THE CONTINUITY OF CARE: ASSESSING THE STRUCTURE OF VA'S HEALTHCARE NETWORK

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

WEDNESDAY, JUNE 26, 2024

Serial No. 118–71

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

56–329 WASHINGTON : 2026

COMMITTEE ON VETERANS' AFFAIRS

MIKE BOST, Illinois, *Chairman*

AUMUA AMATA COLEMAN RADEWAGEN, American Samoa, *Vice-Chairwoman*
JACK BERGMAN, Michigan
NANCY MACE, South Carolina
MATTHEW M. ROSENDALE, SR., Montana
MARIANNETTE MILLER-MEEKS, Iowa
GREGORY F. MURPHY, North Carolina
C. SCOTT FRANKLIN, Florida
DERRICK VAN ORDEN, Wisconsin
MORGAN LUTTRELL, Texas
JUAN CISCOMANI, Arizona
ELIJAH CRANE, Arizona
KEITH SELF, Texas
JENNIFER A. KIGGANS, Virginia

MARK TAKANO, California, *Ranking Member*
JULIA BROWNLEY, California
MIKE LEVIN, California
CHRIS PAPPAS, New Hampshire
FRANK J. MRVAN, Indiana
SHEILA CHERFILUS-MCCORMICK, Florida
CHRISTOPHER R. DELUZIO, Pennsylvania
MORGAN MCGARVEY, Kentucky
DELIA C. RAMIREZ, Illinois
GREG LANDSMAN, Ohio
NIKKI BUDZINSKI, Illinois

JON CLARK, *Staff Director*
MATT REEL, *Democratic Staff Director*

SUBCOMMITTEE ON HEALTH

MARIANNETTE MILLER-MEEKS, Iowa, *Chairwoman*

AUMUA AMATA COLEMAN RADEWAGEN, American Samoa
JACK BERGMAN, Michigan
GREGORY F. MURPHY, North Carolina
DERRICK VAN ORDEN, Wisconsin
MORGAN LUTTRELL, Texas
JENNIFER A. KIGGANS, Virginia

JULIA BROWNLEY, California, *Ranking Member*
MIKE LEVIN, California
CHRISTOPHER R. DELUZIO, Pennsylvania
GREG LANDSMAN, Ohio
NIKKI BUDZINSKI, Illinois

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

C O N T E N T S

WEDNESDAY, JUNE 26, 2024

THE CONTINUITY OF CARE: ASSESSING THE STRUCTURE OF VA'S HEALTHCARE NETWORK

WEDNESDAY, JUNE 26, 2024

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:13 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meek, Radwagen, Bergman, Murphy, Van Orden, Luttrell, Kiggans, Brownley, Levin, and Landsman.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. This meeting will now come to order. Before we proceed, I must express my deep disappointment that the U.S. Department of Veterans Affairs (VA) once again failed to send one of the key witnesses we requested. This trend by the Biden administration of not providing the necessary witnesses is truly unacceptable and undermines the oversight responsibilities of this committee that both parties and Congress as a whole take very seriously. We cannot effectively address the critical issues facing our veterans healthcare system without the full cooperation of the VA.

As a 24-year Army veteran, a physician, and a former nurse, I strongly believe that veterans deserve the utmost quality in care. Having served in these positions and as the former Iowa Director of Public Health, I have a deep understanding of providing safe and effective care as it remains one of my top priorities in Congress, to ensure veterans receive the best health care that meets their needs as a patient.

In 1996, Congress approved Veterans Health Administration's (VHA) establishment of the Veterans Integrated Service Networks, also known as VISNs, as part of the major reorganization to decentralize and improve VA healthcare. Currently, there are 18 VISNs that manage and oversee 172 medical centers around the country, throughout the country, and in the territories. Each VISN director is responsible for implementing VA policies, providing leadership for comprehensive coordinated care, and ensuring all facilities in the VISN are adequately staffed and resourced. The VA's undersecretary for health oversees these directors and is responsible for holding them accountable for their successes and for the failures of their networks.

Over the year, VISNs have evolved significantly, sometimes leading to inconsistent administrative practices across the networks. This has resulted in variable treatments, differences in care quality, and accessibility issues for veterans nationwide. A veteran should be able to walk into any VA medical facility across the country and receive the same quality care. However, these administrative variabilities across the VISNs have often caused veterans to receive different treatment based upon their location rather than based upon their healthcare needs.

The VISNs have shown significant growth in their administrative offices but have lacked corresponding improvements in patient care. This lack of improvement is not surprising since VA lacks a comprehensive policy which details the VISN's roles and responsibilities.

Just this week, the committee received an alarming report from the VA's Office of the Inspector General (OIG) about the VA Eastern Colorado healthcare system. The reports highlighted a lack of proactive oversight from VISN leaders, which resulted in employees working in a toxic and an unsafe work environment. VISN leadership also failed to fill vacancies in key clinical positions, which have severely impacted the delivery of care and staff morale. Notably, the Inspector General concluded there were alleged instances of patient harm due to inadequate physician support and unclear processes.

The VA must ensure all visits have clearly defined roles and responsibilities or else we will continue to see significant problems in the delivery of care. That starts with the VA's Under Secretary of Health, Dr. Elnahal, holding his senior leaders accountable if they are not delivering our VA's mission.

Earlier this month, our committee heard from Secretary McDonough to discuss the over $10 million and bonuses that were, I would say, improperly awarded to VA's DC senior executives. Although most of these bonuses have been clawed back, I understand every VISN director was offered an identical 25 percent bonus.

I agree that quality medical administrators deserve to be well paid and rewarded for their service and care. However, when every VISN director gets a huge bonus, regardless of their performance or the performance of the VA medical centers in their VISN, we are going to have a problem. Our veterans deserve better, and it is our duty to ensure that they receive the high quality, reliable health care that they have earned.

During today's hearing, I look forward to examining the current challenges within the VISN structure and identifying actionable solutions so that we can improve the continuity of care for today and tomorrow's veterans. Additionally, I am eager to explore how implementing comprehensive policies and oversight can enhance patient care and ensure a high standard of health care for our veterans.

I would also like to give a warm welcome to Dr. Kizer, VA's former Under Secretary of Health, who helped design the VISN system in the 1990's. Thank you for being here today. Thank you all for being here. I look forward to our discussion today about this important topic.

Because of the interference with another hearing today, we will come back to Ranking Member Brownley for her opening remarks when she arrives.

I would like now to introduce the witnesses testifying before us today. We have, excuse me, Mr. Al Montoya, Deputy Assistant Under Secretary for Health Operations. Accompanying Mr. Montoya is Mr. Ryan Lilly, Director of VISN 1. We also have Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for Healthcare Inspection, and Dr. Ken Kizer, Distinguished Professor Emeritus, University of California, Davis School of Medicine.

Mr. Montoya, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF ALFRED MONTOYA

Mr. MONTOYA. Thank you. Good afternoon, Chairwoman Miller-Meeks, Representative Landsman, and committee members, thank you for the invitation to testify before you today on the evolution, stability, and oversight of the Veterans Integrated Service Networks or VISN. My name is Al Montoya, Deputy Assistant Under Secretary for Health for Operations with the Veterans Health Administration. Joining me today is Mr. Ryan Lilly, our Network Director for VISN 1, VA's New England healthcare system. The Department of Veterans Affairs is steadfast in its mission to provide high-quality healthcare services to our Nation's veterans. At the core of VA's extensive healthcare system is a resolute dedication to ensuring veterans receive timely and comprehensive medical care tailored to their unique needs. VA prioritizes veterans' well-being and positive health outcomes by offering a wide range of services, from primary care to specialized treatments with a patient-centered approach.

The Veterans Health Administration is the most extensive integrated healthcare system in the United States. Today, VHA comprises 18 VISNs, overseeing VA medical centers and managing the healthcare needs within their geographic areas. This structure allows for a consolidated service delivery, training, and support across the medical facilities within each VISN. In the current fiscal year, VA has provided services to 5.98 million veterans through over 1300 facilities, including 170 medical centers and more than 740 community-based outpatient clinics spanning 18 VISNs.

Outside of VA-specific facilities, our exceptional partnership with the Department of Defense ensures that veterans receive the best care available, regardless of their circumstances. Army Veteran Raymond Turner served from 2000 to 2003 with deployments to Iraq and Afghanistan. Injured in Afghanistan, Ray underwent numerous surgeries, including the amputation of his right leg. During one of those surgeries at a community hospital, he became paralyzed. Ray's situation was unique. Neither a retired veteran nor actively serving his care initiated conversations about collaborative approaches between VA and DOD, significantly impacting his quality of life. After becoming paralyzed, Ray told the spinal cord injury team at the VA Illiana Healthcare System that he chose Walter Reed National Military Medical Center for his care. In response to Ray's complex needs, VA arranged a care in the community sharing agreement so Ray could access care at Walter Reed. There, he un-

derwent numerous surgeries, including an osteointegration leg surgery the doctors said could give him a chance to walk again.

Shortly after his daughter took her first steps, Ray's unbreakable resolve allowed him to take his first steps since becoming paralyzed. Today he is walking again, riding motorcycles, raising his daughter. He recently completed his first hand bike marathon and is slated to undertake four more to complete the armed forces serious challenge.

VA must maintain a flexible infrastructure to meet the changing needs of the evolving veteran population. VA's strategic plans unequivocally guide priorities and objectives, enabling informed decisions on healthcare delivery. VHA consistently evaluates population trends and conducts market assessments mandated by the VA Mission Act of 2018 to ensure strategically located facilities reliably provide accessible care.

Each VISN comprises required base positions and discretionary positions determined by the VISN director. Consolidated Units provide direct support services across multiple VISNs, including human resources, emergency management, telehealth, and sterile processing.

Assessments of key performance indicators during consolidated unit establishment, review, and expansion consistently ensure continued visits to stability and adaptability. VA has made significant strides in improving healthcare delivery, with VA medical centers consistently outperforming non-VA facilities and patient satisfaction and quality ratings.

The Office of Quality and Patient Safety, established in 2020, firmly elevated the importance of quality and patient safety, contributing to overall improvement. Programs facilitating VISN oversight include the National Improvement Office Engagement Protocol for Improvements in Quality, Evidence Based Practice Program, Medical-Legal Risk Management Program, the National Center for Patient Safety, VISN Chief Medical Officers Oversight, and the Position Transparency Initiative report.

Additionally, VA has implemented Tiered Huddles to improve quality and safety across the enterprise. These huddles allow for open communication and enable staff to escalate critical issues, fostering a culture of continuous improvement and responsiveness to emerging challenges.

Chairwoman Miller-Meeks, Representative Landsman, this concludes my testimony. Thank you, again, for the invitation to join you today. VA leadership is unwavering in our commitment to continuously improving healthcare delivery and tailoring services to provide high-quality, veteran-centric care across the enterprise. My colleague and I are prepared to answer your questions.

[THE PREPARED STATEMENT OF ALFRED MONTOYA APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Montoya. We also have Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for Healthcare Inspections, and Dr. Ken Kizer. Now, Dr. Kroviak, you are recognized for 5 minutes to deliver your opening remarks.

STATEMENT OF JULIE KROVIAK

Dr. KROVIAK. Dr. Miller-Meeks and members of the subcommittee, OIG's Office of Healthcare Inspections routinely reviews and publicly reports on the quality of healthcare VHA provides, as well as any risks to patient safety across the Nation. In many of these reviews, lack of oversight by VISN leaders and staff is a key contributor to identified deficiencies or adverse patient outcomes. Given its importance, the OIG has increased its focus on VISN leaders' roles and actions in supporting facility leaders and staff to deliver high-quality care. Through this effort, the OIG has repeatedly discovered inconsistent practices and inefficiencies that run counter to VHA's initiative to transform into a high-reliability organization. Accountability has frequently been discussed at hearings regarding leadership, hospital operations, and quality of care delivery at VA. Holding leaders and staff accountable for their actions, inactions, and decisions is important. When roles and responsibilities are not defined and standardized across the highest levels of leadership, ensuring that accountability is challenging. Unclear reporting lines, optional participation of facility leads in sharing critical metrics with VISN leaders, and general confusion over VISN authority undermine the essential functions of medical facilities and further highlight a VISN structure that is ineffective in ensuring consistent delivery of safe care to patients. This lack of defined roles and responsibilities not only creates limitations in taking administrative action for clear failures, but it also limits the ability of qualified and experienced leaders to take ownership and exercise authority over performance improvement initiatives. Ultimately, in a healthcare system as large as VHA, lack of a standardized leadership structure hinders progress and increases risks.

In my written testimony, I provide several examples of reports in which we identified risk to patients receiving care at VA. At the Tuscaloosa VA Medical Center, we found a patient safety manager had not performed their essential functions for close to a year, and neither the facility leaders nor the VISN patient safety office were aware. At the Albuquerque VA Medical Center, we found that even though the VISN had conducted an inspection of the facility's sterile processing service operations and made multiple recommendations, poor communication, delayed formal notification, and absent VISN follow up resulted in no corrective actions being initiated for more than a year from the original VISN findings. At the Montana VA healthcare system, confusion between the medical center director and VISN chief medical officer's responsibilities delayed reporting of the facility chief of staff's substandard practice of obstetrics and gynecology to the State licensing board. After resigning from the VA, that provider was able to practice privately in California.

VA care has evolved and expanded dramatically since the creation of the VISN structure. The size of VHA, the increasing demands of meeting complex healthcare needs, the escalating costs of healthcare, and the simultaneous implementation of massive initiatives such as Community Care, the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, and the Electronic Health Record modernization require a standardized internal oversight structure that can assume accountability for the efficient and effective implementation of not

only these high cost and necessary efforts, but also for safe and consistent practice of day-to-day patient care activities upon which veterans and their families rely.

Dr. Miller-Meeks, this concludes my statement. I would be happy to take any questions you or other members may have.

[THE PREPARED STATEMENT OF JULIE KROVIAK APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Kroviak, Dr. Kizer, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF KENNETH KIZER

Dr. KIZER. Thank you. Good afternoon, Chairwoman Dr. Miller-Meeks, I guess Ranking Member Brownley in absentia, and members of the subcommittee, thank you for asking me to spend some time with you this afternoon exploring issues related to the organizational structure of the VA healthcare system.

In appearing before you today, please know that I do not represent any agency, organization, or other entity. I was advised by committee staff that you wished me to participate in today's hearing because I am the person who originally conceptualized and operationalized the VISNs in the mid-and late–1990's. I am here as an individual, as a veteran, as a medical practitioner, and a health system leader with more than 40 years of healthcare executive experience. I might also note that I am the father of a 80-percent service connected veteran.

The VISNs, well, I have provided written comments that provide some historical context and that describe the, some of my thoughts about the evolution of the VISNs. They were one element in a radical re-engineering of the VA healthcare system that has been well-described in many other publications. I do think, and it has been commented already, much has happened over the last 25 years since the VISNs were fully implemented. The VA has and does face many challenges today that it did not necessarily face then, not that it did not face a lot of challenges then as well. One of the things I would say at the outset here is I do not think that VA has done enough to develop and nurture and grow the necessary leadership and management skills needed to address the system's many challenges and the special role that it has in our healthcare ecosystem today.

I was—I am mindful of the clock. I was asked some general questions that I would just touch on very briefly. One of the general questions that was posed to me by staff in advance of this hearing was whether I believe that the VISNs continue to be the preferred organizational structure for the VA healthcare system. I think, in a word, yes. The rationale and conceptual underpinnings of that is sound. The fact that so much of the rest of American healthcare is pursuing integrated delivery network structures, I think should provide the committee with some reassurance that it is a sound structure. In saying this, though, I do think it is worth considering whether the present number and configuration of the VISNs is optimal and whether some selective reconfiguration might be in order, especially with regard to those networks that over the years have experienced marked increases in the number of enrolled veterans they serve.

A second general question that was posed to me was whether I thought the performance and accountability problems that have been called out both today and in other settings are due to the VISN structure. To that I would respond with a unequivocal no. The structures are, of course, not independent of the people who work in them and of the leaders and managers whose job it is to ensure that staff achieve the desired outcomes, whether that be in quality of care, cost management, or other domains. It has been my experience over the years that lapses or failures in leadership, whether it is system wide, regional or local, and poor execution of established policies and procedures or insufficient delineation of what those roles and responsibilities are, are much more likely explanations for performance or accountability problems than is organizational structure. It is ultimately about the people and how assiduously they attend to their roles and responsibilities.

Many other things I could say many other questions are addressed in my written testimony. Recognizing that my 5 minutes have elapsed, I will stop here and am happy to try to respond to any questions that you or members of the committee may have.

[THE PREPARED STATEMENT OF KENNETH KIZER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Kizer. As a fellow veteran, let me also thank both you and your child for your service to our great nation. We will now proceed to questioning. As is my practice, I will defer my questions until the end. Therefore, I now recognize Representative Landsman for 5 minutes for any questions he may have.

Mr. LANDSMAN. Thank you, Madam Chair, and thank you all for being here. Folks on the committee have heard me talk a lot about the Cincinnati Children's Hospital. I represent Cincinnati. They have become the best, if not one of the best. I think at the latest ratings has them as the best children's hospital in the country. They got that way by becoming the best at getting better. That was their thing. They set out over a decade or two ago, really, around serious safety events, and they have gotten a safety award. They wanted to really understand why they got the safety award and what would it mean to be a truly safe hospital. One of, you know, one of the board members said, well, you know, if you could get your serious safety event number down to zero, that would mean you are pretty safe. At that point, even though they had just gotten an award, when the other board member asked, well, what is ours now, the administration person in the room said 15. Fifteen people had been irreparably harmed or they lost their life because of the care. In any event, they took it very seriously. Now they measure everything. Everyone is trained.

I was reading as I was preparing for the hearing on the VHA's High Reliability Organizations initiative, which is intended to minimize safety issues and harm. I was hoping, Mr. Montoya and Dr. Kizer, to hear from both of you what specific steps the VHA implemented under this initiative since I think it began in 2019, or at least that would be helpful. How does the progress they have made compare to what we see in similar initiatives in the private sector, both within and outside the medical field?

Mr. MONTOYA. Yes, thank you so much for that question. I think this is a topic that is near and dear to my heart. As an Air Force veteran who flew on the back of C–130's, I am very familiar with high reliability. It is the checklist that you have in place. It is making sure that you are reducing that variability. One of the things that makes me passionate about this topic as well, is I actually was the co-chair for the initial high-reliability efforts across the enterprise back in 2019. Back then, I was a medical center director. As we know, high reliability focuses on three pillars, a culture of leadership, commitment, a culture of safety, and a culture of continuous process improvement.

In VHA, we have actually now rolled that out across every single medical center, as well as throughout central office. I think that is important as well, because when we look at central office, our job is to support the field and really make sure that they are delivering the best care.

Now, we actually do see some positive trends that are happening, and I think this last month, and I know this was a brief to the committee as well, this last year, rather, for the last 12 months, we have seen significant improvements in our sales metrics. Things like cardiovascular risk management, mental health, continuity of care, significant improvements, smaller improvements in sepsis early management, ED admit to depart times, and the like. The list goes on and on. I think what is substantial about this list is that we had no meaningful decline in these performance metrics as well. I think it shows that high reliability is in action. It is alive, it is moving forward. I always like to say, though, with high reliability is it is a journey. The moment you plant that flag and you say, we have made it, is a moment that you lose sight on making sure that every veteran is safe. It is a journey. Part of that journey is learning from those issues that happen so we can continuously get better.

Dr. KIZER. Thank you. I would actually second your comments about Cincinnati Children's Hospital. I know the facility. I have been there, and I strongly endorse all of the things that they have done to improve their performance over the years. I would make a modest correction to what has been said. VHA's journey, high reliability journey actually began in the 1990's. It was a specifically called out objective of the transformation. A number of steps were put in place and progress was being made. Regrettably, some of my successors did not see it as a priority. In essence, it was shelved for quite a few years until Dr. Stone basically resurrected it in, well, 5 years ago or so. I will——

Mr. LANDSMAN. Thank you very much for your early leadership on this, and thank you all for your leadership. I would love to be in touch. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Landsman. Representative Radwagen, you are now recognized for 5 minutes for any questions you may have.

Ms. RADEWAGEN. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley, Congressmen, for holding this hearing today. Thank you to the witnesses for your testimony. Dr. Kroviak, what has the OIG found regarding the adequacy of training and preparation for VISN leaders? Are there gaps in the current train-

ing programs that contribute to the oversight and accountability issues?

Dr. KROVIAK. We have not studied the training of the leadership at the VISN level, but it is really hard to understand what training would be appropriate when there are not clearly defined roles and responsibilities to target what you are looking for in a leadership role. Which is the energy behind my written testimony and the reports we have been writing to suggest that confusion has definitely impacted delivery of care at the facilities and frontline.

Ms. RADEWAGEN. Dr. Kroviak, what specific performance metrics does the OIG recommend for evaluating the effectiveness of VISN leadership, and how can these metrics be used to improve accountability and oversight?

Dr. KROVIAK. We have not made any specific recommendations on metrics that should be assessed. It goes back to understanding what roles and responsibilities, and authorities, the leaders at the VISN level would need to ensure more consistent practice of policies at the frontline. Our reports repeatedly describe situations at the facility level. When we go to understand VISN leader awareness, understanding, or potential response to those situations, we are met with a wide variety of impressions of what the VISN oversight role is, between passive consultant or active oversight body. That is where our concerns are.

Ms. RADEWAGEN. Dr. Kizer, how critical do you believe it is to have a policy clearly defining the VISN roles and responsibilities? Do you believe the VISN are currently functioning as effectively as intended?

Dr. KIZER. To your first question, I think it is absolutely necessary to have clearly articulated roles and responsibilities understanding that there is also, in a system as large and complex and diverse as the VA healthcare system, that there is a need to have some flexibility designed in, when necessary, to deal with unique or special local circumstances. Going back to what I said at the outset, I think having those roles and responsibilities clearly articulated is really the foundation for how you hold managers accountable, how you measure performance, and many other things that need to be done as a leader. Frankly, I forget what your second question was.

Ms. RADEWAGEN. Thank you, Madam Chairwoman. I yield back the balance of my time.

Ms. MILLER-MEEKS. Thank you, Representative Radewagen. The Chair now recognizes Ranking Member Brownley for her opening statement.

Ms. BROWLEY. I will pass on my opening statement. Thanks.

Ms. MILLER-MEEKS. Then the Chair now recognizes Ranking Member Brownley for 5 minutes for any questions that she may have.

Ms. BROWLEY. Great, great, great. Thank you so much. I thank the panel for being here. I apologize for being late, but we have got committee markups going on all over Congress, I think. I apologize. Mr. Montoya, I wanted to ask you, in a 2019 report that I requested, I think Congresswoman Kuster was on the committee then; we both requested. Following a series of highly public failures in VISN oversight, U.S. Government Accountability Office (GAO)

recommended that VA establish a comprehensive policy that clearly defines VISN leaders, roles, and responsibilities. To date, VHA has not implemented that recommendation. I am wondering why not? If you could tell me why not?

Mr. MONTOYA. Yes. Thank you so much for that question, ma'am. I think, as for the why not, I think we will have to pull that one back, for the record, to get you an exact answer. I will tell you that we are working in earnest right now to get that policy done this year by the end of 2024. I agree with you, I think it is important to delineate the roles and responsibilities of VISN directors, medical center directors, and everyone in between there to include central office. I think absent of that policy, though, there still is that understanding from network directors on what their roles are. I do understand your concern about variability, and we are working on that for 2024.

Ms. BROWLEY. Who in VHA is responsible to make this happen?

Mr. MONTOYA. Ma'am, I have picked that one up, and I am moving that one forward to get it done by 2024. The update that I got this week was that it is on track.

Ms. BROWLEY. You are responsible?

Mr. MONTOYA. I am now, ma'am.

Ms. BROWLEY. You are now?

Mr. MONTOYA. I am working on it, ma'am.

Ms. BROWLEY. Someone else was, is what you are trying——

Mr. MONTOYA. In my role as Deputy Assistant Under Secretary for Health for Operations, I help move policies and directives through. This is one that I am working for.

Ms. BROWLEY. You believe it will be done by the end of 2024? Did you just say that?

Mr. MONTOYA. I did, ma'am.

Ms. BROWLEY. Okay.

Mr. MONTOYA. I do believe it will be done by then.

Ms. BROWLEY. Okay, very good. Do you have any idea why it is taken 5 years?

Mr. MONTOYA. I do not. I apologize.

Ms. BROWLEY. Okay. All right. Very good. Dr. Kizer, so, it is my understanding that you were really the creator of the structure of VISNs in the VA. I am just curious, from your perspective, if you were challenged with doing that again today, would it virtually look like the same model, or would it change a lot or change a little? If you could speak to that? I apologize if someone has already asked the question.

Dr. KIZER. They have not asked that specific question. To answer your question, I think it is important to understand that the VISNs were part of a wholesale re-engineering of the system that included many other elements of change. Restructuring, in addition to how the facilities were grouped and organized together. In brief, I believe that the conceptual underpinnings and the rationale for the VISNs is very sound. I would pursue the same strategy today, whether it resulted in the carbon copy of what exists today or what would exist——

Ms. BROWLEY. Roughly, you think it is——

Dr. KIZER. Yes.

Ms. BROWLEY [continuing]. the right structure?

Dr. KIZER. You know, I think you can get some affirmation of that by the fact that the rest of American healthcare is pursuing that same strategy.

Ms. BROWLEY. Sure. One of my frustrations—I have been on the committee now for 12 years, and one of my frustrations is, there is a lot of wonderful things going on in the VA, across the country, but they are in pockets. They are not across the board. One of my frustrations, it seems as though medical centers have a lot of autonomy, and I understand why they would have autonomy. On the other hand, it also seems as though some decide to do and pursue what this body has decided upon in terms of policy, and then regulations are formed, and they decide to follow it or not follow it. Is that your idea of how it should work?

Dr. KIZER. No. I have to confess that I believe that VA is a national system of care and that folks who enter it should be able to expect and recognize the same system wherever and in what manner they enter the system, which means that there has to be some significant degree of consistency about how things are done and how problems are approached across the system. That is not to say that in a system as large and that provides care in as many diverse settings as the VA, that there does not have to be, need to be some flexibility to address local circumstances. Having said that, there is a, in the VA, just like in any other healthcare organization or in any other organization, period, there is a chain of command. There is a way that things are done, and folks either get it or they can be invited to go elsewhere.

Ms. BROWLEY. Thank you. My time is up. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Ranking Member Brownley. The Chair now recognizes General Bergman for 5 minutes for any questions he may have.

Mr. BERGMAN. Thank you, Madam Chairwoman, and thank you all for being here. It is always instructive for me as a military veteran to listen to you all talk about what our health care system is doing for our veterans and their families around the country. I was told when I first got to Congress 8 years ago, if you have seen one VISN, you have seen one VISN. Which means that there is a certain amount of maneuverability, if you will, in operations and procedures, and rightly so. You got to give your leaders at the VISN level the flexibility to do the right thing for the veterans in their area. Would anybody care to offer? We can play. Everybody can throw a number out if they would like. We can go right down the line to what percentage of operations, total operations of a VISN, what percentage of that total operations is standardized across all VISNs? Think of the bell curve, 80/20. You got to have 20 percent flexibility. Is it 80 percent? What is it? What would you say the percentage of standardized operations if you went from one VISN every day to the next VISN, you would see exactly the same thing?

Mr. LILLY. I will jump in on that one. It is largely standardized. I would say north——

Mr. BERGMAN. That is not a number.

Mr. LILLY. North of 90 percent would be my number.

Mr. BERGMAN. 90-plus percent standardized. Okay.

Mr. MONTOYA. General Bergman, it is good to see you. I actually would agree with Mr. Lilly here as we have a little bit of more in-

sider knowledge on the VISN standardization work that is been going on. I would say above 90 percent.

Dr. KROVIAK. I am in oversight. We have a skewed perspective because we get called to the drama. I do not have a number that would do justice. We report on zero percent.

Mr. BERGMAN. Zero percent standardization?

Dr. KROVIAK. Our reports highlight when we go to the VISN that there is inconsistency across the country as to their role and understanding their role. It is ultimately part of the issue in whatever we are investigating or inspecting onsite. No question.

Mr. BERGMAN. Okay. Dr. Kizer.

Dr. KIZER. Since I am not in the VA I am not sure that I am the best person to answer that. I would have——

Mr. BERGMAN. Well, since you were one of the architects of the system——

Dr. KIZER. Yes.

Mr. BERGMAN [continuing]. what was your hope?

Dr. KIZER. That it would be somewhere around 80 percent to 90 percent——

Mr. BERGMAN. Okay.

Dr. KIZER [continuing]. standardized. I would have to be provided with a lot of information to convince you——

Mr. BERGMAN. Okay.

Dr. KIZER [continuing]. that that is a fixed thing.

Mr. BERGMAN. Continuing down that road, Dr. Kizer, are VISN directors able to effectively, within that 80 percent to 90 percent level, hold medical center directors accountable?

Dr. KIZER. They should be able to, yes.

Mr. BERGMAN. Does a bonus program that gives all VISN and medical center directors $50,000 bonuses regardless of their performance sound like, I mean, accountability? Or can we hold somebody, 80 percent—again, I am a Marine. There was really, it was either all or nothing. You were either held accountable, that sort of thing. Does that sound like accountability to you? If it is across the board everybody gets the same? Is that what you envisioned?

Dr. KIZER. I would only say that since my daughter is a Marine and my son-in-law is also a Marine, I do understand the Marine mentality. I would have to say that that is not what I would have anticipated, no.

Mr. BERGMAN. Okay. Dr. Kroviak, do you feel that the VHA holds VISN directors accountable when there are failures at the VA medical centers under their individual leadership?

Dr. KROVIAK. I can only describe what we report on. Admittedly, our focus on the higher levels of leadership has been in the past few years as part of the High Reliability Organization (HRO). We just published two reports on Monday that describe an absolute absence of VISN awareness and leadership in holding medical center facility directors accountable, mostly because they did not know what was going on. I cannot say that we have seen the accountability. Again, when you do not have defined roles and responsibilities, holding someone accountable is incredibly challenging, without that clear cut definition of what they are supposed to be doing.

Mr. BERGMAN. All the way back to roles and responsibilities clearly defined, so that there are metrics to be and target whatever

achievement to be done. There is a certain level of standardization. We still, there is always going to be exceptions. I see I am over my time here. If we can get it 80-percent-plus right, for our veterans, when it comes to the functioning of the medical centers, of the VISNs in general, that is Okay, because there is going to be a 20 percent movement, and hopefully toward the positive side, not making the same mistake twice.

With that, Madam Chairwoman, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Bergman. The Chair now recognizes representative Kiggans for 5 minutes for any questions she may have.

Ms. KIGGANS. Thank you, Madam Chair. Mr. Montoya, I understand that every VISN director has recently received a 25 percent critical skill incentive bonus. Do you think it is appropriate that every director receive the same $50,000-plus bonus, regardless of their performance?

Mr. MONTOYA. Thank you for that question, ma'am. I think that the critical skills incentives, which is not a bonus, but it is to help with their market pay, was initiated and completed in accordance with the law.

Ms. KIGGANS. Dr. Kroviak, this week, committee staff received two alarming OIG reports and one Office of the Medical Inspector (OMI) report about the VA Medical Center in Aurora, Colorado. This echoes the troubling issues we have seen in the Hampton VA Medical Center. Could more engaged oversight from VISN leadership and VA health operations have prevented possible adverse patient outcomes?

Dr. KROVIAK. The opportunity to intervene earlier with more aggressive oversight unequivocally could have been a game changer for the findings we had in those two facility reports. No question.

Ms. KIGGANS. Do you believe that similar issues will continue to arise until the Under Secretary for Health, Dr. Elnahal, clearly defines the roles and responsibilities for VISNs?

Dr. KROVIAK. I think we will continue to find these gaps in provision of care, and in costs and efficiencies—all the things that we want to control and work better, until a defined role and responsibility is set at that oversight level, we will not see the improvements that we all want.

Ms. KIGGANS. Thank you. Dr. Kizer, you mentioned that the VA has not yet achieved its goal of becoming a highly reliable organization and has faced major managerial missteps. Do you believe the VA has done enough to develop the necessary leadership and managerial skills within its workforce to address these challenges?

Dr. KIZER. As I commented earlier, I do not think enough has been done to develop, nurture, and grow the managerial skills that are needed within the VA healthcare system. I say that being mindful that there are internal training programs and there are opportunities for VA leaders to go to private sector training programs. Managing the VA, a national government-run healthcare system, involves a lot of things that will never surface in a private executive healthcare training program. I think VA needs to do a better job of both identifying what the essential leadership and management skills are and developing training programs that will support a leadership pathway. Succession planning, so that the

folks who assume levels, whether at the facility, the network, or Veterans Affairs Central Office (VACO), do have the appropriate training and skills to accomplish their job.

Ms. KIGGANS. Thank you. Dr. Kroviak, multiple whistleblowers have reached out to our office regarding allegations of mismanagement and poor standards of care at the VA hospital, most used by veterans in my district, Hampton. Have you been investigating these findings? If so, can you share some of the findings with the committee today?

Dr. KROVIAK. We have current work in Hampton, but it is in process. We would look forward to briefing your office with those responses.

Ms. KIGGANS. Do you know when or when do you think this report from these investigations will be available? I know we have asked for it a couple times and it has been past the deadline.

Dr. KROVIAK. I apologize. I will get that to you in your office, what our expectations on publication are.

Ms. KIGGANS. Thank you. We are looking forward to that response. Mr. Lilly, if you were to become aware of allegations of mismanagement and poor standards of care at a VA medical center in your VISN, how would you address and correct these allegations if they were found to be substantiated?

Mr. LILLY. Well, the first thing I do is investigate them. Certainly, send a team to dig into the issue further. If there was some concern of misconduct or poor performance from a senior leader, that would be an Office of Accountability and Whistleblower Protection (OAWP) referral by policy. Then if there was, that was found to be true, then I would take the appropriate action against that leader.

Ms. KIGGANS. All right, thank you very much. I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you very much, Representative Kiggans. I now recognize myself for 5 minutes. Dr. Kizer, in a 2009 article, you mentioned that before the VISNs were established, the quality of care was irregular, service was fragmented and disjointed, and the care was often difficult to access for veterans. Do you believe that today the quality of care has once again become irregular and difficult for veterans to access due to the lack of oversight and accountability between the VA central office and the VISNs?

Dr. KIZER. I need to tease that apart a little bit. There have been in recent years, and continue to be a plethora of peer reviewed studies which consistently show that the quality of care in VA is equal and often superior to what is provided in the private sector. That is not to say that it is uniformly superior or consistent across the system. I think that is where some of the problems occur, is in that consistency.

Ms. MILLER-MEEKS. That is why I specifically did not say poor quality of care, I just said become irregular.

Dr. KIZER. Ergo, why I tried to tease it apart. I think that we are nothing like the situation that I inherited in 1994. We are vastly, or the VA is vastly better than it was then, but it is not where it needs to be. There is still robust opportunities for core quality improvement, especially with regard to ensuring consistency of care

and ease of access. I think that continues to be one of the most challenging problems that VA has, is just making care more convenient and more easily accessible. I mean, you can have absolutely great care, but if you cannot get to it, it does not accomplish the purpose or the goal. Accessibility is a fundamental part of good quality.

Ms. MILLER-MEEKS. Thank you. I got that it is not where you thought it would be. Mr. Montoya, it has been over 5 years since the GAO recommended that the undersecretary for health clearly define roles and responsibilities for business. Let me put this in perspective. In that time, I would have done my general surgery internship, my almost 4 years of an ophthalmology residency, and my 1 year of a Glaucoma fellowship. Quite honestly, it is unacceptable and there is no excuse for not developing a policy that merely defines the roles and responsibilities. You know, we defeated Nazi Germany in 4 years. We could not do that. If you cannot even develop a policy within 5 years, so to say that you are on track to get it by December of this year, quite honestly, it is a little bit disappointing. You may or may not have been the person responsible. However, you are the person responsible now. A better answer would have been, it has been over 5 years, we will have roles and responsibilities policy in place in a month. I mean, it is mind boggling.

To then have directors of VISNs get a payment, increase, bonus, whatever you want to call it, incentive pay to be market based, I will be more than happy to take over a VISN at the current pay without the bonus.

You cannot hold people accountable. You cannot impact performance measures in the military. We say if you fail to plan, you plan to fail. You are planning to fail. The problem is that failure impacts our veterans.

You had conceptualization of a system that was well done, and you have VISNs. We expect there to be variability. What do I mean by that? One VISN may be an expert in a medical procedure such as transplants, so that type of centers of excellence is acceptable in variability. For a VISN director not to know what they are supposed to do, how they are held accountable, what the metrics are for their performance, and then how they hold each individual medical center accountable, as we saw in the OIG report in Denver, Colorado, and what happened there with their cardiothoracic unit, you know, that type of variability in irregularity is not acceptable.

In May 2023, the VA reported that a directive was under review to describe the roles and responsibilities of VISNs. A year later, this directive is still not published, and the VA has now pushed the publication back from October to December of this year. I just want to know, you know, before we go into our next term of Congress in 2025, can we have the VA's commitment that the directive will be published this year? Then what do you recommend I do to hold you accountable if you do not have it by December 2024?

Mr. MONTOYA. I think it is an excellent question, ma'am. I will take it upon myself to hold myself accountable to making sure that this is completed so that we can close this out. I certainly understand the importance and urgency on this one.

Ms. MILLER-MEEKS. Thank you very much. I yield back my time. I think Representative Brownley had another question that she wanted. Representative Brownley, I will yield you an additional 5 minutes.

Ms. BROWLEY. Thank you, Madam Chair. Mr. Lilly, you talked about if there was disciplinary action that needed to be taken, that you would take it. How much authority do you have? Do you have final authority?

Mr. LILLY. Well, it depends on the case. If it were a medical center director, who is a direct report of mine, I am a recommending official for discipline, and then my boss is the deciding official.

Ms. BROWLEY. Who is your boss?

Mr. LILLY. RimaAnn Nelson.

Ms. BROWLEY. Pardon me?

Mr. LILLY. RimaAnn Nelson.

Ms. BROWLEY. Okay. Something less than that, you have full authority?

Mr. BERGMAN. Well, for an individual underneath that. Say a facility chief of staff, the facility director would be the recommending official and I would be the deciding official.

Ms. BROWLEY. Thank you. Dr. Kizer, back to you again. I am a Californian, so I was in the State legislature, and I believe the University of California system is the best public university system in the world. I know you are a very, very smart man. Based on the testimony of four people here, or three people here who said 90 percent, 90 percent, zero percent, and you indicated that you would want it to be at 90 percent. What would be your recommendations? Or having heard that, would you have had a different answer than my first question which you had said no, just make a few changes here and there, but basically, the model is a good one?

Dr. KIZER. Yes, I think the structural model is a good one, but that is not the question that you are asking. The question that you are asking has to do with how you manage the people that are then part of the structure and that make things work. I think that is where much of the conversation today has dealt with some gaps, perhaps, in how the system approaches the roles and responsibilities of those individuals that participate in the structure. I think, as I said earlier, while the goal might be 80 to 90 percent, standardization or consistency, whatever word you want to use, I would need to see a significant amount of information to convince me that that is the case today. I am not saying that it is not. I am not disputing what has been said, but that does not necessarily jive with observations that, informal observations that I have made.

Ms. BROWLEY. Well, I hear what you are saying is that it is not the structure, it is how one manages the people. I hear that. If there is this, you know, broad inconsistency across the board, there is something about following the policies that, to me, is not about managing people, it is about following the policies and someone holding that person accountable. Right?

Dr. KIZER. Yes. Well, I am not sure how you differentiate that from managing the people. I mean, you have policies that says this is what is supposed to be done or this is how you should approach things and you have a management structure. If folks are not following those policies, then it is an execution of policy problem that

is really a personnel matter, not an organizational structural matter.

Ms. BROWLEY. Dr. Kroviak, so when you have visited all these facilities, have you, kind of, evaluated the network directors and all of these to ask them, you know, how they are managing people or how they are executing policies that are coming from headquarters or from Congress?

Dr. KROVIAK. It certainly depends on what we are inspecting at a certain facility, how high we are going to take it to understand who knew what, who directed what. We almost often, now, in our facility level reports talk to VISN leadership to understand what they knew, what they might have directed, what they heard, all these things. We get incredibly inconsistent responses across the board.

To your point, it is a policy and procedures, to a certain extent. We repeatedly find issues to where these policies and procedures are not being practiced consistently because there is confusion on the frontline. They might have misinterpreted policy. If you are tracking and trending that with an internal oversight structure that makes it somebody's responsibility, they can then intervene before there is real damage or issues to say, oh, we have a training issue, or there is confusion, or, you know, there are staffing concerns as to why we cannot consistently, or we are not consistently seeing high performance in this one area; that there truly is a structural issue that can enforce this more consistent practice of good policy.

Ms. BROWLEY. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you. Ranking Member Brownley. I now recognize myself for 5 minutes. Dr. Kroviak, given the OIG's findings of leadership and inaction at several VISNs, do you believe the Under Secretary of Health has been effective in intervening and taking corrective action when needed?

Dr. KROVIAK. Our most recent reports, where we describe issues where there was VISN absence, there are recommendations that are directed to the Under Secretary for health. We recognize him as the authority that will need to intervene with action plans. We have not closed those recommendations we just published two reports on Monday. We will use rigor to walk through those responses we see from his office to correct and hopefully modify and bring forward some of the standardization that we are describing as needed in roles and responsibilities.

Ms. MILLER-MEEKS. Can you provide examples where inaction at the highest leadership level exacerbated the problems at the VISNs?

Dr. KROVIAK. I will talk about what we released Monday in Denver. I mean, it is compelling to read that story to where there is so much negative activity happening at that facility, that when you have that type of exodus of clinical staff, when you have closure of a cardiothoracic thoracic surgery program, when you have shattered a relationship with a residency program, how that quote, unquote, noise does not make it to the higher level for an immediate intervention, rescue, whatever you want to call it just knowledge. Our team was appropriately baffled by that story, and again, it strengthened the argument we have that standardization of roles

and responsibilities can help. This is not a passive structure, and cannot continue to be a passive structure.

Ms. MILLER-MEEKS. As a physician and a military veteran, it was astonishing to me that an entire cardiothoracic unit, which is one of the most common medical problems that our veterans face, the most common, that as we are trying to develop all of these other programs, what would be a very basic program at a VA medical center or any medical center, could not operate and went to a pause for 11 months. Even more astonishing is the fact that the VISN leadership did not know. Thank you for teeing up my question for me, for Mr. Montoya. I really appreciate that.

Mr. Montoya, you are responsible for overseeing the performance of the visits. The OIG report that we just mentioned reported significant leadership and operational failures at the VA Eastern Colorado Healthcare System over a 2-year period, with VISN leaders largely ignorant of these issues and the fact that the cardiothoracic center went into a pause for 11 months after having closed earlier. How did these issues go unnoticed for so long, and what steps are being taken to ensure that the VA central office and VISN leadership promptly identify and address similar problems in the future?

Mr. MONTOYA. Yes, thank you so much for that. I think it would be easier for me to answer the latter question and then progress backward if I could, because I think how can we prevent things like this from happening in the future? It is really making sure that we are getting out there and supporting the VISNs, that we are getting out there to medical centers.

I think predominantly a good part of my job is actually being out in the field. In fact, tomorrow I will be in Nashville speaking with that team there and helping out with their academic affiliation on Friday, making very frequent visits out into the field to see what is actually going on.

I think, when we look at Denver, when this was raised, Dr. Elnahal did urgently send a review team out there to take a look at what was occurring in Denver and then to make sure that we were appropriately putting the resources there to take quick action. I think this is one, I personally have a staff member there of my team this week. I will be making a trip out there next month as part of my travels to make sure that there is progress, to make sure that we are holding them accountable for moving forward in the improvement efforts that have to happen.

Ms. MILLER-MEEKS. Well, maybe before traveling, that having a defined policy of roles and responsibilities of the VISN directors might be a priority with that I yield back. Ranking Member Brownley, would you have any closing remarks?

Ms. BROWLEY. I will just say that this is a topic that I would like to spend, you know, a whole day going after and trying to figure it out and figure out, you know, collectively how we can improve upon things. As I said earlier, you know, being on this committee for 12 years, my greatest frustration is the inconsistency across the board. I understand there has to be some, you know, decision-making that is different from one place to another. I mean, I kind of get that, but it is, you know, we are up here and we are trying to solve problems, and maybe folks out in the field think we are doing a lousy job. I do not know. They just do not feel like it is appro-

priate to follow through on some things. It just seems like there is a lot that we try to move forward to help things along and are just, you know, simply ignored in some medical centers across the board. I want to hold the VISNs, you know, accountable for that.

I mean, I would really like to spend a whole lot of time trying to figure out, you know, what, Mr. Lilly is doing on a daily basis, you know, Mr. Montoya, what you are doing and, you know, getting the Inspector General here with her suggestions on what we can do.

I know that there is a committee that was put, put forward in 2023, I think, to look at inconsistencies across the board. You are sort of saying it is 90 percent consistent, but yet you have set up an advisory group to look at inconsistencies. It seems to me you are acknowledging that those inconsistencies are there. Maybe you are just acknowledging that it is 10 percent, and only 10 percent, and you want to get it to 100.

It is not, this is not a time for me to ask more questions, but I, you know, I would like to get to the bottom of this and see what we can do to make more improvements so we do not have a Denver situation. You know, we have talked a lot about Denver, but we could identify, you know, many others across the board where there has just been really sort of catastrophic mistakes that have been made, and there has not been the accountability there.

I will yield back.

Ms. MILLER-MEEKS. Thank you very much, Ranking Member Brownley. Mr. Montoya, thank you for letting us know. I think many of us, and I would say of the VA facilities in my district at the Iowa City VA and Des Moines, VA. They are excellent facilities which deliver excellent care, and part of that is the people who work there. You also gave us an idea of performance and improvement and how it has increased. What you did not give us, however, is the entire range and what the confidence interval is. Overall, you may have improved, but have the worst gotten worse? Are they doing worse or are they improving? We do not have that delta, if you will, to make an assessment.

I would like to thank everyone for their participation in today's hearing and for the productive conversation. I would agree that the conversation could be much longer. Unfortunately, we have votes coming up at 3:30. It is important to me and to my colleagues on both sides of the aisle that we ensure that all veterans receive consistent, high-quality care across all the VA healthcare system.

I look forward to continuing our efforts to establish clear and consistent policies across all VISNs, working with the department stakeholders and my colleagues on this subcommittee.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Hearing no objections, so ordered.

I thank the members and the witnesses for their attendance and their participation today. This hearing is now adjourned.

[Whereupon, at 3:20 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Alfred Montoya

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and Committee Members. Thank you for the invitation to testify before you today on the evolution, stability, and oversight of the Veterans Integrated Service Networks (VISN). Joining me today is Ryan Lilly, Network Director, VISN 1.

The Department of Veterans Affairs (VA) is unwavering in its mission to provide high-quality health care services to the Nation's Veterans. At the core of VA's extensive health care system lies a steadfast dedication to ensuring Veterans receive timely and comprehensive medical care tailored to their unique needs. VA prioritizes the well-being and positive health outcomes of Veterans by offering a wide range of services, from primary care to specialized treatments, with a patient-centered approach.

VISN Overview and Evolution

The Veterans Health Administration (VHA), the most extensive, integrated health care system in the United States, drives VA's health care delivery. In the mid–1990's, VHA underwent a significant restructuring, resulting in the consolidation of the organization from seven regions to four and the creation of 22 VISNs. This decentralized operational decision-making and introduced performance measures and accountability systems for VISN directors and staff. The focus shifted from an inpatient-centered model to one that focused on the delivery of outpatient and primary care through community-based outpatient clinics (CBOC). In addition, the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104–262) expanded Veteran access to care. By 1999, VHA had established 22 VISNs, opened 302 CBOCs, reduced hospital admissions by 350,000, and allocated resources based on shifts in the Veteran population. In 2015, VA again realigned its organizational maps into one map with five districts, maneuvering existing VISNs to fit within the five Department-level districts.

Today, the network is divided into 18 VISNs, each overseeing VA medical centers (VAMC) and managing health care needs within their respective geographic areas. This organizational structure allows for consolidated service delivery, training, consultation, and remediation support across VAMCs within each VISN's jurisdiction. In fiscal year (FY) 2024 to date, VA provided health care services to 9.26 million Veterans through its extensive network of over 1,300 facilities, including 170 VAMCs and more than 740 CBOCs, spanning 18 VISNs throughout the enterprise.

VISN Stability

VHA is committed to providing accessible health care to Veterans and is constantly evolving to meet its mission. As the Veteran population changes, VA must maintain a flexible health care delivery infrastructure to respond to the changing and often unique needs of the population. VA's Strategic Plan[1] provides a guide for describing and accomplishing the agency's priorities over the next 5–7 years through short-term and long-term range objectives, enabling informed decisions related to health care and service delivery. To ensure no threats or challenges arise, VHA regularly evaluates the trends of the populations it serves. This initiative is rooted in the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, which mandates that VA conduct market assessments and develop recommendations for modernizing medical facilities. The market assessments

[1] The "Fiscal Years 2022–2028 Strategic Plan" is available here: https://department.va.gov/wp-content/uploads/2022/09/ va-strategic-plan–2022–2028.pdf. The Departments of Defense and Veterans Affairs "Joint Strategic Plan for Fiscal Years 2022–2027" is available here: https://www.va.gov/opa/docs/remediation-required/oei/
JEC__Joint__Strategic__Plan__2022__2027__FINAL.pdf.

ensure that VISNs have strategically located facilities to provide accessible care to Veterans, including those in rural and underserved areas.

The VISN Organizational Structure Workgroup[2] convenes annually in person, and virtually, throughout the year to conduct data calls and discuss topics related to full-time employee cap, mandatory versus discretionary VISN positions, and audits to ensure compliance with organizational charts, vacancy rates, and accurate position inventories in the human resources system of record. Each VISN comprises required base positions, mandated by policy, and discretionary positions, determined by the VISN Network Director, to meet the total core VISN full-time employee allocation. Additionally, Consolidated Units (CU) provide direct support services and operate as part of a multi-VISN consortium. Four required CUs exist at each VISN: human resources, emergency management, telehealth services, and sterile processing services.

Assessments of standardized key performance indicators during the establishment, review, and expansion of these CUs ensure the VISN's stability and adaptability to evolving Veteran needs. To support VISN stability, VA is actively assessing community care and internal health care functions and creating staffing models. Additionally, VA continues to update our VISN staffing standard and conduct Functional Assessments for other VISN CUs, like the Clinical Contact Centers and Clinical Resource Hubs, guiding the creation of staffing models tailored to each unit's needs. The largest CUs, human resources, have completed multiple staffing models and are on track to finalize their remaining staffing models by the end of CY 2024.

VISN Oversight

VA has made significant strides in improving health care delivery for Veterans, with VAMCs consistently outperforming[3] non-VA facilities in patient satisfaction metrics and overall hospital quality ratings. These strides were aided, in part, with the establishment of the Office of Quality and Patient Safety (QPS) in 2020. QPS, in turn, established the Office of Quality Management alongside the existing work of the Office of Analytics and Performance Integration and the National Center for Patient Safety. This alignment elevated the importance and visibility of quality and patient safety by providing advocacy and support to Communities of Practice at the VISNs, facilities, and VA Central Office, contributing to the overall improvement in health care delivery for Veterans.

Coordinating programs that help facilitate VISN oversight include the following:

- The National Improvement Office uses a systematic process to monitor health care quality and patient experience data. Through this process, VHA can celebrate successes and direct resources to facilities most needing structured improvement support.
- The Engagement Protocol for Improvements in Quality (or EPIQ) monitors health care quality and patient experience data, identifying facilities needing structured improvement support and providing subject matter expertise to drive collaborative quality improvement efforts based on quality measure data.
- The Evidence Based Practice Program oversees the implementation of VA/Department of Defense Clinical Practice Guidelines across VAMCs, coordinating with the VISN Quality Offices.
- The Medical-Legal Risk Management Program provides oversight, training, and procedural guidance to address quality of care at individual provider and patient levels and ensure compliance with regulatory and directive-driven requirements.
- The National Center for Patient Safety strengthens oversight by leveraging existing processes and developing new programs, including patient safety metrics,

[2] The VISN Organizational Structure Workgroup is comprised of two co-chairs and 11 members, including VISN Network Directors, workforce management consultants, and specialists in finance, human resources, and operations.

[3] Based on patient surveys between July 2021 and June 2022, VA hospitals received a higher percentage of satisfaction ratings than non-VA hospitals for **communication with doctors** (87 percent vs. 48 percent), **communication with nurses** (59 percent vs. 35 percent), **responsiveness of hospital staff** (63 percent vs. 34 percent), **communication about medicines** (80 percent vs. 38 percent), **cleanliness of the hospital environment** (69 percent vs. 52 percent), **quietness of the hospital environment** (49 percent vs. 38 percent), **discharge information** (65 percent vs. 55 percent), **care transition** (76 percent vs. 35 percent), and for patient **willingness to recommend the hospital** (76 percent vs. 52 percent). For more information visit here: https://news.va.gov/press-room/nationwide-patient-survey-shows-va-hospitals-outperform-non-va-hospitals/.

culture data, quality management processes (specifically, root cause analyses), performance indicators, and program evaluations.

- VISN Directors ensure compliance at the medical center level, with VISN Chief Medical Officers providing oversight of credentialing and privileging processes, annual facility assessments, and privileging actions and reporting.
- The Position Transparency Initiative report includes a dashboard tracking vacancy percentage, which is published bi-weekly to improve position inventory accuracy.

VA has also implemented Tiered Huddles to improve quality and safety across the Enterprise. As VA continues its journey toward becoming a high-reliability organization, these Huddles allow open communication and enable staff to escalate critical issues to senior management, fostering a culture of continuous improvement and responsiveness to emerging challenges.

Conclusion

Chairwoman Miller-Meeks, Ranking Member Brownley, this concludes my testimony. Thank you once again for the invitation to join you today. VA leadership remains dedicated to continuously improving health care delivery and tailoring services to provide high-quality, Veteran-centric care across the enterprise. My colleagues and I are prepared to respond to your questions.

Prepared Statement of Julie Kroviak

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, the Office of Inspector General (OIG) oversees the delivery of health care by the Veterans Health Administration (VHA), including examining the role of Veterans Integrated Service Networks (VISNs) in the governance of VA medical facilities located within each of their 18 networks.[1] The OIG's Office of Healthcare Inspections routinely reviews and publicly reports on the quality of health care VHA provides, as well as any risks to patient safety, across the Nation. In many of these reviews, lack of oversight by VISN leaders and staff is a key contributor to identified deficiencies or adverse patient outcomes. Given its importance, the OIG has increased its focus on VISN leaders' roles and actions in supporting facility leaders and staff to deliver high-quality care. Through this effort, the OIG has repeatedly discovered inconsistent practices and inefficiencies that run counter to VHA's initiative to transform into a high reliability organization (HRO).

In February 2019, VHA's Office of Healthcare Transformation outlined definitive steps toward becoming an HRO grounded by the basic tenet of a "just culture." Within a just culture, personnel at every level understand and react to not just identifiable risks and errors, but any vulnerabilities that could lead to patient harm. Leaders that promote such accountability and react with transparency and fairness to their staff's misconduct and missteps help establish a culture in which staff feel not only responsible for, but also secure in, reporting all concerns.

When conducting work at VHA facilities, OIG teams often interview VISN leaders to gauge their understanding of the issues impacting their local facilities, and their role in supporting the facilities to remedy any weaknesses and risks to patients or personnel. Many VISN leaders' responses demonstrate at best a "loose" understanding of problems related to staffing shortages, patient safety, and workplace culture. Repeatedly, quality management officers and chief medical officers within VISNs suggest problems can be attributed to failures of facility leaders to *bring* issues to their attention or request support—pointing to their lack of authority to require facilities to report events. A structure that permits such passive oversight will repeatedly fail to meet the needs of its patients.

THE CURRENT VISN STRUCTURE DOES NOT ENSURE ACCOUNTABILITY

The Government Accountability Office (GAO) recommended in June 2019 that the under secretary for health clearly define VISN roles and responsibilities for man-

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

aging and overseeing medical centers.[2] Currently, GAO reports this recommendation remains open. However, VA projects publication in October 2024 of a directive that will include the roles and responsibilities of VISNs and medical centers as part of a set of core functions tailored to differentiate the authority and span of control for all VHA operational units, including management and oversight responsibilities. The policies and procedures in place at the VA Central Office regarding VISN oversight of medical facilities lack clearly defined and standardized responsibilities, leading to inconsistent oversight and deficient engagement with facility leaders.

The two reports published earlier this week on the VA Eastern Colorado Health Care System in Aurora provide more recent examples of disengaged VISN leaders.[3] OIG reports focusing on the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico, and the Montana VA Health Care System also clearly demonstrate how VISN leaders' failures to understand and carry out their duties can have serious consequences.[4]

Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact of Resident Education at the VA Eastern Colorado Health Care System in Aurora

An OIG healthcare team reviewed allegations that facility leaders implemented staffing changes that adversely affected the provision of cardiothoracic (CT) surgeries. The OIG determined that the facility director, chief of staff, deputy chief of staff for inpatient operations, and the acting chief of surgery proceeded with plans to resume CT surgeries following an 11-month pause due to insufficient staffing without notifying or seeking approval from VISN and VA Central Office leaders. During an interview with the VISN director, the OIG escalated concerns regarding the facility's readiness to resume surgeries and the VISN's possible lack of awareness of these plans. The VISN director acknowledged a lack of awareness and formally requested an evaluation by the National Surgery Office.

In the medical intensive care unit (ICU), facility leaders also suddenly changed the operating model without any notification to, or preparation for, clinical staff. A transition from an open to a closed ICU model (a shift that changes which care providers have primary responsibility) was discussed in December 2022, with a goal of June 2023 for implementation, as recommended by an assessment in 2021 by a VHA team that included the national director for pulmonary and critical care.[5] Yet, the chief of staff made an abrupt decision to accelerate that transition in January 2023 after concerns were raised about the privileging status of the attending ICU hospitalists. The sudden model change was made without adequate planning and staff input, which led to inadequate resident supervision, an ineffective teaching environment, and fractured trust among clinical staff. More effective VISN oversight as well as communication between facility and VISN may have provided an opportunity to reconcile privileging concerns and ICU operations in a manner that engaged clinical staff and other stakeholders, including the academic affiliate whose residents were affected by the changes.

VA concurred with the OIG's six recommendations and provided acceptable corrective action plans. The follow-up process begins 90 days from publication.

Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety

This second report focused on allegations that senior leaders failed to practice HRO principles and created a culture of fear and retaliation among staff at the facility. The OIG found key senior leaders fostered an environment in which a significant number of clinical and administrative leaders and frontline staff from multiple

---

[2] GAO, *Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities*, June 19, 2019.

[3] VA OIG, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, June 24, 2024; VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, June 24, 2024.

[4] VA OIG, *Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico*, April 30, 3024; VA OIG, *Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena*, February 6, 2024.

[5] An open ICU model includes multiple physicians or teams, whether assigned to the ICU or not, to provide care to a patient in the ICU. A closed ICU model includes only the team specifically assigned to the ICU to manage all ICU patients.

service lines felt psychologically unsafe, deeply disrespected, and dismissed. They feared that speaking up or offering a difference of opinion would result in reprisal. Further, instability in top positions at the service level affected continuity in strong leadership, with many clinical service and section-level resignations and vacancies. Former medical facility leaders cited that a psychologically unsafe work environment was a major factor in their decision to leave facility employment. The OIG made seven recommendations that VA concurred with and provided acceptable action plans for. The follow-up process will begin 90 days after publication.

In both reports about the Aurora healthcare system, events and interviews substantiate that this facility's culture and key functions were crumbling for close to 2 years. There were clear signs: sudden exits of critical clinical leaders, a fractured relationship with an academic affiliate, and a prolonged closure of cardiothoracic surgery services. Yet, the OIG team's interview with the then VISN chief medical officer revealed a leader who described limited awareness of the gravity of the issues, stating he "hadn't heard much noise from the Director." Additional interviews with current VISN leaders reflected frustration with the passivity of this former VISN chief medical officer. This pervasive passivity the OIG has seen in multiple VISNs contributes to the ongoing governance concerns being spotlighted in today's hearing.

Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico

The OIG received allegations that the facility did not take action to address problems identified during a VISN inspection of the facility's sterile processing service (SPS) operations. Patients were at risk for infection when reusable medical devices used in patient care lacked documentation that high-level disinfection had been conducted. The OIG team determined that while there were multiple VISN inspection findings and recommendations related to facility SPS operations, the VISN delayed official notifications of them to facility leaders. During interviews, the OIG team concluded that VISN and facility leaders had different expectations as to whether facility actions should have been initiated prior to a formal VISN report being issued. However, had the VISN assumed a more active role, leaders could have more quickly recognized and addressed delays in corrective actions. The OIG found the lack of VISN oversight to hold the facility accountable to a timely remediation plan resulted in delayed implementation of sustainable, corrective actions for more than a year from the original findings.

Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena

The highest-level clinical leader in a VA medical facility is the chief of staff. Oversight of their clinical practice requires VISN support. In this report, the OIG found that a chief of staff was practicing gynecologic and obstetric care without privileges. The chief of staff's failure to follow evidence-based clinical standards for care placed one patient and her fetus at risk. Another patient was given an inadequate postoperative antibiotic. Finally, preoperative testing was not completed for surgical procedures in 32 of 35 cases. Despite the clear violation of privileging policy that is critical to safe clinical practice, when facility and VISN leaders were questioned regarding accountability, the VISN chief medical officer claimed the responsibility was the medical center director's. Because of undefined roles and responsibilities of VISN leaders, and absent facility leaders' initiative to seek out VISN support, patients were placed at unnecessary risk.

VISN LEADERS ARE NOT PROVIDING THE NECESSARY SUPPORT TO FACILITY LEADERS TO DEVELOP AND MAINTAIN A CULTURE OF PATIENT SAFETY

Healthcare systems committed to patient safety routinely follow protocols that prioritize high-quality care. They have structured and proactive quality and safety management oversight teams. They exercise a shared responsibility to recognize and report perceived risks while holding individuals and leaders accountable for ensuring patient safety is a continuous activity. VHA is this country's largest integrated healthcare system, and the volume and complexity of patient encounters require deliberate and clear lines of communication and information sharing. Dotted reporting lines, optional participation in sharing critical metrics, and confusion over authority undermine the essential functions of medical facilities and further highlight the fail-

ure of the current VISN structure to ensure consistent delivery of safe care to patients.

Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama

In this report, the OIG found that the facility's patient safety manager was derelict in performing required essential safety functions, such as reviewing and addressing reported incidents and completing root cause analyses for over a year, which essentially paralyzed the facility's entire patient safety program.[6] Facility and VISN leaders were completely unaware. The VISN patient safety officer acknowledged the inconsistent attendance of the patient safety manager at weekly calls and VISN-led patient safety committee meetings, but also noted that facility patient safety manager's participation was optional. The VISN patient safety officer did not know the extent to which the facility's patient safety program was out of compliance with VHA requirements because of an overreliance on briefings (from which the facility manager was often missing) and insufficient proactive outreach that would have revealed incident reporting, reviews, and remediations were not being done. This passive oversight is not in keeping with HRO principles.

The OIG made 11 recommendations, of which two called on the VISN to ensure the reporting and tracking of actions taken on patient safety events. All recommendations have been closed as implemented.

Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia

This report outlines failures in responsibility at multiple levels of VHA, including the VISN, facility, and service line, in reacting to deficiencies in sterile processing at the medical center.[7] VHA Directive1116(2) charged the VISN SPS Management Board with the oversight of SPS and reprocessing of critical and semicritical reusable medical devices at all medical facilities in the VISN.[8] In addition, the VISN SPS Management Board is required to conduct a VISN-led inspection at each facility. After each inspection, the VISN develops recommendations to improve the reviewed processes. While the VISN SPS lead is responsible for ensuring that action plans to address the recommendations are followed to completion, the OIG's review of the VISN SPS Management Board's meeting minutes found no documentation to support that this occurred.

Two of the nine recommendations from this report were addressed to the VISN director: The first is to review the facility's water management program and ensure its compliance with VHA guidance and monitor future compliance. The second is to make certain that the VISN SPS Management Board review the facility's water test results and that any necessary corrective actions be taken and reported to the National Program Office. These recommendations are open and the OIG will review VA's progress on implementing them during the routine follow-up process starting 90 days after the report's publication.

Cyclical Inspections Find Deficiencies in Staff Privileging

During the OIG's proactive cyclical inspections of medical facilities, healthcare teams found deficiencies in medical staff privileging activities, including failures to conduct ongoing and focused performance evaluations that help ensure providers are practicing competently. Several facilities that were visited for the Fiscal Year 2023 OIG Comprehensive Healthcare Inspection Program (CHIP) were found to have the same weaknesses related to these activities as those in prior OIG reports. Facilities in Augusta, Maine; Roseburg, Oregon; and Manchester, New Hampshire, are just three examples where repeat findings of deficiencies in medical staff privileging prompted OIG teams to direct recommendations to VISN leaders to ensure appropriate attention and support are provided to facilities struggling to comply with these critical activities.[9]

---

[6] VA OIG, *Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama*, February 27, 2023.

[7] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin*, Georgia, March 6, 2024.

[8] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016, was in place during the time of the events discussed in the report. It was rescinded and replaced by VHA Directive 1116, *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023.

[9] VA OIG, *Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta*, April 3, 2024; VA OIG, *Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon*, May 15, 2024; VA OIG, *Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire*, March 6, 2024.

Reporting to State Licensing Boards

The impact of failed internal VISN oversight of quality and competency of healthcare providers extends beyond the walls of VA's hospitals and clinics. The OIG has repeatedly reported on VISN breakdowns in ensuring that facilities comply with policies to report providers who do not meet acceptable care standards to State licensing boards. Typically, the facility has the responsibility to begin the process to report a provider to a State licensing board. However, in the Montana VA Health Care System case referenced earlier, there was confusion as to whether the VISN chief medical officer and the VISN credentialing and privileging team should be responsible because the chief of staff was a member of the executive leadership team. After the facility failed to report the chief of staff to the State licensing boards for his substandard gynecologic care, he resigned from his VA position and was able to practice medicine in the State of California.

VISN LEADERS HAVE LIMITED PARTICIPATION IN CRITICAL AND COSTLY DECISIONS RELATED TO FACILITY STAFFING AND REFERRALS OF VETERANS TO COMMUNITY CARE

In Fiscal Year 2022, more than 40 percent of veterans were provided care through the Veterans Community Care Program (VCCP), with that number continuing to rise.[10] The magnitude of the related increasing costs and staffing to manage these referrals are significant and warrant standardized VISN-level coordination. There should be more effective controls of clinical and administrative resources to make the most efficient and effective use of taxpayer dollars while meeting the needs of veterans seeking care.

Recently published CHIP reports highlight the massive expense of community care and the burdens placed on facilities to coordinate referrals. For example, in a recent inspection of the VA Eastern Kansas Health Care System in Topeka, the OIG noted that its Fiscal Year 2022 annual medical care budget of $504,398,232 had increased by approximately 24 percent compared to the previous year's budget of $406,670,320.[11] The facility director and associate director reported spending had increased due to community care expenditures. In another inspection of the VA Maryland Health Care System in Baltimore, the director reported in an interview with the OIG team that nearly 100 personnel were recruited to just schedule and coordinate community care for veterans.[12]

A recent OIG report examined the high usage of community care services for primary care, the impact of that use, and leaders' oversight of VA outpatient clinics at the VA Loma Linda Healthcare System in California.[13] The OIG found that after a new company assumed management of five community-based outpatient clinics, the contractor's staffing challenges limited the number of patients that clinic staff could see within prescribed timeframes. As a result, system leaders paused enrollment of new patients at all five community-based outpatient clinics and referred patients for primary care to the community.

However, the lack of oversight of contracted community-based outpatient clinics, and frequent changes of leaders at the VA healthcare system and the new company, highlighted an opportunity for VISN oversight and support of management of primary care services. In response to the OIG findings, the VISN has committed to collaborating on an assessment of the management of the community-based outpatient clinic steering committee and will provide ongoing programmatic monitoring through the VISN 22 Community Care Operational Dashboard. This collaboration is imperative if the healthcare system and VISN leaders want to return patients for primary care to the system, as they stated.

In the coming weeks, the OIG will publish its first proactive cyclical Care in the Community review of the VISN 9 VA Midsouth Healthcare Network.[14] This report will reveal the significant challenges this VISN is facing in ensuring timely access to high-quality care in the community for its veterans. During interviews, the OIG

---

[10] VHA Office of Integrated Veteran Care, *VHA Community Care Growth Trends Briefing*, March 2024.

[11] VA OIG, *Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka*, April 25, 2024.

[12] VA OIG, *Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore*, May 2, 2024.

[13] VA OIG, *Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California*, April 23, 2024.

[14] VISN 9 includes VA healthcare facilities affiliated with the Lexington VA Health Care System in Kentucky; the Tennessee Valley Healthcare System in Nashville and Murfreesboro, Tennessee; James H. Quillen VA Medical Center in Mountain Home, Tennessee; the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis, Tennessee; and the Robley Rex VA Medical Center in Louisville, Kentucky.

team asked VISN 9 and facility leaders to share top concerns for their community care programs overall. These included care coordination, quality of care, and increasing costs. Beyond the well-known administrative challenges of trying to obtain medical documentation from community providers, leaders also stated that contractual agreements with third-party administrators of community care can impede required VISN oversight of the administrators' quality assessments and any subsequent corrective actions. VISN leaders also felt that because of these agreements, they had little ability to control costs.

With pending reductions in some VHA staffing and persistent staffing shortages in other critical clinical positions, the VISNs should consider their oversight role regarding financial and staffing decisions of medical facilities. This would help align available resources and community care expectations. Every decision must be informed and strategic, guided by an oversight structure that is standardized and data-driven.

CONCLUSION

The OIG has repeatedly published healthcare reports that find there are effective and comprehensive VHA policies and skilled and dedicated staff aggressively working to carry them out to provide high-quality and timely care to veterans. Yet, OIG oversight teams also continue to find the inconsistent application or misinterpretation of policy, insufficient VA personnel training, and other issues that could be mitigated by a clear and consistent structure of authority and accountability. Such a structure would clarify roles and responsibilities for those who could track and identify trends in noncompliance in real time and intervene proactively. Knowing that suicide prevention is the top priority for VHA, I want to reiterate the importance of how such a structure cannot only help advance its goals but also make a real difference in the lives of veterans. Despite clear policy and the recognized priority of using simple screening tools to assess veterans for suicide risk, the OIG has found that compliance across the system remains poor. In light of such performance, exploring options to monitor and mitigate barriers to complying with the most basic activities of suicide prevention—including risk assessments, safety plans for high-risk patients, safe storage discussions regarding firearms, and the necessary consultations—must be considered, in addition to the need for increased oversight of facilities enterprise-wide.

VHA care has evolved and expanded dramatically since the creation of the VISN structure. The size of VHA, the increasing demands of meeting complex healthcare needs, the escalating cost of health care, and the simultaneous implementation of massive initiatives—such as community care, the PACT Act, and electronic healthcare record modernization—require a standardized internal oversight structure that can assume accountability for the efficient and effective implementation of these high-cost but necessary efforts. We owe it to veterans who put their trust in VA, to the personnel working daily to meet their needs, and to the taxpayers who expect strong stewardship of their dollars. The OIG strongly encourages VA leaders at every level to use oversight reports as risk assessment tools to proactively address identified vulnerabilities in their own offices, networks, and facilities. The findings should also stimulate discussions about the VISN structure and its role in ensuring and supporting consistent high-quality care to veterans.

Madam Chair, this concludes my statement. I would be happy to answer any questions you or members of the subcommittee may have.

Prepared Statement of Kenneth Kizer

Thank you Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee for asking me to be with you today as you explore issues related to the organizational structure of the Department of Veterans Affairs Healthcare System broadly and issues of continuity of care and accountability of the Veterans Integrated Service Networks (VISNs) particularly.

In appearing before you today, please know that I do not represent any government agency, private organization, or other entity. I was advised by Committee staff that you wished me to participate in today's hearing because I am the person who originally conceptualized and then operationalized the Veteran Health Administration's (VHA) VISN structure in the mid-and late 1990's during my 5-year tenure as VA's then Under Secretary for Health. I am here today representing only myself as a veteran, a medical practitioner, and a health system leader with more than 40 years of healthcare executive experience. My comments reflect my personal views.

Historical Context

Since its founding in 1924, the Veterans Healthcare System has been restructured several times to address changing needs and circumstances.

Thirty years ago, I was recruited into VA as the first Under Secretary for Health to come from outside the organization. My charge was to re-engineer the system to address numerous systemic problems, including fragmented, disjointed and overall poor quality of care; difficulties in access to care; and uncontrolled rising costs, among other things.

Working closely with the Congress and then Clinton administration, the VHA organizational transformation that I engineered sought especially to make superior quality of care predictable and consistent throughout the system, to improve access to care, to make VA health care value equal or superior to care provided in the private sector, and to make VHA a high reliability organization. Multiple documents of various kinds discuss the strategies and tactics pursued to accomplish these goals.

Establishment of the VISN organizational structure was one key component of the 5-pronged re-engineering strategy that included: (1) reorganizing care delivery assets for the purposes of increasing accountability and improving efficiency of operations and utilization of resources; (2) implementing structures, policies and procedures aimed at better integrating and coordinating services; (3) improving the quality of care; (4) modernizing VHA's information management infrastructure, including implementation of a systemwide electronic health record; and (5) aligning system finances with desired outcomes, which included establishing a new resource allocation methodology.

The performance improvements this re-engineering produced were both rapid and dramatic and were tangibly demonstrated in many and diverse ways, including by systemwide enrollment more than doubling within 4 years – i.e., Veterans voted with their feet.

The VHA's transformation of the late 1990's has been described and discussed in multiple books and hundreds of refereed and other professional journal articles, as well as in myriad reports by the Government Accountability Office, Congressional Budget Office, VA Office of Inspector General, and various consulting organizations. Literally hundreds of research studies have documented VHA's improved quality of care, operational efficiency, and access. It also has been the subject of multiple doctoral dissertations and similar academic activities.

In these sundry reports, the VA Healthcare System's transformation has been characterized as the largest and most successful healthcare turnaround in U.S. history, or by similar verbiage. And it has been regularly used as a case study in healthcare executive training programs (see, for example, the Harvard Business Review case study published in 2007).

Perhaps one of the best validations of the strategies used to accomplish VHA's transformation is that over the past 25 years much of the rest of American healthcare, in spite of different financing mechanisms, has pursued substantially similar change strategies and tactics as were pioneered by VHA 30 years ago.

When I left the VA in 1999, I viewed VHA's transformation as a work in progress, notwithstanding its already demonstrable success. In the subsequent 25 years the original principles and goals of that re-engineering effort have been variously and inconsistently pursued or re-affirmed. As just one example, efforts that I launched to evolve VHA into a high reliability organization were continued for some time after I left VA but were later abandoned, only to be relaunched anew in 2019 by Dr. Richard A. Stone, the then Acting Under Secretary for Health.

While the overall improvements in quality of care, efficiency, and access resulting from VHA's re-engineering in the late 1990's are very well documented, it has to be acknowledged that the continued evolution of the system that I envisioned only partially occurred. And, regrettably, there have been some major managerial missteps over the years, some of which I have written about in articles published by respected professional journals.

VHA's overall superior quality of care has been and continues to be well documented by academic studies and reports in professional journals, but there continues to be robust opportunities for improving overall systemwide performance, especially with regard to the consistency of high quality care being provided, ease of access to care, and assuring demonstrable accountability at all levels of the organization. Importantly, the Covid–19 pandemic, new policies and priorities, and new patient populations also have created novel challenges and problems for the VHA.

All of this makes the VA Healthcare System one of the most complex and difficult to manage healthcare organizations in the world. The system's large size and national scope in and of themselves present enormous management challenges. In ad-

dition, no other healthcare system treats as many highly sensitive conditions, many of them exacerbated by or acquired through military service and, thus, largely unknown outside of the VHA. Further, no other healthcare system in the U.S. is statutorily mandated to fulfill so many different core missions, which include providing medical care for eligible Veterans, educating and training more than 40 types of health professionals, conducting research to improve Veterans care, preparing for public health emergencies and providing contingency support for the military and private healthcare sectors, and combatting homelessness. These disparate missions can complement each other, but sometimes also conflict.

Clearly, VHA's managerial challenges have increased in recent years for multiple reasons and especially because of enactment of the MISSION Act of 2018. In brief, this new law requires that the VHA function both as a fully integrated healthcare delivery system (as it has done since the 1990's) and as a payor for now millions of enrollees getting care in the community at a cost of over $30 billion in 2023. Importantly, these two different functional roles – i.e., being an integrated delivery system and a large healthcare payer—require different guiding philosophies and principles, operating infrastructures, skill sets, and authorities, which is probably why no private healthcare system in the U.S. tries to simultaneously accomplish both of these functions. Pursuing these roles concomitantly materially complicates and confounds management's ability to accomplish either, especially with regard to predicting funding needs and the number of patients that will be cared for each year so that staffing and other resources are available to provide needed services.

Added to the new managerial tasks associated with the MISSION Act, the VHA also has had to manage through the many immediate and on-going challenges wrought by the Covid–19 pandemic, as well as the materially increased numbers of patients with conditions related to toxic exposures that have been or are projected to be enrolled consequent to the PACT Act of 2023. The PACT Act is the largest expansion of benefits to veterans and survivors in decades.

Having good leadership is critical to the success of any organization, big or small, and leadership problems are a recurring challenge in all enterprises. Indeed, if exercising effective leadership were easy, then I suppose that our libraries and bookstores would not be filled with so many tomes promising to produce effective leaders. The very definition of leadership is constantly changing and leadership styles continually evolving.

Because the VA Healthcare System is now the managerially most complex healthcare organization in the Nation, having highly skilled and savvy leadership is especially critical for its successful management. In this regard, I do not believe that VA has done enough in the past, nor does enough now, to develop, nurture and grow the leadership and managerial skills needed in its workforce to address the system's challenges and to fulfill the sacred trust and promise the Nation has made to its military veterans.

VHA needs a much more robust, healthcare-specific leadership development program than it now has. This leadership program needs to be tailored specifically to the issues, challenges, and circumstances that VHA leaders confront in managing a national, government run healthcare system. These are not the same skills that may be learned in typical private sector healthcare executive training programs.

Finally in this regard, I should note that having been a medical practitioner, state regulator, healthcare payor, executive leader, and consultant in or for the private healthcare sector for much longer than I was with VA, I am mindful that no healthcare system always "gets it right." Leadership failures and errors of care occur in all health systems. And as the spouse of a now deceased patient who had several serious chronic health conditions, as well as being a patient myself, I have had the opportunity to observe the front lines of care at some of the most renowned healthcare institutions in the country. Sadly, I have witnessed first-hand egregious lapses in the care provided by these premier organizations. I mention this merely to underscore that healthcare broadly is very much a work in progress and has myriad opportunities for improvement in every setting.

Committee Staff Questions

Committee staff requested that I respond to several specific questions, which I will do in the paragraphs that follow, but first I want to briefly address four general questions that were more or less posed to me in my conversation with staff prior to this hearing.

First, do you believe the VISN structure continues to be the preferred organizational structure for the VA Healthcare System?

In a word, "yes".

The original selection of 22 VISNs in 1995 was based on experiential information available at that time indicating that a delivery system should have between 200,000 and 400,000 users and a broad mix of care delivery assets rooted upon robust primary care to achieve integrated, coordinated, and continuous care in an efficient manner. It was understood that these numbers might vary based on the disease burden of the population, geography, climate, and possibly other factors. With that foundation in mind, the catchment areas of the original VISNs were determined according to prevailing patient referral patterns between and among facilities, the ability of each VISN to provide a continuum of primary to tertiary care with VHA's then existing care delivery assets, and, to a lesser extent, on State or county jurisdictional boundaries. Establishing 22 VISNS was a point-in-time pragmatic judgment based on these criteria. It was expected that the number of VISNs would change over time as circumstances changed and as the system evolved according to other transformation strategies. And this is what has happened.

Because it is often not recognized, I should note that the VISN structure was also intended to provide redundancy of internal oversight to facilitate accountability for outcomes, quality, and costs, as well as adherence to established policies and procedures. If oversight and accountability fail at the local level, then it can be exercised at the regional (i.e., VISN) level. If it fails at both local and regional levels, then it can be exercised at the national level. Of course, VHA also has an unparalleled number of entities providing external oversight. This committee is one of those many entities.

The fact the so much of the rest of American healthcare has or is in the process of trying to establish integrated delivery networks should reassure the Committee that the conceptual underpinnings of and rationale behind the VISN structure are quite sound.

In saying this, however, I believe it is worth considering whether the present number and configuration of the VISNs is optimal or whether some selective reconfiguration might be in order, especially with regard to those networks that over the years have experienced marked increases in the number of enrolled Veterans they serve.

Second, do you think the performance and accountability problems that have been observed in the VA Healthcare System are due to the VISN structure?

In a word, "no".

Structures are not independent of the people who work in them, nor of the leaders and managers whose job it is to ensure that staff achieve desired outcomes, whether that be in quality of care, cost management, or other domains. It has been my experience over the past 40 years in executive leadership roles of various kinds that lapses or failures in leadership and poor execution of established policies and procedures and/or insufficient delineation of roles and responsibilities are much more likely explanations for performance or accountability problems than organizational structure.

Too often performance problems are incorrectly attributed to organization structural issues when lapses in leadership and poor execution of policies and procedures are instead the actual root causes of a problem. It is critical not to confuse problems in leadership or adherence to policies with issues of structure.

Third, how do you think the right balance should be achieved between having national, systemwide standardization and having regional or local flexibility that facilitates local leaders and care providers address sometimes unique situational circumstances?

One of the most difficult challenges confronting the leadership of any large health system (or any service provider, for that matter) is finding the right balance between organization-wide standardization and regional or local flexibility that allows local managers and service providers to address unique or unusual local circumstances. This is an especially difficult challenge for VHA because the system is national – indeed, the only national healthcare system in the U.S. It must provide care in many very different settings and circumstances which often present quite different challenges.

Having said this, however, I would note that it is imperative that VHA have significant standardization of its policies and procedures and processes of care so that both caregivers and patients, as well as health system leaders, know what they can reasonably expect regardless of where they are in the system.

Perhaps the most prominent example of VA's failure to standardize over the past 25 years is what occurred with VistA, VHA's once highly acclaimed electronic health record. VA leadership never should have allowed widespread facility-based

"customization" of VistA to occur, causing an originally standardized systemwide EHR to morph into 170+ versions of VistA that created digital chaos.

As a now outside observer of the VA Healthcare System, albeit one who has and continues to see it through multiple different lenses, it appears to me that the system might benefit from increased standardization in a number of areas. Conversely, it would benefit from continued flexibility in areas where there is no demonstrable benefit or value achieved by standardization.

And fourth, do you think VHA has optimally leveraged its diverse and wide-ranging assets and its advantages as a national healthcare system to optimize care delivery?

Notwithstanding some gaps and vulnerabilities, the VA Healthcare System has enormous human, technological, intellectual, educational and training, investigational, and policy assets that few, if any, other health systems have. Regrettably, too often, VA has not capitalized on its many assets and fully used them to its advantage in caring for Veterans.

Let me offer just one possible example of how these various resources could be used to address a current VHA problem.

VHA continues to face significant shortages of mental health caregivers, as does the rest of American healthcare. To address this ongoing problem, VHA could use its various caregiving and educational tools to launch a multi-pronged mental health care enhancement initiative that aligns these resources and tools around a goal of increasing mental health care capacity. In so doing, it would need to be understood that: (1) no one strategy can fill the need for mental health care providers; (2) the private sector can be of only limited help since it is often worse off than VHA; and (3) there are no quick fixes. This mental health enhancement initiative would have both short-and long-term goals aimed at better utilizing existing mental health care assets and developing new assets. Tactics that might be utilized in this strategy – all of which are within VHA's control to do—include:

- Reassign existing GME and other training slots to increase mental health care trainees/providers. A similar strategy was pursued in the late 1990's to increase the number of primary care providers in VHA, increasing the number of its then more than 9,000 funded GME positions for primary care specialties from 34 percent of the total in 1994 to 49 percent in 2000.
- As a national system of care, rethink how assets in better resourced areas might be utilized or deployed in ways to aide shortage areas, taking advantage of time zone differences, technology, the lack of State licensure restrictions, and other things.
- Extensively leverage technology to support, extend and augment providers (e.g., telehealth, mobile device apps, and virtual reality/immersive technologies).
- Develop in-house training programs that would empower non-mental health care providers to expand their competence in taking care of mental health patients.
- Establish new types of mental health care providers to fill gaps in services. Remember that the specialty of clinical psychology was born in the VA.
- Develop and fully utilize partnerships with community care organizations and providers. This means much more than just referring Veterans to community care providers; some examples of innovative community partnerships are mentioned in the 2023 National Academies of Sciences, Engineering, and Medicine workshop report that was prepared for VHA.

Among the many other potential opportunities in this vein I would especially call out expanding use of telehealth and immersive technology, pioneering application or uses of machine learning and augmented/artificial intelligence, and systemwide use of expanded function clinical call centers

Finally, committee staff have asked that I address the below specific questions.

A 2019 GAO report indicated a lack of a comprehensive policy defining VISN roles and responsibilities, which is still an open recommendation. How critical do you believe it is to have such a policy in place?

As already noted, in a system as large and complex as the Veterans Healthcare System it is essential to have managerial and leadership roles and responsibilities clearly defined at the local, regional, and national levels. It is also critical to understand when flexibility in those roles and responsibilities is needed or otherwise acceptable. Since roles and responsibilities will change as policies, technologies, methods of care, and other circumstances evolve, it also is necessary to have agile processes for revising and redefining those roles and responsibilities.

Having said the above, I also should note that it is essential to have clarity about an organization's mission(s) so that leadership roles and responsibilities can be clearly aligned with that (those) mission(s). For example, notwithstanding the perceived clear direction of the MISSION Act, its implementation involves many operational subtleties, nuances and judgments since, as previously noted, functioning as a healthcare integrated delivery system or as a large healthcare payer involves different guiding philosophies and principles, operating infrastructures, skill sets, and authorities. Respectfully, I would suggest that the Committee spend some time further exploring this complex matter.

Do you believe that VACO possesses sufficient knowledge and detail about the activities and conditions at the VISN level and the medical facilities under them to ensure proper accountability?

Since I have not worked for the VA for some time, I do not feel I have sufficient current information to comment on how much knowledge and detail VACO has about the activities and conditions at the VISN and VAMC level.

However, based on the information presented to the "Red Team" Executive Roundtable during its review of the Veterans Community Care Program (VCCP) last January, my colleagues and I were surprised that VACO representatives were not able to answer a number of seemingly basic questions. These included questions about the extent of VISN and VAMC funding shortfalls, community care referral practices and procedures and to what extent these were standardized, and impacts of the VCCP on VA's other statutory missions such as health professional education and training or its "fourth mission" of emergency preparedness and public health emergency contingency support. I hope that our queries spurred VACO to fill in its seeming gaps in knowledge that were evident at that time.

What are the most significant changes you've observed in the VISN structure and operations over the years?

I will refer here to comments already made about the number of VISNs and evolution of the system.

As a broad statement, and understanding that some variability in performance is to be expected across the VISNs and VAMCs, I am disappointed that there is not more systemwide consistency and uniformity in the processes of care and administrative procedures so that both patients and caregivers know they are in the same healthcare system regardless of where in the country or how they are interfacing with it.

A good example of the kind of desirable consistency that the VHA has achieved is found in its pharmaceutical management program.

When I started my tenure as Under Secretary for Health in 1994, the most frequently voiced problem and source of frustration that Veterans complained about was the different pharmaceuticals available at different VAMCs. No two VAMCs had the same formulary of drugs. Having so many local drug formularies not only frustrated patients but also jeopardized quality of care and made no managerial sense. To address this variability over the course of a couple years we created and implemented a national formulary. Subsequently, as a result, Veteran complaints dropped dramatically, and it facilitated increased efficiency of dispensing and mail order distribution, as well as improving quality of care in multiple ways. The National Formulary also allowed VA to negotiate better prices for drugs from the pharmaceutical companies. In this vein, it is worth noting that VHA's consolidated mail out pharmacy program was the first healthcare service anywhere to consistently operate at a six-sigma level of excellence.

There have been concerns about administrative variability between VISNs. How do you think this issue can be effectively addressed?

Addressing this should begin with having clearly defined managerial and leadership roles and responsibilities and clarifying when consistency is necessary or advantageous, and why. Importantly, this is not to say that all administrative variability is bad. In some things, it may not matter whether there is administrative consistency or not. The key is knowing when and where it does matter, and why, and then developing standard operating procedures and policies for those matters.

Of course, even with managerial and leadership roles clarified, it is necessary to have appropriately skilled and experienced people in leadership and management positions to effectively carry out those roles and responsibilities.

Given the variations in administrative practices and care quality across different VISNs, what measures do you believe are necessary to ensure consistency and uniform standards across the entire system?

Much of what I said previously applies here as well, although variability in care quality worries me more than variability in administrative procedures (unless, of course, variability in administrative practices adversely impacts quality of care).

Ensuring consistent high quality care, which includes convenient and easy access, should be VACO's immutable top priority, and continuous quality improvement should be built into and inherent to the fabric of the organization. Quality improvement should be integral to everything that is done. Of course, improvement begins with having accurate measurement of performance and ensuring that what truly matters is being measured. There are numerous specific tactics that can be utilized to drive improved and consistent quality of care, and VACO should have a robust menu of these tactics that can be applied or utilized in different situations or circumstances.

I am not close enough to current performance measurement and quality improvement activities at VACO to opine on what specific interventions may or may not be needed at this time.

Considering the variations in the size and scope of different VISNs, what do you believe is the optimal approach to ensure consistency in the sizing of these networks? How can the VHA balance the need for efficient management with the requirement to provide comprehensive care across diverse and geographically dispersed veteran populations?

This was largely addressed previously.

I would again emphasize that while network size (both geography and the number and type of enrollees) impacts efficiency of operations and provision of comprehensive care, having clearly defined managerial/leadership roles and responsibilities, standardized operating policies and procedures (including for inter-network support and assistance), and standardized but continuously improving processes of care are likely to have a much greater impact on providing consistent comprehensive care than VISN size per se.

Access to care remains a critical issue for veterans. What strategies do you think are most effective for improving access to care within the VISN system? How can VISNs ensure that veterans in both urban and rural areas receive timely and high-quality healthcare services?

Convenient and easy access is an essential component of high quality care.

Importantly, ensuring access to high quality healthcare services begins with having adequate numbers of appropriately trained and skilled staff. Without sufficient staff, the VHA can neither provide timely access nor high quality care, notwithstanding the potential for technology to support and augment staff.

As far as technology is concerned, I am optimistic that various established and emerging technologies can be used to facilitate convenient access, especially expanded use of telehealth and use of individual mobile device apps, as well as regionalized multi-purpose clinical contact centers (i.e., VA Health Connect).

I am also enthusiastic about how some private health plans are using AI to identify high risk or especially vulnerable patients that once they are identified can then be enrolled into intensive case management programs to ensure these patients have continuous easy access. It is my impression that AI may be more astute at identifying these vulnerable patients than traditional primary care teams.

Based on what I hear from Veterans and VA caregivers alike, perhaps the biggest leap forward in improving access to VA care would be to have a reliable and easy to use patient scheduling system, along with state-of-the-art telephone systems. Given how foundational these technologies are to access, it is very concerning that they continue to be prominent sources of frustration for both VA patients and caregivers. Ideally, any improved scheduling system would include mechanisms and means for Veterans to self-schedule their appointments.

I am mindful that VA is doing numerous things to improve access and that VA's timeliness of access has substantially improved in recent years and is now generally better than in the private sector. I will defer to others on the witness panel to describe those efforts.

Thank you for the opportunity to meet with you today. I hope that my comments are helpful as you continue to provide oversight of the Veterans Healthcare System.

Prepared Statement of U.S. Government Accountability Office

United States Government Accountability Office

GAO

Statement for the Record to the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 2:15 p.m. ET
Wednesday, June 26, 2024

VETERANS HEALTH CARE

VHA Is Taking Steps but Has Not Completed Implementing Priority Recommendations to Improve Its Oversight of Regional Networks

Statement for the Record by Sharon M. Silas, Director, Health Care

GAO-24-107641

GAO Highlights

Highlights of GAO-24-107641, a statement for the record to the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VHA operates one of the nation's largest health care systems. GAO and others have identified challenges VHA faces in managing and overseeing its health care system.

This statement provides information on the status of priority recommendations GAO made in two reports to strengthen VHA oversight of VISNs: (1) a report from June 2019, GAO-19-462, and (2) another report from September 2019, GAO-19-670. For this statement, GAO reviewed VHA information on the steps it has taken to implement the recommendations.

What GAO Recommends

GAO made three recommendations in the June 2019 report and five recommendations in the September 2019 report. From each of these reports, one priority recommendation has not been implemented.

View GAO-24-107641. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

June 26, 2024

VETERANS HEALTH CARE

VHA Is Taking Steps but Has Not Completed Implementing Priority Recommendations to Improve Its Oversight of Regional Networks

What GAO Found

Within the Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) has 18 regional networks—referred to as Veterans Integrated Service Networks (VISN) that manage and oversee 172 medical centers and other medical facilities. Each year GAO identifies priority recommendations, which are recommendations that have not been implemented that GAO believes warrant priority attention from VA. In 2024, this included priority recommendations that, if implemented, would help improve VHA's ability to oversee and hold VISNs and medical centers accountable. In addition, since 2015, GAO has identified VA health care as a government program that is at high risk for fraud, waste, abuse, and mismanagement due to inadequate oversight and accountability in its operations.

In June 2019, GAO found that VHA's oversight of VISNs was limited and made three recommendations to improve that oversight. VHA has implemented two but has not yet implemented one of these recommendations, which GAO has identified as a priority recommendation. Specifically, GAO recommended that VHA clearly define VISN roles and responsibilities for managing and overseeing medical centers. VHA agreed in principle with this recommendation. In June 2024, VHA reported plans to publish a directive by December 2024 that includes the roles and responsibilities of VISNs.

In September 2019, GAO found weaknesses in VHA's process for allocating funds to VISNs and medical centers and made five recommendations. VHA has implemented four of the five recommendations. As of June 2024, VHA has partially, but not fully implemented the remaining recommendation, which GAO has also identified as a priority recommendation. GAO recommended that VHA revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workloads that received adjusted funding levels. These approaches could include adjusting the level of services offered. VHA has reported taking steps to address this recommendation.

Since VA health care was added to the High-Risk List in 2015, GAO has made 42 recommendations to VA related to its oversight of VISNs and VISN management. As of June 2024, VHA has implemented 37 of those recommendations. Of the five recommendations that have not been implemented, there are two priority recommendations that warrant immediate attention from VA. Implementing these recommendations will help ensure VHA is operating appropriately and efficiently and in turn help to ensure medical centers are providing quality and timely care to veterans.

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for the opportunity to submit this statement highlighting some of our work examining the Veterans Health Administration's (VHA) oversight of its regional networks.

VHA, within the Department of Veterans Affairs (VA), operates one of the nation's largest health care systems, with 18 regional networks—referred to as Veterans Integrated Service Networks (VISN)—that manage and oversee 172 medical centers and other medical facilities. We and others have identified challenges VHA faces in managing and overseeing its health care system, including VHA's ability to ensure that its medical centers provide veterans with timely access to quality health care.

We added VA health care to our High-Risk List in 2015, in part, because of VHA's inadequate oversight and accountability, including its oversight of VISNs, and it remains on the High-Risk List.[1] Since being added to the High-Risk List in 2015, we have made 42 recommendations to VA related to its oversight of VISNs and VISN management. As of June 2024, VA has implemented 37 of those recommendations, but 5 have not been implemented. In addition to the High-Risk List, each year we identify recommendations that have not been implemented that should warrant priority attention from VA.[2] In 2024, this included priority recommendations that, if implemented, would clarify VISNs' roles and responsibilities and improve VHA's ability to oversee and hold VISNs and VA medical centers accountable.[3]

[1]We maintain a list of government operations that we have identified as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015) and GAO, *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, GAO-23-106203 (Washington, D.C.: Apr. 20, 2023).

[2]Priority recommendations are those that we believe warrant priority attention from heads of key departments or agencies. These recommendations are highlighted because, upon implementation, they may significantly improve government operations by, for example, realizing large dollar savings; eliminating mismanagement, fraud, and abuse; or making progress toward addressing a high risk or duplication issue.

[3]GAO, *Priority Open Recommendations: Department of Veterans Affairs*, GAO-24-107265 (Washington, D.C.: June 3, 2024).

My statement provides information on the status of priority recommendations to strengthen VHA oversight of VISNs from the following two reports:

1. A June 2019 report entitled *Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities* that examined VHA's oversight of VISNs, including the extent to which VHA oversees VISNs' management and oversight of medical centers.[4]
2. A September 2019 report entitled *Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding* that examined VHA's allocation and monitoring of funds to its VISNs and medical centers.[5]

For our June 2019 report, we reviewed policies and related documents that describe VISN-level responsibilities. For our September 2019 report, we reviewed documents on VHA's processes for allocating funds to VISNs and medical centers and requirements for monitoring the use of funds. For both reports, we interviewed officials from VHA central office and from all 18 VISNs. The reports include a full description of their respective scope and methodology.[6] In addition, for this statement, we reviewed information on VHA's progress implementing the recommendations from the reports.

The work on which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA's health care delivery system is organized regionally, around VISNs. The VISNs were established in 1995 as part of a strategy to decentralize VA health care decisions and bring decision-making closer to the point of care. VISNs were initially designed to be the basic budgetary and

[4]See GAO, Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities, GAO-19-462 (Washington, D.C.: June 19, 2019).

[5]See GAO, *Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding*, GAO-19-670 (Washington, D.C.: Sept. 23, 2019).

[6]See GAO-19-462 and GAO-19-670.

planning unit of VHA. VISN directors were given the autonomy and authority to develop and implement local management, administrative, and staffing arrangements when necessary to meet health care needs. Since then, the number of VISNs has decreased from the original 22 to 18, VISN boundaries have been realigned, and the staffing structure has changed to help support emerging VHA-wide health care needs.

VISNs manage regional markets that deliver health care, social services, and support services to veterans. Each VISN is responsible for overseeing medical centers within a defined geographic area. VISNs manage the day-to-day functions of medical centers within their networks through efforts such as periodic strategic, business, and financial planning meetings. For example:

- As part of its broader oversight approach, VHA designated VISNs as one part of the organization responsible for monitoring risks across their regions. However, VHA is still early in its efforts to implement its oversight approach.
- Each year, VHA allocates funds for general patient care—known as general purpose funds—to its 18 VISNs, and these general purpose funds are then further allocated to the medical centers within each VISN. VHA guidance permits VISNs to make adjustments to the general purpose funding levels allocated to each medical center.

VHA Has Taken Some Steps to Address a Priority Recommendation to Define VISN Roles and Responsibilities in Managing Medical Centers

In our June 2019 report, we found that VHA's oversight of VISNs was limited and made three recommendations.[7] Specifically, we recommended that VHA (1) develop a process to assess the overall performance of VISNs in managing and overseeing medical centers; (2) establish a process to routinely oversee VISN staffing, to include ensuring VISNs are consistent with VHA's standardized VISN staffing levels and positions, and documenting the rationale for approving staffing that does not adhere to VHA's standardized approach; and (3) develop a comprehensive policy clearly defining VISNs' roles and responsibilities in managing and overseeing medical centers. VHA has implemented the first two recommendations. The third recommendation, which we

[7]See GAO-19-462.

identified as a priority recommendation for VHA in 2020, has not been implemented, as of June 2024.[8]

VHA agreed in principle with the third recommendation and has taken some steps to address it. In May 2023, VHA reported that a directive was under review that will describe the roles and responsibilities of VISNs, including for the management and oversight of medical centers. As of June 2024, VHA reported that publication of the directive is projected for December 2024.

It remains critical that VHA develop a policy that clearly defines VISN roles and responsibilities. Without taking this action, it will be difficult for VHA to develop an effective oversight process that ensures adequate monitoring of VISN activities. We will continue to follow up with VHA officials on their progress in implementing this priority recommendation. When VHA completes these activities, we will evaluate the extent to which it has addressed our recommendation.

VHA Has Not Fully Implemented a Priority Recommendation to Help VISNs Improve Efficiency at Medical Centers with Declining Workloads

In our September 2019 report, we found weaknesses in VHA's processes for allocating funds to VISNs and medical centers, and we made five recommendations.[9] Specifically, we recommended that VHA (1) use workload data from the most recently completed fiscal year to allocate funds; (2) establish a formal process to document VHA's review of VISNs' adjustments to medical center allocation levels; (3) revise existing guidance to require VISNs to provide information on adjustment amounts and the reasons for doing so; (4) require VISNs to provide explanations for redistributions of allocated funds between VISNs and medical centers and then review the amounts redistributed; and (5) revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels. These approaches could include adjusting the level of services offered.[10] VHA has implemented four of the five recommendations. As of June 2024,

[8]See GAO, *Priority Open Recommendations: Department of Veterans Affairs*, GAO-20-537PR (Washington, D.C.: Apr. 20, 2020).

[9]See GAO-19-670.

[10]An example of an adjustment to the level of services offered could include consolidating services that are offered at multiple locations.

VHA has partially, but not fully implemented the fifth recommendation, which we identified as a priority recommendation in 2020.[11]

VHA agreed in principle with the fifth recommendation and has reported taking steps to address it. For example, VHA stated that it has conducted market assessments, and the information from these assessments is being used to increase the quality of care and veterans' access to it. VHA reported that adjusting medical centers' level of service may be considered along with other alternatives in response to the market assessments. We will continue to follow up with VHA officials on their progress in implementing this priority recommendation. When VHA completes its activities, we will evaluate whether VHA has fully implemented the recommendation.

In closing, improving the ability of VISNs to effectively monitor and allocate resources within their respective regions should be a priority for VHA. We acknowledge that VHA has implemented many of our prior recommendations and taken steps towards implementing the two priority recommendations described in this statement. By addressing remaining weaknesses in its oversight of VISNs, VHA will be better prepared to operate its vast health care system appropriately and efficiently to provide quality and timely care to veterans.

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee, this concludes my statement for the record.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this statement for the record, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement.

GAO staff who made contributions to this testimony include Janina Austin (Assistant Director), Alison Goetsch (Analyst-In-Charge), Jacquelyn Hamilton, and Cathleen Hamann Whitmore.

[11]See GAO-20-537PR.

Prepared Statement of Alzheimer's Association and Alzheimer's Impact Movement

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the U.S. House Committee on Veterans Affairs Subcommittee on Health hearing on "The Continuity of Care: Assessing the Structure of VA's Healthcare Network." The Association and AIM thank the Subcommittee for its continued leadership on issues, such as the Department of Veterans Affairs (VA) health care network, that are important to our Nation's veterans living with Alzheimer's and other dementia and their caregivers. This statement highlights the importance of dementia care and support programs at the VA and discusses how our Nation's veterans living with dementia are benefiting from such programs.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Nearly half a million American veterans have Alzheimer's—and as the population ages, that number is expected to grow. In 2015, an estimated 486,000 veterans were living with Alzheimer's. The annual number of veterans newly diagnosed with dementia has increased by more than 22 percent since 2008. For veterans, the prevalence may grow even faster in future years because they have a higher risk of developing dementia. The significant increase in the number of veterans with Alzheimer's and other dementias will place a heavy burden on the VA health care system and, in particular, rural health practices.

Home-and Community-Based Services (HCBS): The Impact on Family Caregivers and Needs of the Alzheimer's and Dementia Community

We are grateful for the VA's continuing commitment to supporting veterans living with Alzheimer's and other dementia by offering an array of long-term care and support services, such as assisted living, residential, adult day, and home health care.

HCBS allow people with dementia to remain in their homes while providing family caregivers with much-needed support. These services empower caregivers to provide quality care for their loved ones while allowing them to manage and improve their own health.

While 83 percent of care provided to older adults in the United States comes from family members, friends, or other unpaid caregivers, nearly half of these caregivers do so for individuals with Alzheimer's or other dementia. Of the total lifetime cost of caring for someone with dementia, 70 percent is borne by families—either through out-of-pocket health and long-term care expenses or from the value of unpaid care. In 2023, caregivers of people with Alzheimer's or other dementias provided an estimated 18.4 billion hours of informal—that is, unpaid—assistance, a contribution valued at $350 billion.

Several states are implementing innovative solutions to address Alzheimer's by developing critical, cost-effective, dementia-specific HCBS programs. These programs are allowing people with dementia and their caregivers to access services and support that are uniquely tailored to meet their needs, allowing them to remain in their homes and communities longer and enjoy a greater quality of life. Building off of innovative solutions by several states, the VA, through the Veterans Health Administration (VHA), should consider adopting a core set of home-and community-based services that are specifically designed for people with dementia. A core set of HCBS, in addition to other services, will allow people with Alzheimer's to continue to remain in their communities and be independent for as long as possible.

Supporting Veterans' Access to High Quality Long-Term Care Services

While people living with Alzheimer's and other dementia and their caregivers often prefer to keep the individual living in the home for as long as is manageable, they make up a significant portion of all long-term care residents. More than 60 percent of the VA's costs of caring for those with Alzheimer's is for nursing home care. Given our constituents' intensive use of these services, the quality of this care is of the utmost importance.

While much of the training for long-term care staff is regulated at the State level, we encourage the Subcommittee to consider proposals that support State VHA Medical Centers in implementing and improving dementia training for direct care workers, as well as their oversight of these activities. Training policies should be competency-based, should target providers in a broad range of settings and not limited to dementia-specific programs or settings, and should enable staff to (1) provide person-centered dementia care based on a thorough knowledge of the care recipient and their needs; (2) advance optimal functioning and high quality of life; and (3) incorporate problem-solving approaches into care practices.

We also urge the Subcommittee to support VHA Medical Centers in the following efforts: (1) any training curriculum should be delivered by knowledgeable staff that has hands-on experience and demonstrated competency in providing dementia care; (2) continuing education should be offered and encouraged; and (3) training should be portable, meaning that these workers should have the opportunity to transfer their skills or education from one setting to another.

VA's Continued Role in Addressing Alzheimer's Disease in Rural Areas

We are grateful for the VA's participation in the Department of Health and Human Services (HHS) Advisory Council on Alzheimer's Research, Care, and Services, which plays a key role in developing and annually updating the National Plan to Address Alzheimer's Disease as set forth by the National Alzheimer's Project Act (P.L. 111–375). The National Plan is a roadmap of strategies and actions of how HHS and its partners can accelerate research, expand treatments, improve care, support people living with dementia and their caregivers, and encourage action to reduce risk factors. The most recent update to the Plan was released in December 2023, and includes a number of highlights on VA's continued work to better serve our Nation's veterans living with dementia.

The VA continues to collaborate with Federal agencies on a number of the key goals of the National Plan detailing rural health care, including Action 2.A.1, which is to educate health care providers on Alzheimer's disease. The VA's Geriatric Scholars Program is a workforce development program to infuse geriatrics into VA primary care settings by conducting intensive training in geriatrics, including rural interdisciplinary team training. The program includes an intensive workshop on quality improvement, and each participating Scholar initiates a local quality improvement project to demonstrate learning and improve care or clinic efficiency. The program also includes a wide variety of training activities focused on dementia, including training sessions on dementia caregiver coordinator education and rural caregiver education. Finally, the program provides participants with hands-on experience and practical skills in geriatric care necessary for adequately treating the aging population.

We also ask that the Subcommittee continue to support the Veterans Health Administration's 20 Geriatric Research, Education, and Clinical Centers (GRECCs), which are geriatric centers of excellence focused on aging. GRECCs reported in the 2023 National Plan Update that their work included 78 research grants in dementia covering basic science to clinical care and health services research and 25 clinical innovation projects that directly served veterans with dementia and their families. GRECC faculty have developed numerous clinical programs to aid family members and care providers, including e-Consults for Behaviors in Dementia, Health Care Directives for Veterans with Dementia, Reaching Out to Rural Caregivers and Veterans with Dementia Utilizing Clinical Video-Telehealth and Virtual Dementia Caregiver Support Programs. The GRECC Program produced 56 educational programs for staff and trainees on best practices in dementia care, including the use of simulation technology to demonstrate techniques for communication and facilitating ADLs for veterans with dementia. Finally, GRECC authors published 259 manuscripts in peer-reviewed journals in Fiscal Year 2022 on their research and clinical work in dementia. The VA must continue supporting the GRECCs in disseminating findings from this research to integrate scientifically proven dementia interventions into local and rural communities.

Additionally, the VA also continues to collaborate with the Indian Health Service (IHS) and Centers for Disease Control and Prevention on the National Plan Action 2.A.6 to strengthen the ability of primary care teams in Indian country to meet the needs of people with Alzheimer's and related dementias and their caregivers. For example, in 2022, the IHS launched the Indian Health GeriScholars Pilot, developed with the support and collaboration of the VA Office of Rural Health. Modeled after the VA Geriatric Scholars Program, the Indian Health GeriScholars pilot provides primary care clinicians at IHS, Tribal, and Urban Indian Organization health programs with an individual intensive learning track for professional continuing education.

These are only a few examples of ways in which the VA remains involved in working to ensure a high-quality, well-trained dementia care workforce and continue bridging the gap in cognitive services in rural areas. The National Alzheimer's Project Act as a whole has led to great achievements in the treatment and research of Alzheimer's disease; however, this important law expires soon. The bipartisan NAPA Reauthorization Act (H.R. 619/S. 133) and Alzheimer's Accountability and Investment Act (H.R. 620/S. 134) would extend the National Plan, and ensure researchers at NIH continue to receive the funding necessary to sustain vital Alzheimer's and dementia research. These bills will ensure the Nation continues addressing Alzheimer's as a national priority, providing continuity for the community.

Program for Advancing Cognitive Disorders Education for Rural Staff (PACERS)

The VA Employee Education System and South Central Mental Illness Research Education and Clinical Center administer the Program for Advancing Cognitive Disorders Education for Rural Staff, also known as PACERS. The PACERS program at the VA is designed to enhance dementia care through a specialized training program for clinicians who care for veterans with cognitive disorders. It aims to improve outcomes for veterans and their caregivers, especially those living in rural communities. The program includes six e-learning courses and five videos that focus on normal cognitive aging and dementia caregiving, addressing decision-making and safety in dementia, and reviewing case studies in treating dementia. In rural settings with limited resources, the PACERS program is a crucial tool for health care professionals to better provide patients with high-quality care within the constraints of rural health care infrastructure. The VA may consider adopting similar online programs to further enhance dementia care training for rural physicians at the Veterans Health Administration.

Conclusion

The Alzheimer's Association and AIM appreciate the Subcommittee's steadfast support for veterans and their caregivers and the continued commitment to advancing issues important to the millions of military families affected by Alzheimer's and other dementia. We look forward to working with the Subcommittee and other Members of Congress in a bipartisan way to advance policies that will ensure access to high-quality dementia care and support in rural areas, especially as the population of veterans living with dementia continues to grow.