Mr. Chairman, Ranking Member Michaud and Committee Members:

My name is Dan Collard. I am a former hospital operator and a senior leader at Studer Group, a healthcare consulting firm.

Thank you for the opportunity to address this committee on the issue of Veterans' Health and the underlying elements of culture and leadership.

I listened with interest Monday night, when I heard Mr. Griffin from the Inspector General's office make the statement, "If you've seen one VISN, you've seen one VISN. It seems both the testimony of the witnesses and your questions centered on evidence and variance.

In Studer Group's work with over 900 healthcare organizations, it is clear that those that implement standardized approaches to care, produce the best outcomes. These organizations build cultures of accountability, alignment, consistency and sustainability. We also find that their evidence-based approaches extend beyond evidence-based care, to a framework of "evidenced-based leadership". This approach ensures that leaders are not only held accountable for the right goals, but have the skills, tools and knowledge to achieve those goals. These leaders ensure consistency in the workplace for their employees and consistency of the care environment for their physician colleagues. As the public has watched the VHA issues unfold in the past sixty days, it is clear that the tolerance for variance is chief among its ailments. As referenced repeatedly, the amount of variance and the lack of willingness to standardize leadership has created an unfortunately predictable outcome. As we would say, "What you permit, you promote."

Evidence: The data that demonstrates the correlation between evidence-based care, quality outcomes, patient experience and lower costs continues to mount. When one reviews the publicly reported data, it is clear that better healthcare is less costly healthcare. Data also suggests a strong correlation between a patient's perception of care and actual clinical outcomes. Further, there is data that correlates specific questions like preparation for at-home care and the likelihood of readmission. A review of VHA facilities within publicly reportable readmission databases indicates only a handful that appear in the top quartile, a few more above the national mean, and unfortunately too many in the lower ranks of American healthcare.

Connect this proof with employee engagement and one begins to see definite trends. A study published by the University Alabama at Birmingham shows the correlation between employee engagement and the likelihood of the creation of workarounds which increases safety issues. I was reminded of this study as I read the various reports of what we now know from whistleblowers about the veterans' wait lists and the related mortalities.

On standardization: The largest healthcare systems in the United States have driven improvements by harvesting and implementing best practices across their systems. When organizations like Community Health Systems identify a best practice, they move with urgency to put the practice into place across their 205 facilities. This includes patient safety protocols, caregiver to patient interactions around medication instructions and a leader accountability platform. I was concerned when I heard the witnesses reference the amount of time they thought it would take to make changes. As John Kotter reminds us, the biggest obstacle to achieving high performance is not achieving the needed urgency for change. Mr. Walz, I think this is part of the answer to your question about the Big Idea. No matter what is decided, the VA must embark upon change with a never-before-seen sense of urgency and with a proven, outcome based solution.

Studer Group observes that it can be as straightforward as transferring the rigor and discipline from areas in which an organization excels to areas that are sub-par. Imagine if the VHA electronic health record or benefits management systems that have been hailed as cutting edge could be the impetus to create scheduling software whose current version is archaic at best. Imagine if the high-performing facilities referenced in earlier testimony could be held out as models and indeed replicated with what Mr. Matkovsky refers to as "exceptional leadership and culture." We wouldn't have tolerated the operation of 21 different navies or armies, air forces, marines or coast guards when these veterans were on active duty. Why would we tolerate 21 versions of Veteran's Health? Our armed forces ensure readiness, by putting in place systems of verification and validation of skills…of both front line soldiers and sailors as well as their leaders. We find safe, effective, timely healthcare to be no different.

Finally, we must insist that the Veterans Health Administration does not continue to fall victim to the disease process known as "terminal uniqueness". Many health systems work with an organized labor environment. Many have a large geographic footprint with a corporate office thousands of miles from where care is being delivered. Many organizations serve a large indigent and disadvantaged patient population. And yet these organizations find a way to not only survive, but thrive.

I ask that this Committee compel the secretary and his leadership team to move forward with urgency, standardize evidence-based approaches across the entire enterprise, ensure methods of validation and verification are put into place and support outcomes-focused leadership development to ensure consistency across what should be the greatest health system in the country. I ask this today, not only as a healthcare professional, but as the son of a deceased Marine Corp veteran, whom I saw all too often let down by the VA. Thank you.