

# Commission on Care

## Final Report

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**COMMISSION ON CARE**

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June 30, 2016



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## EXECUTIVE SUMMARY

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Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.<sup>1</sup> The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

### Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

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<sup>1</sup> Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

### **Mission**

Provide eligible veterans prompt access to quality health care.

### **Values**

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model, Leadership Implementation, History as a Context for Systemic Transformation, Veteran Feedback, and Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

## Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

### Redesigning the Veterans' Health Care Delivery System

#### The VHA Care System

***Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.***

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

*The Commission Recommends That . . .*

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> <li>▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System.</li> <li>▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.</li> </ul>
Care Coordination	<ul style="list-style-type: none"> <li>▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers.</li> <li>▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.</li> <li>▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients).</li> <li>▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.</li> </ul>

## Clinical Operations

### **Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.**

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.<sup>2</sup>

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.<sup>3</sup> For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.<sup>4</sup>

<sup>2</sup> RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/assessment\\_b\\_health\\_care\\_capabilities.pdf](http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf).

<sup>3</sup> Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/Assessment\\_G\\_Staffing\\_Productivity.pdf](http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf).

<sup>4</sup> *Ibid.*, 95.

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

*The Commission Recommends That . . .*

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

***Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.***

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.<sup>5</sup> Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).<sup>6</sup>

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.<sup>7</sup> The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.<sup>8</sup>

*The Commission Recommends That . . .*

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

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<sup>5</sup> MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

<sup>6</sup> VHA Clinical Appeals, VHA Directive 2006-057 (2006).

<sup>7</sup> "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

<sup>8</sup> MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

***Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.***

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.<sup>9</sup>

VHA has a program of system engineering – Veterans Engineering Resource Center (VERC) – that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

*The Commission Recommends That . . .*

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA’s reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

## Health Care Equity

***Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.***

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

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<sup>9</sup> The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/Assessment\\_F\\_Workflow\\_Clinical.pdf](http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf).

A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.<sup>10</sup> VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

*The Commission Recommends That . . .*

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.<sup>11</sup>

## Facility and Capital Assets

### ***Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.***

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

<sup>10</sup> Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

<sup>11</sup> Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf).

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

*The Commission Recommends That . . .*

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

## Information Technology

***Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.***

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.<sup>12</sup> VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

*The Commission Recommends That . . .*

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

<sup>12</sup> The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/integrated\\_report.pdf](http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf).

and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

## Supply Chain

### **Recommendation #8: Transform the management of the supply chain in VHA.**

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.<sup>13</sup>

*The Commission Recommends That . . .*

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

<sup>13</sup> The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/Assessment\\_J\\_Supplies.pdf](http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf).

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

## Governance, Leadership, and Workforce

### Board of Directors

#### ***Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.***

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.<sup>14</sup> As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.<sup>15</sup> The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”<sup>16</sup> The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,<sup>17</sup> and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”<sup>18</sup> offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

#### *The Commission Recommends That . . .*

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

<sup>14</sup> The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/integrated\\_report.pdf](http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf).

<sup>15</sup> Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/integrated\\_report.pdf](http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf).

- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

## Leadership

***Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.***

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

*The Commission Recommends That . . .*

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

***Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.***

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

*The Commission Recommends That . . .*

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

***Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.***

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

*The Commission Recommends That . . .*

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

**Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.**

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set— identical to private-sector standards— will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

*The Commission Recommends That . . .*

*Organizational Performance Measurement*

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

*Personnel Performance Management System*

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

**Diversity and Cultural Competence**

**Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.**

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

*The Commission Recommends That . . .*

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

## Workforce

***Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.***

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

*The Commission Recommends That . . .*

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
  - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
  - Promotes veteran preferences and hiring.

- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
  - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
  - Provides due process and appeals standards to adverse personnel actions.
  - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
  - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
  - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
  - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
  - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

***Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.***

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

*The Commission Recommends That . . .*

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

## Eligibility

### **Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.**

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

*The Commission Recommends That . . .*

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

### **Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.**

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.<sup>19</sup>

*The Commission Recommends That . . .*

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

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<sup>19</sup> The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, [http://www.va.gov/opa/choiceact/documents/assessments/integrated\\_report.pdf](http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf).

underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

## Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.