

**STATEMENT OF  
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DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH**

**July 14, 2022**

Good morning, Chairwoman Brownley, Ranking Member Bergman and Members of the Subcommittee. Thank you for the opportunity to discuss the Department's commitment to providing Veterans with world-class, integrated care. I am joined today by Ms. Laura Duke, Chief Financial Officer, VHA, Dr. Julianne Flynn, Chief of Staff, South Texas Veterans Health Care System, and Dr. Lisa Arfons, Acting Deputy Executive Director, Office of Veteran Access to Care.

The Veterans Health Administration's (VHA) approximately 380,000 employees, one third of whom are Veterans, come to work every day with one goal in mind: to serve Veterans, their families, caregivers, and survivors as well as they have served our country. The President has called this a sacred obligation with a mission that unites us all. For us, Veterans are our mission.

Our employees prove daily that we will face any challenge and go to any length – including during the worst pandemic in more than 100 years – to ensure Veterans receive the care and services they have earned and deserve. Despite the strain of the pandemic, VA employees worked tirelessly to ensure that Veterans received care – deferring time off and retirement out of their own sense of dedication – and this passion continues today. A recent study in The Lancet Regional Health found that our employees succeeded,<sup>1</sup> and that VA's strategy likely saved Veteran lives. Importantly, we know that some Veterans chose to defer routine care during the pandemic, and we continue to stand ready to help Veterans meet their individual health care goals.

Hailing from communities across the Nation, the population of Veterans VA serves is unique with rich diversity, seniority in age, health challenges specific to military service, and a high percentage of Veterans choosing to live in rural areas, among other factors. This requires VA to be exceptionally proactive and innovative to achieve meaningful access and outcomes for each Veteran in our care. Furthermore, the population we serve continues to evolve, with record numbers of women Veterans enrolling in VHA health care and VA's work with Congress on military environmental exposures enabling more Veterans to seek care for health concerns incurred during military service. We must cultivate a thriving health care system for current and future generations of Veterans across both direct and community care.

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<sup>1</sup> Available online: <https://www.sciencedirect.com/science/article/pii/S2667193X21000892#bib0011>.

## Access to Trusted, High Quality Care

As VA strives to lead through the pandemic and beyond, we want Veterans to know that our sacred obligation includes ensuring access to high quality health care they trust — whether they are in a VA facility, receiving VA care virtually or seeking care in the community. Community care is an essential element of Veteran access to care, and VA is proud of the more than 1.2 million health care providers who serve Veterans in the community and supplement the excellent care provided through VA’s direct care system. Notably, however, Veteran trust in community care lags behind trust in VA’s direct care system, and quality of care is more difficult to measure and monitor given that private sector systems generally do not collect or report the depth of quality data that VA shares for its direct care system. VA desires to provide Veterans with comparative information to inform their health care decisions, but such information from the private sector remains limited at this time.

Peer-reviewed studies provide the best window into comparative quality, and VA direct care has been consistently shown to outperform most private sector hospitals in core measures of inpatient quality of care. VHA also achieves superior levels for important inpatient safety measures (e.g., surgical complications) compared with the private sector. Multiple peer-reviewed scientific studies demonstrate that the quality of health care Veterans receive from VA is as good, if not better, than what is available outside VA direct care – inpatient care, outpatient care, surgery, mental health, and emergency care.

A 2018 study published in the Journal of General Internal Medicine found that VA hospitals generally provided better quality care than non-VA hospitals and that VA's outpatient services were of higher quality when compared to non-VA hospitals or non-VA outpatient centers.<sup>2</sup> VA performed better on patient safety, inpatient mortality, and inpatient effectiveness; for outpatient care, VA performed better than non-VA sites in preventive care (cancer screenings) as well as diabetes, cardiovascular disease, and depression management. Another study published in the Journal of Surgical Research in 2020, which compared surgical safety and patient satisfaction indicators at 34 VA medical centers (VAMC) with 319 nearby non-VA hospitals in three disparate regions of the United States, found that the VAMCs matched or outperformed neighboring non-VA sites in surgical quality metrics and patient satisfaction ratings in all three regions.<sup>3</sup>

Regarding mental health care, a 2019 study published in the journal Medical Care concluded that patients hospitalized on inpatient psychiatric units in community-based general hospitals were twice as likely to experience adverse events or medication errors as Veterans on inpatient mental health units in VHA hospitals.<sup>4</sup> When

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<sup>2</sup> [Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings - PubMed \(nih.gov\)](#)

<sup>3</sup> [A Comparison of Surgical Quality and Patient Satisfaction Indicators Between VA Hospitals and Hospitals Near VA Hospitals - PubMed \(nih.gov\)](#)

<sup>4</sup> [Comparing Rates of Adverse Events and Medical Errors on Inpatient Psychiatric Units at Veterans Health Administration and Community-based General Hospitals - PubMed \(nih.gov\)](#)

it comes to emergency care, an important study published earlier<sup>5</sup> this year showed that Veterans requiring emergency care who were transported to VA hospitals had a substantially lower risk of death within one month than those transported to non-VA hospitals; that corresponds to a 20 percent lower mortality rate among Veterans taken to VA hospitals. The advantage was particularly large for Hispanic and Black patients, older patients, and patients who arrived with relatively low mortality risk.

While these quality achievements are a clear demonstration of VA's long-standing commitment to excellence in providing care through VA facilities, it also means VA must closely monitor Veteran experience and available indicators of quality of care from community providers. Through the Third Party Administrators (TPA) that manage our Community Care Network, VA tracks and trends available patient safety and quality data for Veterans receiving care in the community. VA also oversees Clinical Quality Monitoring Plans implemented by the TPAs, which are required to include quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement, and peer review. The TPAs' Clinical Quality Monitoring Plans must include a detailed description of the purpose, methods, proposed goals, and objectives designed to ensure the highest quality of clinical care for Veterans seeking care in the community. Further, under the contract TPAs must identify, track, trend, and report interventions to resolve any potential or identified quality issues using the most current quality measures, including Serious Reportable Events, Hospital Acquired Conditions as reported to the Centers for Medicare & Medicaid Services, and Agency for Healthcare Research and Quality Patient Safety Indicators.

In an effort to enhance community care quality, VA has also made internal clinical training available, free of charge, to community providers and has created focused training on traumatic brain injury, posttraumatic stress disorder, military sexual trauma, suicide prevention, and military culture. VA also collects and reviews Veteran experience information in the community and analyzes customer experience data and insights in real-time to inform service recovery and performance improvement efforts.

Importantly, the Government Accountability Office, health care literature, and VA's proactive assessment of Veteran experience all indicate that fragmentation in the experience of health care is inherently at odds with quality. Veteran feedback shows that Veterans seeking care in the community sometimes experience difficulties retrieving records of the care that was received from a community provider or struggle to get an external clinician to coordinate with their VA team. Despite VA proactively and securely sending necessary clinical information to a Veteran's community provider, duplicative tests occur, and some Veterans are offered care for which they are unexpectedly and improperly billed by community providers. Fragmentation of care is known to be a barrier to quality, but importantly, Veteran feedback also shows that this fragmentation is a stressor for Veterans.

## **Health Care Trends**

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<sup>5</sup> [Mortality among US veterans after emergency visits to Veterans Affairs and other hospitals: retrospective cohort study \(bmj.com\)](https://www.bmj.com/lookup/doi/10.1136/bmj.m1171)

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (the MISSION Act) changed how VA furnishes care through community providers. Three years after the MISSION Act's implementation, VA's analysis shows that this landmark law has perpetuated and in some cases accelerated trends that have been observed over the last decade: 1) Veteran reliance – or the amount of health care for which Veterans rely on VA – has been growing, while total enrollment has remained relatively stable over the same time period; 2) VA direct care is growing, but community care is growing faster than direct care; 3) growth is not uniform across the country; and 4) Veterans are experiencing fragmentation of care, and trust scores for community care lag behind the direct care system. These observations will be evaluated in greater depth over the coming months, and VA will continue to work to understand the effects of COVID-19 on these trends.

VA strives to center everything we do on Veteran experience, access, and outcomes. It is extremely important to note that community care growth does not appear to be due to Veteran preference and may instead be influenced by operational factors (e.g., distance to the nearest VA emergency department). Veteran experience data indicates Veterans generally have higher trust in VA's direct care system.

From fiscal year (FY) 2014 to FY 2021, the number of community care authorizations increased by 161 percent, and the number of veterans authorized to seek community care increased by 86 percent, and community care appointments now represent more than a third of all appointments VA provides to Veterans. Last fall, the Congressional Budget Office (CBO) published a report that examined the effects of VA's changing policies toward community care and "determined that since 2014, Veterans' access to community care has expanded significantly."<sup>6</sup>

Since VA implemented the MISSION Act in June 2019, more than 3.4 million Veterans have received care through community providers, including through the use of emergency department and walk-in care options. Moreover, the number of Veterans being authorized to use community care has increased every year since 2014 with a record high number of authorizations made and appointments completed – the latter, more than 33 million – in FY 2021.

To better understand the impact of the growth in community care, VHA conducted an analysis of FY 2021 workload provided in both VHA and community care settings. The VHA analysis examined the workload for all services and identified that 73% of all services are available in both VHA facilities and community care settings. VHA found that 44 percent of services available in both settings were provided through community care. While the percentage of care provided through community care would have been slightly lower if COVID-19 had not occurred, it is significant to note that VA is rapidly approaching a point where half of all care available in both settings is provided through community care. Operational leaders already note concern for the potential of a

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<sup>6</sup> Available online: <https://www.cbo.gov/publication/57583>.

“spiral effect” in some areas, where workload and talent are shifting externally and thus threaten to harm VA’s training, research, and emergency preparedness missions.

Even in the absence of resource constraints, if the balance of care provided in the community continues on its current upward trajectory, we anticipate that certain VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity.

## **Integrated Veteran Care**

As the community care aspect of VA’s system has expanded, VA has heard from Veterans, community care providers, and VA employees that the separate VA systems for scheduling and accessing direct VA care and community care are not customer centric. As an example, Veterans seeking mammography care in VA today would be assigned a clinical Women Veterans Healthcare coordinator to support their care coordination needs, whereas Veterans seeking a mammography in the community are assigned help from an administrative community care coordinator. VA believes that a Women Veterans Healthcare Coordinator should support the important care coordination needs for Veterans receiving a mammography regardless of whether they receive that care in VA or in the community. Simply put, VA should design our delivery system around Veteran needs, not VA organizational requirements. In fall 2020, VHA conducted a functional assessment of clinical, administrative, and financial operations and identified opportunities to reduce overlap and duplication. VHA then announced that it would form an Office of Integrated Veteran Care and would begin development of an integrated access and care coordination model.

The goal of strengthening integration is to create a seamless, coordinated care experience for Veterans, whether they receive that care in a VA facility, through VA telehealth, or in the community care, or via telehealth. By striving toward a seamless, integrated Veteran experience, VA is putting Veterans and their needs at the center of our care delivery model.

A three-phase Integrated Veteran Care implementation plan began in October 2021:

- Phase I: Realign the financial functions of Community Care under the Veterans Health Administration’s Office of Finance and begin the design of the new integrated access and care coordination model.
- Phase II: Realign the policy and operational elements of the Office of Community Care and Office of Veterans Access to Care into an Office of Integrated Veteran Care, establishing oversight for the completion and implementation of the integrated access and care coordination model.
- Phase III: Deploy the integrated access and care coordination model in the field with nationwide training of involved staff. Establish ongoing enhancement based on Veteran and employee feedback.

VA is currently proceeding through Phase II of implementation and is actively working, with the direct engagement of field operational leaders, to solidify an integrated access and care coordination model. VA anticipates implementation of such a model will strengthen Veteran experience, build trust, and help to ensure Veterans are aware of the full range of their health care options, including virtual care.

Developing a seamless, integrated Veteran care experience will also enable VA to provide Veterans with better and more timely information to support decision making for care options, improve bidirectional care data to and from community partners, and facilitate real-time scheduling for appointments.

## **Transparency and Veteran-Centered Design**

As VA works to solidify that integrated access and care coordination model, we are also focused on achieving greater transparency in the information we provide Veterans and on making our regulations and policy fully Veteran-centered.

Regarding transparency, VA began publishing average wait times for primary care, mental health, and specialty care appointments at each of its medical centers in 2014. Since that time, VA has received feedback from Veterans, caregivers, Veterans Service Organizations, oversight authorities, and Congress that led the Department to initiate efforts to revise the wait time metrics presented on the Access to Care website to better reflect Veterans' experience when seeking VA health care. Notably, VA does not use average wait times to determine community care eligibility. Wait time eligibility for community care is always based on the time it takes for an individual Veteran to obtain a specific type of care. As part of this process, VA conducted focus groups that included a diverse representation of Veterans by age, service era, race/ethnicity, utilization type (in-person and telehealth), gender, and geography. While there is no perfect way to measure wait times in aggregate, VA is making changes to the Access to Care website that represent a meaningful improvement in how the Department presents this information to Veterans. In addition to updating the average wait time calculations themselves, website updates also provide Veterans with more relevant information to help inform health care decisions, including:

- Veteran experience information,
- increased detail on timeliness within health care subspecialties; and
- the ability to more easily view relevant medical center information.

Additionally, VA is seeking to make our regulations and policies more Veteran-centered. Section 1703B(e) of title 38, United States Code, requires VA to conduct a review of its access standards and submit a report on the findings and any modifications to the standards to the appropriate committees of Congress at least once every three years. The initial access standards report has been developed and VA's submission is imminent. As we sought Veteran feedback to inform this report and conducted the analysis of Veteran experience, operations, and resource utilization that is described in the trends above, the issue of fragmentation of care resulting from implementation of existing regulations and policies was clearly illuminated as a detriment to Veteran

access and outcomes. Veteran feedback makes clear that some Veterans seeking care in the community are driving further or waiting longer for that care than they would if VA provided that care; on top of these delays, Veterans are also experiencing fragmentation of care, duplicative testing, and unnecessary and improper billing from community providers. In short, some of these Veterans, once referred to the community, are receiving poorer access to and quality of care. VA believes these results explain, at least in part, the lagging community care trust scores. VA is exploring regulatory and policy options that preserve Veteran choice while guiding Veterans to the closest, most accessible, highest quality options available. VA believes that when VA and community providers are engaged in friendly, healthy competition to be the best, most accessible, highest quality option, Veterans will benefit. Every policy proposal and decision we make will continue to be centered on Veterans.

## **Conclusion**

VA is committed to delivering world-class care to our Nation's Veterans. We are proud of the trust and quality we deliver through our facilities, and we continue to strive to ensure quality from community providers. We are working to design our policies and operations to provide Veterans with an integrated experience of care. VA will continue to center on excellence in access and outcomes, focusing our efforts on what matters to Veterans and their families, caregivers, and survivors.

Chairwoman, Ranking Members, and Members of the Subcommittee, thank you for the opportunity to testify before the Subcommittee today to discuss one of VA's top priorities. I am happy to respond to any questions that you have.