STATEMENT OF
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BEFORE THE
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Good morning Chairman Roe, Ranking Member Walz, and Members of the Committee. I appreciate the opportunity to discuss the proposed redesign of the current Department of Veterans Affairs' (VA) Veteran Integrated Service Network (VISN) structure and the status of remedial actions at VISNs 1, 5, and 22. I am accompanied today by Dr. Bryan Gamble, Deputy Chief of Staff at the Orlando VA Medical Center (VAMC).

On March 7, 2018, former VA Secretary David Shulkin announced VA would undertake a systematic review of the VISNs, with a specific focus on VISNs 1, 5 and 22. These three VISNs were challenged with leadership and management issues, low performing facilities, and culture issues. The purpose of the review was to identify VISN strengths and weaknesses, and create a plan to improve VISN oversight, accountability, performance and strengthen lines of communication with VAMCs within that VISN and VA Central Office (VACO). Based on his extensive leadership experience in the military health system, Dr. Bryan Gamble was asked to lead this review and provide recommendations with the goal of informing the redesign process.

Within the Veterans Health Administration (VHA), at times, functional alignment among VACO, VISNs and VAMCs has not always been clear. Our goal is to streamline business processes, ensure clearly defined roles, responsibilities and authorities among all levels in VHA, so that we are functioning in a way that is more efficient, produces better results and accountability. We have also been working with our national

leadership council to develop a new model of governance to help shape the culture, and set expectations and requirements for improved care for Veterans.

Reorganization

A VISN consists of a geographic area which encompasses a population of veteran beneficiaries. The VISN is defined on the basis of VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics and other sites; contractual arrangements with private providers; sharing agreements and other government providers. The VISN is designed to be the basic budgetary and planning unit of the Veterans health care system.

In 1995, VA adopted a new VISN organizational structure to flatten and decentralize VHA's field organization by replacing 4 regions, 33 networks, and 159 independent VAMCs with 22 VISNs that report directly to the Office of the Deputy Under Secretary for Health for Operations and Management. Since that time, two significant reorganizations have occurred resulting in our current structure of 18 VISNs. In addition to these changes in geographic boundaries, investments have been made to standardize the management and oversight of VISNs. VHA has standardized the organizational makeup of the VISN staff to ensure uniformity, as well as strengthening the oversight and management of these positions from VACO. VHA also created a single organizational chart adopted by each VISN office and implemented Quarterly Network Director reviews, which allows for a formal assessment of a VISN's progress at implementing changes and directives.

Systematic review

Since former Secretary Shulkin's announcement, a team led by Dr. Gamble has visited VISNs 1, 5, 22. To look at best practices, the team also visited consistently high performing VISN 23. This team also completed site visits to VAMCs within the following VISNs: Manchester, NH; White River Junction, VT; Loma Linda, CA; Phoenix and

Prescott, AZ; Baltimore, MD; Minneapolis, MN and Washington, D.C. Interviews with leadership and employees were performed; walking tours and inspections of facilities were conducted and performance improvement group meetings were attended. There also were employee listening sessions and clinician-only listening sessions that did not include the facility leadership team.

A **resounding** theme was a dedicated workforce set on providing veterans with the best health care possible, and a clear understanding and willingness from leaders and employees at ALL levels to improve upon deficiencies wherever found. While these three challenged networks are vastly different geographically, the assessment team found common themes across these networks and facilities that included the following opportunities for improvement:

- Inconsistency of Human Resrouces services and hiring;
- Additional emphasis needed on education and training;
- Unintended consequences of Management by Measurement;
- Leadership challenges including turnover, consistency and psychological safety; and
- Employee morale.

VHA is committed to ensuring Veterans get the best care. The findings from this review will be combined with feedback from Network Directors and our on-going modernization effort to formulate the plan for VISN redesign.

Washington DC VA Medical Center OIG Report

One of the key concerns of this committee is the progress of the Washington, DC VAMC. While there is still work to be done, significant progress has been made. In March 2018, the VA Office of Inspector General (OIG) released the report, “Veterans Health Administration - Critical Deficiencies at the Washington DC VA Medical Center.” In summary, OIG found that the DC VAMC (within VISN 5) has for many years suffered

a series of systemic and programmatic failures that made it challenging for health care providers to consistently deliver timely and quality patient care.

Over the past year, substantial progress has been made on the concerns raised by the OIG. These improvement efforts include:

- Establishment of the Incident Command Center (ICC) at the Washington, D.C. VAMC: ICC implemented a robust oversight process that identified and promptly addressed new supply or equipment shortages. ICC instituted a 24-hour hotline for ordering urgent and emergent medical supplies.
- Assured all patients were safe and none were harmed: VHA's National Center for Patient Safety launched a rapid-response approach with onsite visits, bi-weekly and weekly calls with the facility and VISN and ensured all patient safety issues were appropriately addressed. As of January 31, 2018, the facility has cleared their backlog of patient safety incident reports.
- Awarded contract to construct a 14,200 square-foot space for Sterile Processing Services. The $8.9 million project will be completed in March 2019. More than $3.1 million in surgical instruments have been purchased to ensure an appropriate inventory based on the needs of the Veterans served and our surgical teams.
- Transitioned inventory to the General Inventory Package: Medical Surgical Primary Inventory has been entered in the system and the periodic automatic replenishment levels are being validated to ensure stock outages do not occur.
- Secured the off-site warehouse to restrict access and protect medical equipment and supplies.
- Eliminated all pending prosthetics consults greater than 30 days, more than 9,000 to zero.
- Ensured ordering of prosthetics is not interrupted by end-of-fiscal-year financial transitions: At the end of fiscal year 2017, there was no disruption of prosthetic ordering due to lack of funds.

- Allocated resources and expedited hiring into Logistics, Sterile Processing Service vacancies: A year ago, Logistics Service at the DC VAMC was understaffed. Today, 54 staff have been hired; with only 7 positions remaining under recruitment. Sterile Processing Service currently has 15 Sterile Processing Service staff vacancies, 10 of which are currently filled with contract staff.

We know looking at how we operate our networks is imperative. To get the type of accountability that is needed, and to ensure the best quality care this Nation can provide our Veterans is delivered, we have to take a critical look at processes, layers and leaders to ensure we do not see the failures that we saw at the Washington, DC VAMC. As VHA and the Washington, DC VAMC move forward, we are putting in place a reliable pathway for all facilities, VISNs, and business lines to escalate high-priority concerns to senior leadership for prompt action and follow-up. We encourage all employees to speak up and raise concerns to leadership. They are an integral part of our front-line safety net and we take their concerns seriously.

Conclusion

We look forward to this opportunity for our new leadership and improvement efforts to further restore the trust of our Veterans and continue to improve access to care inside and outside VA. Our objective is to give our Nation's Veterans the top quality care they have earned and deserve. Mr. Chairman, we appreciate this Committee's continued support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. This concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.