

Statement for the Record

Of



Presented

By

John Rowan, National President

To the

House Veterans' Affairs Committee

Regarding

**“From Tumult to Transformation: The Commission Care and the
Future of the VA Health Care System”**

September 7, 2016

Chairman Miller, Ranking Member Takano, and distinguished members of this august committee, Vietnam Veterans of America presents for the record, and for your consideration, our observations on the final report of the Commission on Care.

Before we offer VVA's comments, we do want to acknowledge the yeoman efforts, accomplished on a very tight timeline, by the commissioners and the very knowledgeable and gifted commission staff. In particular, we want to applaud the strong and steady leadership of commission chair Nancy Schlichting, who piloted a ship with a diverse crew with very different ideas through very rocky waters. She deserves our praise, and your thanks.

During public meetings of the commission, a number of folks, including the Chairman of this committee, acknowledged that without a buy-in from the veteran's service organizations, the commission's recommendations, their vision, would not go very far. Although there are several very well-thought-out and logical recommendations that ought to be adopted via legislation from Congress or regulation from the Department of Veterans Affairs, the "big picture" as conceptualized by the commission is in many respects problematical, and cannot garner VVA's assent.

Certainly, however, VVA does not quibble with the stated mission of the commission: to enhance and improve a healthcare delivery system that will "provide eligible veterans prompt access to quality health care."

Let us begin with some facts:

- The Commission on Care was borne of the so-called Choice Act, enacted into black-letter law after legislators and the media finally recognized a situation that had existed for some two decades. It was a "scandal" that galvanized Congress to act, however belatedly. In fact, the media often put the adjective "beleaguered" before "VA" in their reportage after the scandal broke. That neither Congress nor the Administration nor the media had taken heed about a long-standing situation before did not even make the back-story.

- The Veterans Health Administration is an integrated managed care network, the largest in the nation. Long before the legislation that created the Choice Act, a provision of which established the Commission on Care, the VHA availed veterans of care by community providers, when necessary or appropriate. More than one out of every ten VA healthcare dollars was expended outside of VA Medical Centers and community-based outpatient clinics, or CBOCs.
- VA Medical Centers, for the most part, provide “one-stop shopping” for primary and specialty care, something that is not afforded at most private-sector hospitals and healthcare facilities. In addition, the VHA, under the gritty leadership of the current Under Secretary for Health Dr. David Shulkin, is making significant strides in transforming the VA health care system and embracing greater community care.
- The quality of care in VHA facilities is good to excellent and is in many areas superior to care from private hospitals or medical centers. This the commission has acknowledged. The issue is, as it has been, one of access into VA healthcare facilities, where there are too few clinicians to meet the needs of the veterans the VA is charged with serving. Yet the shortage of healthcare professionals is hardly limited to the VA; this is a national problem, one that is particularly acute in rural and remote areas as well as in inner cities.

Now, it should be noted at the outset that the commission’s recommendations for transformative change in healthcare delivery are not intended as an immediate palliative; rather, the charge of the commission was to envision what the VA healthcare delivery system should look like in 20 years, and to provide a blueprint on how to get there.

To the commission’s credit, commissioners rejected the goal of some to privatize VA healthcare. They nixed the idea of unfettered “choice,” of giving eligible veterans the option of going to any private-sector healthcare providers of their choosing, with the VA footing the bills, which would have transformed the VA, in effect, into a source of income. They would scrap the time (30 days) and distance (40 miles) criteria for access to community care, one of the provisions of VACAA, the Veterans Access, Choice, and Accountability Act.

Several of the commission's recommendations ought to be seriously considered and adopted, via either legislation or executive action. These, which can be done under the current construct of the VHA, include:

- Convening “an interdisciplinary panel to assist in developing a revised clinical-appeals process” (Recommendation #3).
- Consolidating idea and innovation portals, and best practices and continuous improvement efforts, in the currently underutilized Veterans Engineering Resource Center. The commission imagines the VERC as having considerable input in properly aligning “systemwide activities [that] require substantial change”—human resource management, contracting, purchasing, information technology (Recommendation #4).
- Making health care equity “a strategic priority,” increasing “the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures” (Recommendation #5).
- Because the VHA “not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings . . . it is critical that an objective process be established to streamline and modernize VHA facilities . . .” The commission also offers that the “facility and capital asset realignment process” be modeled after the wildly unpopular but necessary DoD Base Realignment and Closure Commission (BRAC) process “as soon as practicable.” With Congress not overly enthusiastic about the BRAC process for eliminating outmoded or unneeded DoD facilities here in CONUS, to think that legislators will embrace this idea of shuttering VA facilities is pie-in-the-sky (Recommendation #6).
- “. . . VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health” (Recommendation #7).

- Because VHA's supply chain management "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 VA should establish the position of VHA chief supply chain officer, to be compensated "relative to market factors," the first step in achieving "a vertically integrated business unit extending from the front line to central office" (Recommendation #8).

Perhaps the key recommendation of the commission that we can embrace is the need to achieve strong, sustained – and sustainable – leadership on all levels of the VHA. Congress must therefore authorize "new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts." The VHA also should establish "two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs."

What the commission advocates here, and what was a key discussion point during its public meetings, is the need to attract, and to train, the best and the brightest, who would serve for a set term or the long term, and who would be recompensed according to the market in a particular catchment area. To achieve this, Congress must empower the VHA to offer competitive salaries and benefits to attract the most qualified candidates, both from within and from out of the VHA hierarchy (Recommendation #11).

The commission notes the need for "developing the cultural and military competence of [VHA] leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans." The commission is on target in asserting that "cultural and military competency" must be among the criteria for "credentialing" external clinicians to treat veterans (Recommendation #14).

Finally, here is a relatively radical recommendation that warrants congressional scrutiny and consideration: “Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.” The commission recognizes, rightfully, that some former service members in fact “have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service,” thus rendering them ineligible for VA health care and other benefits. “This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides” – care that they vitally need.

The commission proposes, “VA revise its regulations to provide *tentative* eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.” This may not be simply a matter of the VA revising regulations – Congress will need to enact legislation to enable the VA to treat these veterans – but it is an idea worthy of merit.

THE FUNDAMENTAL PROBLEM, however, with the commission’s conceptualization for the future of VA health care commences in the language of its initial recommendation. This calls for “. . . community-based health care networks” that will “integrate health care within communities.” This would essentially fold VA-provided health care into a wider community-oriented network of providers rather than integrating local or regional providers into a VA network. It is this overall structure envisioned by the commission of a “new” VHA that is the problem.

Perhaps more basic to the relationship between clinician and patient is the assumption that most veterans want to choose their primary and specialty healthcare providers. This precept, the second basic issue we have with the commission’s blueprint, is fundamentally flawed. The commissioners tripped up in paying fealty at the altar of Choice, in conceptualizing an entirely new governance structure, in sublimating VA healthcare facilities into an expansive community context dubbed the “VHA Care System.” Yes, by all means VA clinicians should continue to refer veterans to outside providers when and where appropriate to improve access as well as to provide care that VA clinicians are

unable to deliver. However, no, the VA should not cede, as the commission recommends, the role of primary care clinician to non-VA personnel; this would be a critical misstep, undermining the integrity and managed care the VA offers.

If a veteran needs to see a specialist, s/he often has little ability to divine on his or her own whom to go to and must rely on the recommendation of their primary care provider. In the brave new world envisioned by the commission, the veteran can “choose” to see the “credentialed” specialist of his/her choice. Does anybody really think that this will enable a veteran to get same-day service from a busy clinician? Alternatively, provide better care than s/he can receive at a VAMC or CBOC? On the other hand, save the system money?

In addition, consider the potential for this: If a patient who is covered by private health insurance chooses to be treated by a physician not in the network assembled by her health insurer, she has to pay that doctor out of pocket and fill out a claim form to receive some reimbursement from her insurer. Yet what if that veteran wants to go to a clinician whom the VA has not credentialed? Will he have to shell out his own money, even if he has a disability rated at, say, and 70 percent? Will that veteran complain to his Member of Congress, who will then demand from the local VHA Care System why Dr. X has not been “credentialed”? It is not difficult to foresee a bureaucratic headache of major proportions.

“Foundational among the changes” the commission seeks is “forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.” This is the third fundamental misconception of the commission. The governing board that the commission envisions as necessary to achieving a “bold transformation” ignores reality. Their “Board of Directors” would be a paper tiger that, without the power of the purse, can only recommend, not appoint or institute, thus making it a board of *advisors*.

In addition, veteran service organizations and veteran leaders in effect *already function* as an informal board of advisors on the national and local levels. The VA would have far fewer perceptual problems if its leaders and senior managers acknowledged this and worked in concert with VSOs as a matter of course, seeking and embracing our ideas and input at the beginning of a process, not *pro forma* near its conclusion.

The commission also calls for the creation of “a simple-to-administer 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.” Such a system would render VA hiring as separate and unequal to how hiring is done in the rest of the federal government. (There can be little argument that “VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century.”) Hence, the recommendation that “Congress create a new alternative personnel system . . . in collaboration with union partners, employees, and managers . . . that applies to all VHA employees and falls under Title 38 authority . . . and improves flexibility to respond to market conditions relating to compensation, benefits, and recruitment.”

On one hand, this makes eminent good sense: to obtain and retain top professionals in both medical treatment and hospital administration, the VA healthcare system needs to be competitive with the incentives in the private sector. Moreover, certainly, VHA’s ability to hire qualified staff cannot continue to be hamstrung by bureaucratic constraints and ineptitude. While many clinicians choose to work at the VA because of job security and protected pensions, others also feel a calling to use their skills to care for the men and women who have served the nation in uniform, many of whom have special needs derived from their wartime experiences.

On the other hand, however, Congress quite likely will be skeptical at best about setting precedent by creating an alternative personnel system. Convincing you in Congress to in effect turn the VHA into a quasi-governmental entity while continuing to fund its operations will be the ultimate hard sell. It was the wait-time access issue, a long-time reality in many VA medical centers that raised the ire of Congress, *not* the quality of health care delivered by VAMC personnel. Integrating additional healthcare providers into the VA system, where appropriate and when needed, is part of the rejuvenation of the VHA under the current Undersecretary. This makes sense.

The conceptualization of the commission to create a new entity, one in which VA and private sector clinicians, many with similar skill sets, in essence “compete” to treat veterans will not materially improve health care for those veterans who obtain their care at a VA facility. It is likely to dramatically increase the costs of providing care; and it is likely to lead to the underutilization of certain VA medical centers and community-based outpatient clinics and the subsequent shuttering of

several of them, with the consequent turmoil in staff morale and, eventually, the loss of tens of thousands of jobs. Still, the VA must resolve a situation that continues to plague it: “Hiring timelines [for medical professionals] can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.” (See Recommendation #16.)

There is yet one more recommendation that we find problematical.

Prefacing this, the commission acknowledges that the capacity of the VA to provide care “is constrained by appropriated funding.” In its recommendation that Congress or the President charge some entity with examining the “need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria,” the commission opens the door to initiating pilot projects “for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.”

The 1996 eligibility reform act created eight “priority” groups of veterans eligible for VA health care. Priority 7 and Priority 8 veterans, who are not afflicted with service-connected conditions, must agree to a co-pay for the health care and prescription drugs they receive from the VA. They account for some 40 percent of third-party collections by the VA. In addition, the Vet Centers, as a matter of course, do treat the family members of veterans, a necessity to successfully treat many of the mental health maladies suffered by the veterans they love.

To open a beleaguered health care system to non-vets seems counter-productive. Moreover, it also would dilute the very essence of what should be a *veteran-centric* system. Because there is a certain specialness inherent in receiving care in a place where your service is acknowledged, where an array of conditions – traumatic amputations, spinal cord injuries, mental health afflictions – are understood, where you are among your peers. On this, a monetary value cannot be placed (Recommendation #18).

The commission acknowledges the *raison d’etre* for its own creation by the same act of Congress that initiated the so-called Choice Program: the issue of access. Yet it also acknowledges, “Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.”

The commission notes the key question with which Congress must grapple: Does the VA healthcare delivery system, despite the wait-time scandal, require “fundamental, dramatic change – change that requires new direction, new investment, and profound reengineering”? This is a question VVA and other VSOs, MSOs, and veterans across the country need to consider: Can the VA, given the impetus generated by the issue of access, fix itself, or does it require a radical reformation, one that can conceivably result in its demise?

We believe that the VA, specifically the Veterans Health Administration, can fix itself and in fact *is* fixing itself, in great measure because of the impetus generated by passage of the VACAA. We would hope that you in Congress will monitor what VA leadership is accomplishing; and that members of the media who cover veterans issues would focus less on dramatically highlighting the problems and more on what is being done to ameliorate them. When the VA messes up, by all means report it and let Congress call VA leadership on the carpet. However, report, and so acknowledge, some of the good things that the VA has been doing, e.g., making what is now a cure for hepatitis C available to all veterans enrolled in the VA healthcare system. Thousands of lives are being saved, and this, too, ought to be reported.

Vietnam Veterans of America appreciates having the opportunity to submit, for the record, our position and our conclusions *vis a vis* the recommendations of the Commission on Care. In addition, we thank you and members of the Senate Veterans Affairs Committee for all that they have done, and are doing, for veterans and our families.

VIETNAM VETERANS OF AMERICA
Funding Statement
September 7, 2016

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For further information, contact:

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JOHN ROWAN

John Rowan was elected National President of Vietnam Veterans of America at VVA's Twelfth National Convention in Reno, Nevada, in August 2005.

John enlisted in the U.S. Air Force in 1965, two years after graduating from high school in Queens, New York. He went to language school, where he learned Indonesian and Vietnamese. He served with the Air Force's 6990 the Security Squadron in Vietnam and at Kadena Air Base in Okinawa, helping to direct bombing missions.

After his honorable discharge, John began college in 1969. He received a BA in political science from Queens College and a Masters in urban affairs at Hunter College. Following his graduation from Queens College, John worked in the district office of Rep. Ben Rosenthal for two years. He then worked as an investigator for the New York City Council and recently retired from his job as an investigator with the New York City Comptroller's office.

Prior to his election as VVA's National President, John served as a VVA veterans' service representative in New York City. John has been one of the most active and an influential member of VVA since the organization was founded in 1978. He was a founding member and the first president of VVA Chapter 32 in Queens. He served as the chair of VVA's Conference of State Council Presidents for three terms on the national Board of Directors, and as president of VVA's New York State Council.

He lives in Middle Village, New York, with his wife, Mariann.