STATEMENT OF
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THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
"CURRENT STATUS OF REMEDIAL ACTIONS AT VISNS 1, 5, AND 22"

MAY 22, 2018

Chairman Roe, Ranking Member Walz, and distinguished members of the Committee; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime service organization for veterans, comprised of more than 2 million members, and serving every man and woman who has worn the uniform for this country, we thank you for inviting The American Legion to testify today to share our position regarding the current status of remedial actions at VISNS 1,5, and 22.

Background

In 1994, the Veterans Health Administration (VHA) was structured into four regions, and individual VA medical centers reported directly to VHA for budgeting and program management purposes. At that time, VHA was responsible for the care of approximately 25 million veterans.

Each region was led by a region director located in the field (Linthicum, MD; Ann Arbor, MI; Jackson, MS; and San Francisco, CA). The four region directors supervised the operation of the medical care facilities in their regions (which ranged from 36 to 45 facilities per region).

The veterans health care system is the largest health care system in the United States, although it is an anomaly in American health care in so far as being a centrally administered, fully integrated, national health care system that is both funded and operated by the federal government. As it grew in size and complexity, the system became increasingly cumbersome and bureaucratic. It was often perceived to be unresponsive to individual needs and changing circumstances. It seemed to be chronically underfunded and short of staff and supplies, despite its rising costs. By the mid-1990s, the system was widely criticized for being difficult to access, for having long wait times and poor service, for providing care of unpredictable and irregular quality, and for being inefficient and expensive. Many policymakers and health care professionals questioned whether it had a future.[1]

By 1994, the VA had grown to be the country's largest health care provider, with an annual medical care budget of $16.3 billion; 210,000 full-time employees; 172 acute care hospitals, which had 1.1 million admissions per year; 131 skilled nursing facilities, which housed some 72,000 elderly or

[1] Kizer KW, Dudley RA. Extreme makeover: Transformation of the veterans health care system. Annu Rev Public Health. 2009;30:313–39. doi: 10.1146/annurev.publhealth.29.020907.090940.

severely disabled adults; 39 domiciliaries (residential care facilities), which cared for 26,000 persons per year; 350 hospital-based outpatient clinics, which had 24 million annual patient visits; and 206 counseling facilities, which provided treatment for posttraumatic stress disorder (PTSD). The VHA also partnered with almost all states to fund state-owned skilled nursing facilities for elderly veterans and administered a contract and fee-basis care program paying for ~$1 billion of out-of-network services each year.[2]

The VHA was a system based on inpatient care, in contrast to substantially less expensive and patient-friendly ambulatory care. Specialists rather than primary-care physicians dominated the workforce. Finally, like many publicly funded health systems throughout the world, the client base was increasingly needy and growing in numbers.

There was widespread consensus that the veterans health care system needed a major overhaul but little agreement about how to effect the change. Further, the system had to remain fully operational while it was being overhauled.

In 1994, President Bill Clinton appointed Dr. Kenneth Kizer as VA Undersecretary for Health. Dr. Kizer inherited an organization famous for low quality, difficult to access, and high-cost care.[3] Under new leadership recruited from outside the system—the first time this had occurred in more than 30 years—a plan to radically transform VA health care was developed in the winter of 1994–1995, vetted with the Congress (as required by law) and the VA's myriad stakeholders in the spring and summer of 1995, and launched in October 1995.[4]

In March 1995, Dr. Kizer submitted a plan to Congress titled *The Vision for Change - A Plan to Restructure the Veterans Health Administration*.[5] The reorganization plan was the first step in VHA becoming a more efficient and patient-centered health care system.

This new structure intended to decentralize decision-making authority regarding how to provide care and integrate the facilities to develop an interdependent system of care through a new structure – the Veterans Integrated Service Network (VISN). The VISN's primary function was to be the basic budgetary and planning unit of the veterans' health care system.

Dr. Kizer's plan suggested that the number of staff needed to manage a VISN would range between seven and ten full-time employees initially, which over the years ballooned to 220 employees working at the VISN. The geographical boundaries for each new VISN were defined based on natural patient referral patterns at VA medical centers and outpatient clinics, the number of enrolled veterans in the system, and the type of facilities needed to provide care.[6]

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[2] Kizer KW, Dudley RA. Extreme makeover: Transformation of the veterans health care system. Annu Rev Public Health. 2009;30:313–39. doi: 10.1146/annurev.publhealth.29.020907.090940.
[3] https://rogerlmartin.com/docs/default-source/Articles/incentives-governance/aligningthestars
[4] Kizer KW, Dudley RA. Extreme makeover: Transformation of the veterans health care system. Annu Rev Public Health. 2009;30:313–39. doi: 10.1146/annurev.publhealth.29.020907.090940.
[5] https://www.va.gov/HEALTHPOLICYPLANNING/vision_for_change.asp
[6] https://www.burr.senate.gov/imo/media/doc/VISNAct.pdf

In September 1995, Congress authorized VA to implement the plan. The 22 network directors were officially named on September 21, 1995. VISN Directors began assuming their new positions in October 1995, and all were on board by January 29, 1996. The transition of operations from the regional offices to the networks commenced in October 1995.

In October 1995, the restructuring of VHA headquarters also begun. Restructuring included eliminating certain positions and offices, reorganizing other offices and functions, and establishing new offices of Policy, Planning and Performance; Chief Information Officer; and Employee Education. In addition, the Chief Network Officer became part of the integrated Office of the Under Secretary for Health.

At the same time VHA was tasked with implementing Dr. Kizer's VISN for Change, it also had the daunting task of implementing one of the most dramatic legislative changes impacting veterans health care in the 20th century, *The Veterans' Health Care Eligibility Reform Act of 1996.*[7] This law was enacted to help VA improve its management of care and provide this care in more cost-effective ways; it also sought to increase veterans' equity of care. To improve cost-effectiveness, the act allowed VA to provide needed hospital care and health care services to veterans in the most clinically appropriate setting.

Since then, VISN staff and functions have expanded way beyond the original intent of Dr. Kizer's *Vision for Change*. Since the creation of VISNs in 1995, there has been a significant shift in veterans' demographics and geographically where they access care; however, VA has not reassessed the VISN structure.

In September 2016, the Government Accountability Office (GAO) issued a report entitled *VA Health Care*: *Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed.* GAO reported that internal and external reviews of VHA operations have identified deficiencies in its organizational structure and recommended changes that would require significant restructuring to address, including eliminating and consolidating program offices and reducing VHA central office staff. However, VHA does not have a process that ensures recommended organizational structure changes are evaluated to determine appropriate actions and implemented.[8]

For example, VHA chartered a task force to develop a detailed plan to implement selected recommendations from the independent assessment of VHA's operations required by the *Veterans Access, Choice, and Accountability Act of 2014*.[9] It found, among other things, that VHA central office programs and staff had increased dramatically in recent years, resulting in a fragmented and "siloed" organization without any discernible improvement in business or health outcomes. It recommended restructuring and downsizing the VHA's central office.[10] The task force of 18 senior VA and VHA officials conducted work over six months, but did not produce a documented

[7] https://www.congress.gov/bill/104th-congress/house-bill/3118
[8] GAO report (Oct 27, 2016): VA Health care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed
[9] https://www.congress.gov/bill/113th-congress/house-bill/3230
[10] https://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf

implementation plan or initiate implementation of the recommendations. Without a process that documents the assessment, approval, and implementation of organizational structure changes, VHA cannot ensure that it is making appropriate changes, using resources efficiently, holding officials accountable for taking action, and maintaining documentation of decisions made.

In October 2015, VHA began to implement a realignment of its VISN boundaries, which involves decreasing the number of VISNs from 21 to 18 and reassigning some VA medical centers (VAMC) to different VISNs. VHA officials anticipate this process will be completed by the end of fiscal year 2018. VHA officials on the task force implementing the realignment told GAO they thought VISNs could implement the realignment independently without the need for close monitoring. VHA also did not provide guidance to address VISN and VAMC challenges that could have been anticipated, including challenges with services and budgets, double-encumbered positions (two officials in the same position in merging VISNs), and information technology. Further, VHA officials said they do not have plans to evaluate the realignment. VHA's actions are inconsistent with federal internal control standards for monitoring (management should establish monitoring activities, evaluate results, and remediate identified deficiencies) and risk assessment (management should identify, analyze, and respond to changes that could affect the system). Without adequate monitoring, including a plan for evaluating the VISN realignment, VHA cannot be certain that the changes are effectively addressing deficiencies; nor can it ensure lessons learned can be applied to future organizational structure changes.

In March 2018, former VA Secretary David Shulkin announced his plan to reorganize the department's central office by May 1.[11] May 1st has come and gone, but the reorganization has not occurred. A statement from Dr. Shulkin's March 2018 release, he stated:

"*The VISN model was put in place close to 20 years ago, a very innovative model that has served VA well," Shulkin said. "But like any business, the times change, the needs change and it's time for us to look at how we operate our networks differently to get the type of accountability that's needed to make sure we don't see the failures that we saw here in the Washington, D.C. VA."*

Dr. Shulkin also discussed the appointment of a special team to work with its national leadership council to develop a nationwide reorganization plan for its 23 VISNs, which was due to the secretary by July 1.[12]

On March 8, 2018, Dr. Shulkin announced the appointment of a new executive in charge, Bryan Gamble, to oversee three VISNs: the New England Health Care System and the Capitol Health Care Network, which includes Washington, D.C., and parts of Maryland and Virginia, as well as the Desert Pacific Healthcare Network in California, New Mexico and Arizona.[13]

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[11] https://www.usatoday.com/story/news/politics/2018/03/07/va-chief-consolidates-oversight-23-va-hospitals-start-restructuring-effort/404632002/

[12] https://www.dav.org/learn-more/news/2018/va-secretary-announces-immediate-transformations-in-wake-of-scathing-ig-report/

[13] https://federalnewsradio.com/veterans-affairs/2018/03/shulkin-promises-reorganization-plan-for-va-central-office-after-troubling-ig-report/

The Way Forward

The purpose for creating the VISN structure was to decentralize decision-making authority regarding how to provide care and integrate the facilities to develop an interdependent system of care through the VISNs. The VISN's primary function was to be the basic budgetary and planning unit of the veterans' health care system. However, as we all know, the VISN structure has morphed into a broader operation, consuming more staff, resources, funding, and physical space.

As more veterans enrolled in the VA health care system, the VISN responsibility for budget and planning increased and it became more difficult for the VISN to manage. Reoccurrence of system-wide failures are becoming routine that are attributable to leadership failures at the VAMC, VISN and Central Office level. According to the March 7, 2018 VAOIG report citing Critical Deficiencies at the Washington DC VA Medical Center, the VAOIG cited numerous failures at the Washington DC VA Medical Center, the VISN, and VA Central Office.[14] Medical Center, VISN 5, and some VACO leaders knew for years about at least some of the problems outlined in the VAOIG report. The report stated information and documentation outlining some of the failings in the Medical Center reached responsible officials in the Medical Center, VISN 5, and VACO as early as 2013, but there where failures at multiple levels of leadership, in accountability, responsibility, and oversight. This lack of ownership and a pervasive practice of shifting blame to others contributed to a culture of complacency and neglect that placed both patients and assets of the federal government at risk.

Clearly, Dr. Kizer's VISN model is no longer living up to expectations, but rather has grown into a high cost ineffective operation.

In 2016, The American Legion membership voiced serious concerns about the effectiveness of the VISNs and passed Resolution 194, entitled *Department of Veterans Affairs Veteran Integrated Service Networks*. The resolution urges Congress to direct the GAO and VAOIG to conduct a comprehensive study to include purpose, goals, objective, budget and evaluation of the effectiveness of the VISN structure.[15]

The American Legion applauds former Secretary David Shulkin for proposing to look into reorganizing the VISN and VA Central Office. The American Legion believes that the Central Office and VISN realignment is in keeping with Resolution 194, and should continue its course with Veteran Service Organizations being consulted throughout the process to ensure, from a veteran perspective, their concerns are addressed.

Conclusion

As always, The American Legion thanks this Committee for the opportunity to elucidate the position of the 2 million veteran members of this organization. For additional information regarding this testimony, please contact Assistant Director of the Legislative Division, Jeff Steele, at (202) 861-2700 or jsteele@legion.org.

[14] https://www.va.gov/oig/pubs/VAOIG-17-02644-130.pdf
[15] American Legion Resolution No. 194 (2016): *Department of Veterans Affairs Veteran Integrated Service Networks*