Testimony of
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to the
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"The Continuity of Care: Assessing the Structure of VA's Healthcare Network"

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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 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 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 materially restructured several times to address changing needs and circumstances. Thirty years ago, I was asked to come into VA as the first outside Under Secretary for Health in several decades and to re-engineer the system to address numerous serious problems of fragmented, disjointed and overall poor quality care; difficulties in access to care; and uncontrolled rising costs, among other problems.

Working closely with the Congress and the 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 memorialize the strategies and tactics pursued to accomplish these goals.

Establishment of the VISN organizational structure was one component of the 5-pronged, multi-faceted 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 standardized electronic health record; and (5) aligning system finances with desired outcomes, which included establishing a new resource allocation methodology.

The changes and improvements brought about by this reorganization were rapid and dramatic. The tangible improvements were 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, documented, and discussed in multiple books and hundreds of refereed and other professional journal articles, as well as in myriad reports by GAO, CBO, VA OIG and various consulting organizations. It also has been the subject of multiple doctoral dissertations and other academic inquiries.

The VA Healthcare System's transformation in the 1990s has been characterized as the largest and most successful healthcare turnaround in U.S. history, 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).

Recognizing the fundamental differences in how VA and private sector healthcare are financed, it is gratifying to see that in the past 20-25 years the rest of American healthcare has substantially followed many of the same change strategies and tactics pioneered by VA 30 years ago.

When I left the VA in 1999, I viewed VHA's transformation as a work in progress, and in the subsequent 25 years the original principles and goals of the re-engineering have been variously and inconsistently pursued or re-affirmed. 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 to become a high reliability organization has not yet been achieved and there have been some major managerial missteps over the years. I have written several articles in professional journals about some of those missteps.

While VHA's overall superior quality of care has been and continues to be well documented by academic inquiries and reports in professional journals, there continue to be robust opportunities for improving systemwide consistency of quality, facilitating ease of access to care, and assuring accountability at all levels of the organization. Likewise, new policies and new patient populations have created novel challenges and problems for VHA.

In this regard, I would opine that the VA Healthcare System is one of the most complex and difficult to manage healthcare organizations in the world because of its size, the complicated and often highly sensitive conditions which it treats, and its several statutorily mandated and other core missions (i.e., providing medical care for eligible Veterans, graduate medical education and other health professional training, conducting research, emergency preparedness and contingency support for the military and private sector, and combatting homelessness, among other things). These disparate missions both complement and sometimes conflict with

each other. Successful management of the system requires especially experienced and savvy leadership.

The system's managerial challenges have materially increased in recent years because of the MISSION Act, which requires that the system function both as a fully integrated healthcare delivery system (which it has done since the 1990s) and as a payor for now millions of enrollees getting care in the community at a cost of several tens of billions of dollars per year. Importantly, these two different functions require different infrastructures, skill sets, and authorities. No other healthcare system in the U.S. tries to concomitantly accomplish both of these functions.

It is not hyperbole to say that the VA Healthcare System is now the managerially most complex healthcare organization in the nation. And while problems of leadership occur in every healthcare system, and in every business and other type of organization, having effective and experienced leadership is especially critical for VA and VHA. I do not believe that VA has done enough to develop, nurture and grow the necessary 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.

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. Effective leadership is challenging and difficult to produce in all enterprises, big and small. VHA needs a much more robust, healthcare specific leadership development program than it now has. This leadership program has to be tailored specifically to the issues, challenges, and needs that VA 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.

In saying the above, I should note that having been a medical practitioner, state regulator, payor, 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 lapses and 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, and I have witnessed first-hand how the care by these premier providers often leaves much to be desired. I say these things merely to underscore that healthcare broadly is very much a work in progress and has myriad opportunities for improvement everywhere.

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 was based on experiential information from a few other health systems that indicated a delivery system needed to have between 200,000 and 400,000 users and a broad mix of care delivery assets to achieve integrated, coordinated, and continuous care in an efficient manner, understanding 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 then 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 the system evolved according to other transformation strategies. And this is what has happened.

Because it is often not recognized, I should also note that the VISN structure provides needed redundancy of oversight that should 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, and if it fails at both local and regional levels, then it can be exercised at the national level.

The fact the so much of the rest of American healthcare has or is in the process of establishing 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, 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 desired outcomes, whether that be in quality of care, cost management, or other domains. It has been my experience that lapses or failures in leadership – systemwide, regional, or local - 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.

It has been my observation over the past 40 years in leadership roles of various kinds that performance problems are too often incorrectly attributed to organization structural issues instead of understanding how lapses in leadership and poor execution of policies and procedures are 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 and unusual local circumstances. This is an especially difficult challenge for VHA because the system is national – and the only national healthcare system in the U.S. – and it must provide care in very different settings and circumstances that often have quite different challenges.

Having said this, however, I would also 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 the 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 might 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, VA has too often not capitalized on these assets and fully used them to its advantage in caring for Veterans.

Let me offer just one example in this regard.

VHA continues to face significant shortages of mental health caregivers. To address this ongoing problem, VHA could use its various caregiving and educational tools to launch a multi-pronged mental health care enhancement initiative. In doing so, it would need to be understood that: (1) no one strategy can fill the need for mental health care providers; (2) the private sector/community can be of only limited help since it is often worse off than VA; 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 VA'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 VA, increasing the number of 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 NASEM workshop report that was prepared for VHA.

Among the many other potential opportunities in this vein are 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 noted above, 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, along with an understanding of 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 facile processes for revising and redefining these roles and responsibilities.

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 do not presently work for the VA, nor have I for some time, I do not feel I have sufficient 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 posed by members of the Roundtable about the extent of VISN and VAMC funding shortfalls, standard community referral practices, and impacts of the VCCP on VA's other statutory missions such as health professional education and training or its "fourth mission" role in 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 suppose that 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.

Perhaps a good example of a desired degree of consistency that has been achieved is the VA's pharmaceutical management program. When I started my tenure as Under Secretary for Health in 1994, the most frequent 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. Without going into all the reasons why this was frustrating to patients, the ways that it impeded quality of care, and managerially why it made no sense to have so many local drug formularies, suffice it to say that to address this variability we created a national formulary. 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.

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 many 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.

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 above 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 of 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 quality 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 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 to care is an essential component of quality.

Of course, 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, at present, 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, 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. 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. 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 and guidance to the Veterans Healthcare System.