Testimony of
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to the
U.S. House of Representatives Committee on Veterans Affairs,
Subcommittee on Heath,
Hearing on
"The Continuity of Care: Assessing the Structure of VA's Healthcare Network"

Cannon House Office Building, Room 360
June 26, 2024

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 1990s during my five-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 1990s 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 1990s 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 addition, 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 1990s) 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 1990s 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% of the total in 1994 to 49% 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.