans to the system.

Finally, as VA begins to involve community providers at a greater rate, it is essential to ensure that the process for adjudicating medical malpractice claims is the same whether that care was received in the community or within VA. In almost all cases, the current process under 38 U.S.C. §1151 treats malpractice claims the same regardless of where they received care. However, certain unique situations still present inequitable results for veterans.

Clinical Operations

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

PVA generally supports this recommendation as it would allow providers in the VA health care system to practice within the full scope of their licenses. The report also addresses bed capacity reporting as originally established by P.L. 106-117, the "Veterans Millennium Health Care and Benefits Act." It appears to endorse a requirement for VA to report beds as closed, authorized, operating, staffed, and temporarily inactive.

We reiterate our support for reinstating the capacity reporting requirement originally established by P.L. 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996." VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans. Reductions in both inpatient beds and staff in VA's acute and extended care settings have been continuously reported throughout the system of care, particularly since the capacity reporting requirement expired in 2008.

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

PVA supports this recommendation as it aligns VA with widely accepted medical practice. As it stands, each Veteran Integrated Service Network (VISN) has its own process for appealing clinical decisions. Failure to standardize the appeals process across VA naturally produces a disparity in outcomes among similarly situated veterans seeking to bring clinical disputes. Furthermore, external review of final VA decisions is subject to the discretion of the VISN director.

One aspect of current VA policy that is not addressed in the Commission's report is the latent conflict of interest in the patient advocate office that each VA facility employs to manage and resolve complaints. While patient advocates generally serve as the liaison between patients and clinicians, their ability to fully advocate on behalf of the veteran is hampered by the fact that they are forced to present criticism to those who hold the keys to their career. The "program operates under the philosophy of Service Recovery, whereby complaints are identified, resolved, classified, and utilized to improve overall service to veterans."[3] Capturing useful data by documenting complaints in order to facilitate positive changes at VA is productive, but the incentive to downplay patterns of conduct and other pervasive issues exists and limits potential progress. As a solution, PVA has suggested before that the patient advocates should be removed from their current personnel structure and report instead to the MyVA Veterans Experience Office in order to offer more robust, constructive criticism when patterns emerge among veteran complaints.

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

PVA supports this recommendation. The principle of diffusing knowledge and best practices throughout VA is important and should be encouraged. As the report indicates, VA currently has resources, such as the Veterans Engineering Resource Center (VERC), that are underutilized. To truly capitalize on these available benefits, though, VA must thoroughly pursue personnel management reform. A large contributor to stagnant innovation and distribution of best practices is due to persistent, wide-spread vacancies in senior leadership positions. Acting directors or senior managers, as opposed to permanent leaders, have a limited ability to implement long-term changes because of the uncertainty of their tenure. Fixing the issues that pervade the personnel system will go hand-in-hand with success in adopting a continuous improvement methodology.

Health Care Equity

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

PVA supports certain aspects of this recommendation, but we believe that this recommendation perpetuates a false narrative about VA health care prematurely and without a thorough understanding of the scope of the problem. Health care systems across the United States are acknowledging and seeking to address health care equity, inequality and disparities. VA has conducted its own studies and found that disparities do exist. Dealing with these disparities when and where they exist requires affirmative steps to combat the problem. It is essential, however, to thoroughly understand the root causes and true scope of the problem before implementing an effective plan.

[3] VHA Patient Advocacy Program, VHA Handbook 1003.4 (2005).

VA's unique history of providing care for historically underserved populations, particularly poor or near poor veterans with chronic medical conditions and behavioral health conditions, suggests that patterns within the private sector should not be arbitrarily appropriated to VA without thorough examination. Furthermore, because cost is often not a barrier to care within VA, a significant distinction between VA and private sector care must be made based on the absence of typical market influences affecting private sector outcomes.

Before mandating that VA make "implementation of the VHA Health Equity Action Plan (HEAP) nationwide"[4] a strategic priority in the face of all the other competing issues, more research and better information is needed to help inform VA's planning and allocation of resources. The 2015 Evidence Brief relied upon by the Commission's report specifically states that the sources of the disparities identified were not examined.[5] The Evidence Brief concludes that more research, specifically related to the sources or causes of the disparities is needed before an accurate assessment of the issue can be made.[6] To this end, we support the proposal to plus-up the staff dedicated to examining this issue within VA. It will not only encourage VA to determine how pervasive certain issues are and root out causes of the disparities that exist, but it will also permit VA to apply lessons learned from its own successes, such as its leadership on the issue of health care equity in the LGBT community acknowledged by the Commission in its discussion related to diversity and cultural competence.[7]

Facility and Capital Assets

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

Position: PVA strongly supports this recommendation. VA's capital asset management has been substandard, to say the least, in recent years. We support, in accordance with the recommendations of *The Independent Budget*, the expansion of ambulatory or urgent care. We also believe that VA must make a concerted effort to right size its infrastructure, in light of the amount of unused and underutilized capacity in the system. However, we are not absolutely convinced that a BRAC-modeled concept is the most effective way for VA to realign its capital footprint. Finally, we fully support the recommendation the report offers to free the VA of the strict fiscal constraints that have hampered its ability to manage its capital leasing program.

Information Technology

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

[4] Report, p. 54.
[5] Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf, pp. 1, 3, 33.
[6] *Id*., p. 28, 31.
[7] Report, p. 137.

PVA fully supports this proposed recommendation. We have repeatedly advocated for reform to VA's IT system management and enterprise through *The Independent Budget* (IB). The IB strongly opposed IT centralization in 2006 (a move forced by then Chairman of the House VA Committee, Steve Buyer). We believe many of the problems identified by the Commission originated with that centralization, and the report essentially affirms our belief. We believe that the Commission's recommendations could be taken even further to fully decentralize IT into VHA once again. This will provide more health care IT innovation, flexibility with the IT budget and better IT outcomes.

However, we recognize that cost for these reforms remains a significant hurdle to advancement. Indeed, VA's Plan to Consolidate Community Care Programs similarly called for significant IT upgrades in order to be successful. The plan was presented to this Committee in late 2015 and was well-received on both sides of the aisle, but several members of Congress balked at the cost of paying for this necessary upgrade. Ultimately, we strongly believe that this is a cost that must be met for VA to have the opportunity to fully modernize its IT infrastructure. This is particularly true in light of the discussion regarding use of commercial off-the-shelf (COTS) IT products.

PVA has no strong position on whether VA should choose a COTS solution for its IT systems or design its own systems. However, it would seem that leveraging COTS would make innovation and modernization more dynamic and possibly more cost efficient.

Supply Chain

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

The Commission accurately outlines the supply and contracting problems within VHA and VA. The corresponding recommendations are good business concepts if VA and VHA have the funding, ability and leadership to implement them. The recommendation to have VA and VHA re-organize all procurement and logistics operations for VHA under the VHA Chief Supply Chain Officer (CSCO) is the correct organizational solution. However, in order to implement the recommendations, there must be multiple changes in other departments throughout VA and VHA. Absent these changes, implementation of these recommendations will cause disruption, confusion and uncertainty at the Central Office level and will be even worse at the field level.

PVA has also identified some additional concerns with the recommendation. The attempt to standardize medical equipment and supplies, as offered in the report, would include prosthetic equipment. The danger is that there is no leadership or expertise in VHA to manage the standardization of prosthetics. There are certainly prosthetic items and supplies that can be standardized, but even those items must be carefully reviewed by an expert clinical team composed of clinicians, contracting, prosthetic and veteran representatives who use the particular items under consideration. Additionally, the report does not contemplate how far down the supply chain standardization of prosthetic equipment should go.

If VA was to pursue the reforms recommended in this section, PVA has a number of implementation level items that could be offered to improve the process and increase the likelihood of a successful transformation.

Governance, Leadership and Workforce

Board of Directors

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

While PVA understands the intent of this recommendation, we do not support it. We agree with the notion that too frequent turnover of VHA leadership has stymied innovative leadership and transformational change. However, replacing politically-appointed leadership with a Board comprised of leaders representing multiple political ideologies will likely lead to even greater gridlock. At the very least, it is simply trading one political entity for another; it does not get rid of the political interference. We can easily envision a scenario where this new appointed Board becomes a reflection of the political leadership of Congress that has demonstrated no ability whatsoever to govern or compromise. While the current leadership of VA is based on nomination by the President and approval by the Senate, this proposal takes political influence too far. One only need to look at the workings of the Commission itself and a number of its politically-motivated members to realize the potential negative consequences politically-driven decisions could have on the delivery of health care for veterans.

Additionally, while the recommendation places emphasis on ensuring veterans are included on the Board, it does not include any real consideration of veterans' service organization representation.

Leadership

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

PVA supports this recommendation. This recommendation cuts at the necessary leadership to effect the cultural changes required to make VHA a more responsive and dynamic organization.

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

PVA supports this recommendation. Succession planning for leadership is a problem that exists across the federal government, not just at the VA. The process by which senior leaders are brought into the VA system, particularly VHA, is cumbersome and complicated. VA too often loses out on some of the best candidates because of the nature of the HR process that fills open leadership positions. The direct-hire authority proposed by the report could provide improved opportunities to bring on critically needed senior staff in the health care system. Additionally, a

renewed focus on leadership development and management could ensure that the best candidates are retained in the VHA system.

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

PVA generally supports this recommendation. We believe the vision that the Commission provides for how to change the organizational structure of VHA could prove beneficial to improving management of the system and implementation of policy. We are disappointed that the report does not provide more discussion about the inefficiency of the current VISN structure. Additionally, we remain skeptical about the efficacy of the proposed simplification of the VHA budget. While this sounds reasonable out of context, it does not reflect the complicated nature of budget development and appropriations distribution within VHA.

We do support the notion of more transparent and detailed accounting and disclosure of VHA's expenditures. This recommendation is consistent with recommendations made by the IB during debate and passage of legislation to establish advance appropriations for VA health care.

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

PVA generally supports the creation of a workgroup to establish a new performance management system for VHA leadership. However, we are not certain that it is appropriate to establish performance metrics that are identical to those used in the private sector. The nature of VA health care delivery is appreciably different from the delivery of health care in the private sector. While there are some aspects that are similar, the VA health care system is not so much like the private sector that it should be evaluated in exactly the same manner. With this in mind, performance standards for employees and management should not be exactly the same either.

Diversity and Cultural Competence

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

PVA generally supports this recommendation; however, we take exception to the implication that VHA somehow lacks the cultural and military competence to provide veterans' health care. VA is the embodiment of veteran cultural competence, and it is, in fact, one of the notable reasons veterans who receive health care from VA prefer it over the private sector. We strongly support the recommendation that cultural and military competence be criteria for allowing community providers to participate in the VA's integrated health networks. In the past, private

providers have openly testified before the House Committee on Veterans' Affairs that one of their primary concerns with treating veterans is not understanding veterans and their experiences as patients. This very circumstance is one of the primary reasons that the private sector is not the ultimate solution to VA's access problems.

Workforce

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

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

PVA supports many of the pragmatic ideas found in recommendations 15 and 16 related to VHA workforce issues. A modernized and effective human resources operation is vital to any organization, especially one as large as VA. We believe the federal personnel system is one of the largest hindrances to effective management of the VHA system. Recommendations 15 and 16 deal with two aspects critical to successful reform: the authorities which govern the personnel system and the overall management of human resources (HR) within VHA.

The multiple authorities governing the VHA personnel system are incompatible with a dynamic high-performing health care system. Hiring managers and their employees must attempt to understand the end-to-end hiring process under four separate rules systems. This unnecessarily adds complexity to the hiring system which is difficult for both the potential employee and the human resources staff to navigate. The unnaturally slow hiring process also produces lost talent. Quality employees do not often have the luxury to wait around for a VA employment application to be processed. Similarly, when an employee announces his or her forthcoming retirement or departure from VA, HR is unable to begin the recruiting or hiring process for that position until it is actually vacated. It not only causes an unnecessary vacancy – exacerbated by the lengthy hiring time – but it also prevents a warm handoff between employees and any chance for training or shadowing.

PVA also believes that VA has suffered from its inability to be competitive with its private sector health care counterparts who do not face the same restrictions on pay and benefits for critical staff. We support the recommendations to align pay and benefits to make the VA more competitive for important staff with the private sector.

The broad recommendation to consolidate all personnel authorities into one alternative personnel system will bring wide benefits, but it must also include increased flexibility in the actual hiring process. It must also establish clear standards for disciplining or removing poor performing employees without diminishing current due process protections afforded by law.

In short, the VHA workforce arena is ripe for numerous practical changes that would provide realistic opportunities to reconcile personnel reform and preservation of the due process protections currently afforded to VHA employees.

Eligibility

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

PVA supports this recommendation. This recommendation mirrors legislation introduced earlier this year—S. 1567 and H.R. 4683, the "Fairness for Veterans Act"—which PVA publicly supported. There is overwhelming evidence that the effects of war can cause psychological harm, drastically changing the personality and behavior of service members. Sometimes those effects manifest and adversely affect the terms of the veteran's discharge. It is a poor irony and ultimately unjust to withhold care for an injury incurred during service solely because that injury provoked or caused the actions which led to their discharge classification. While most commanders are dedicated and caring leaders, many do not have the intimate knowledge of a service member's behavior prior to the trauma they experienced during military service. Other leaders may even find it "expedient" to rapidly discharge an individual to rid themselves of a problem in the unit. Too often these discharges are determined without regard to the cause of the altered behavior. Having an effective mechanism to review the discharge in a deliberate manner can ensure that veterans deserving of care for injuries incurred as a result of their service are not denied.

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

PVA is very cautious of this recommendation. The Commission generally supports with evidence its belief that the issue of eligibility needs to be reexamined or updated in order to better align capacity and demand. But it does not support or even present a rationale for why this undertaking should be conducted by an entity outside VA or Congress. The recommendation to outsource this task treads into the territory of eligibility with a different, and potentially harmful, perspective – that of business efficiency.

The benefits currently afforded to, for example, Priority Group 4 veterans reflects years of hard work and advocacy that forced our country's representatives to make tough business decisions within the context of long-accepted philosophical principles. What this country owes its veterans and what it can afford to pay cannot always be reconciled. It does not absolve this nation's responsibilities to its veterans. In such circumstances VA and Congress should act from the perspective that they must fight not just to better manage resources but to also find the necessary appropriations to cover the obligation. "Restructuring the debt" and trimming veterans from the rolls based on a cold and calculated business-driven decision is not an option. The budget must not be balanced on the backs of veterans.

Conclusion

Mr. Chairman, we would like to thank you once again for the opportunity to testify on this important issue. This concludes our statement for the record. We would be happy to answer any questions the Committee may have.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2016

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $200,000.

Fiscal Year 2015

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $425,000.

Fiscal Year 2014

No federal grants or contracts received.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.