REORGANIZATION OF THE VETERANS HEALTH ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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REORGANIZATION OF THE VETERANS HEALTH ADMINISTRATION

THURSDAY, APRIL 6, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to call, at 9:01 a.m., in room 334, Cannon House Office Building, Hon. Tim Hutchinson (chairman of the subcommittee) presiding.

Present: Representatives Hutchinson, Smith, Bilirakis, Quinn, Edwards, Tejeda, Gutierrez, Bishop, and Doyle.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. This meeting will come to order—wherever the gavel is—I will take an opportunity to bang that gavel when I get one. I would like to take this opportunity to welcome our distinguished panels of witnesses who are taking time to testify before our subcommittee this morning. I would also like to thank the leadership of the American Legion and Vietnam Veterans of America who have submitted written testimony for this hearing. I look forward to hearing each of your testimony on the Veterans Health Administration proposed reorganization entitled *Vision for Change*, a plan to restructure and decentralize current VA field operations. The proposal seeks to reorganize the current 4-region structure into 22 Veterans Integrated Service networks or VISNs. The primary focus of the reorganization is to decentralize decision making authority to the field and to organizationally flatten and remove management layers from central office. The VISN structure was developed through a rather comprehensive process that included academics, employees, hands-on managers, and most importantly, those who will be directly affected by this process, the veterans themselves. I applaud Dr. Kizer for his leadership and his willingness to consider divergent viewpoints on a very complex and very needed undertaking.

In today's competitive health care market, our veterans deserve a health care delivery system that is responsive to their needs, understanding that health care is driven by local market conditions, I am very supportive of a structure that will afford maximum management flexibility to those closest to the delivery of health care. In my own district in northwest Arkansas, it will be very important to my veterans that planning and budgetary issues be resolved at a level where they can feel that their input is most meaningful and best understood. Understanding the enormity of this reorganization

and the inherent reluctance of bureaucracies to accept change, I want to extend my cooperation to you, Dr. Kizer, and to your staff in this effort to focus VA's health care efforts on the goal of placing patients first.

Over the years this committee has worked on a very bipartisan basis to ensure that veterans' health care remains a priority. And as Chairman, I want to certainly recognize the efforts of the Chairman of the full committee, Bob Stump, and all of the contributions that he has made, as well as the long-time Chairman and now Ranking Minority Leader on the full committee, Sonny Montgomery, in fostering this climate of bipartisanship. Unavoidably, I will briefly leave the hearing at 9:45 to testify before the Joint Economic Committee; and during my absence Mike Bilirakis—and Mr. Bilirakis will be here a little later—will be chairing the hearing at that time. Now I want to thank Mike for his willingness to do that. Once again, I welcome each of our witnesses, and I look forward to each of their testimony.

Mr. Edwards, the ranking member of Texas, is unavoidably detained at the White House this morning so we will forgive him, recognizing that priority. And so when Chet gets here, we will give him an opportunity to give an opening statement.

I want to welcome Dr. Kizer, who will be our witness on the first panel. And, Dr. Kizer, all of your written statement will be included in the record. And we would ask you to keep your comments to 10 minutes or less so that each member of the subcommittee will have an opportunity to ask questions.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY NORA EGAN, COORDINATOR OF THE TRANSITION WORK GROUP; JULE MORAVEC, Ph.D., DIRECTOR OF WESTERN REGION, VETERANS HEALTH ADMINISTRATION

STATEMENT OF DR. KENNETH W. KIZER

Dr. KIZER. Thank you and good morning, Mr. Chairman and members of the subcommittee. I am quite pleased to be here this morning to have an opportunity to discuss my plan to restructure the Veterans Health Administration (VHA). I know how hard you are working these days, and I appreciate your scheduling this hearing at this time. With me today at the table are Dr. Jule Moravec, the Associate Chief Medical Director for Operations, and Nora Egan, Coordinator of the team that has helped prepare the *Vision for Change* document that specifies our plan for reorganizing the Veterans Health Administration.

As you know, copies of the plan, *Vision for Change*, were sent to the committee on March 17 of this year.

In brief, this reorganization is designed to improve the delivery of health care to veterans, to improve the quality of that care, to increase the efficiency with which we provide it, and to establish accountability for outcomes and bottom-line results. I should also add that the reorganization plan is designed to retain or continue those things in the system that are functioning well, as well as to

complement our several other statutory missions, in addition to providing medical care.

Perhaps the first issue that I would comment on this morning is: Why change the Veterans Health Administration? There are a number of reasons that warrant pointing out at this time.

First, technological advances, economic factors; the rise of managed health care; and a variety of other forces all profoundly changing how health care is delivered in this country. There has been a marked shift away from inpatient care and a dramatic rise in ambulatory, or outpatient, care. Many complex medical conditions that previously required hospitalization are now routinely treated at home or in outpatient settings. This trend toward moving care into ambulatory settings, or at home, is going to continue for some years to come. Indeed, I believe that it will not be all that long before the traditional, general, acute-care hospital becomes a large intensive care unit, taking care of only the sickest or most complicated of patients. Essentially all other medical care will be provided in ambulatory settings, at home, in hospices, or in various types of extended-care facilities.

The second reason why we should change the Veterans Health Administration is that there have been a number of reports in recent years that have concluded that structural changes—indeed, very fundamental structural changes—are needed in the system. In the aggregate these reports have consistently found that VA needs to become more flexible, more customer-focused, more decentralized, and more cost effective.

And finally, for a variety of reasons, there has been a fundamental reanalysis of how government should function in recent years. The National Performance Review and other activities are being undertaken to re-invent Government, to minimize bureaucracy, to reward efficiency and innovation in government, and to empower employees to make government work better for citizens.

Mr. Chairman, our plan for restructuring the Veterans Health Administration will position our veterans' health care program to adapt to the rapidly-changing, larger health care environment that we must function within. It will improve customer service, and it should certainly improve the efficiency of our operation.

Moving to a few details, the foundation for accomplishing these changes in the veterans' health care system involves the dissolution of the current hierarchical central office, regional office and network structure that is currently in effect. In its place we would create a federation of Veterans Integrated Service Networks supported by a national headquarters. At this time, the plan calls for 22 of these integrated service networks with each network including from 5 to 11 medical centers and various other VA assets. The chart gives you a schematic depiction of what some of these other assets are, including long-term care facility or medical centers, various clinics, vet centers, et cetera.

The network boundaries have been established to preserve existing patient-referral patterns; to include aggregations of patients and facilities that would be needed to support a continuum of primary, secondary, and tertiary care; and to a lesser extent, to be consistent with political jurisdictional boundaries such as state lines.

It is envisioned that these networks, or VISNs, will become the basic budgetary and planning unit for delivery of veterans' health care.

As an integrated system of care, the new VISN structure will emphasize the pooling of resources, the delivery of outpatient and primary care, partnerships, and customer service. A premium will be placed on improved patient services, rigorous cost management, process improvement and outcomes. Emphasis will be placed on the integration of ambulatory care, with acute and extended inpatient services to provide a coordinated continuum of care. Redundant administrative structures and processes will be eliminated. And each layer or process in the new organization will be expected to add value to the delivery of services in the field.

Each VISN Director will be assisted by a small staff of professional, technical, and support personnel, the number varying with the size and complexity of the individual network. Again, on the chart here you can see a schematic of basically how the VISN will relate to the Office of the Under Secretary and to other components that I will get to in a moment.

During the transition from where we are—or how we are organized at this point to the new organization—we will continue to utilize personnel in the existing 4 Regional Offices as Support Service Centers, as you can see on the chart there. Expertise in areas such as construction management, finance, planning and quality assurance will be preserved to ensure continuity of operations while the regions dissolve and the VISNs become operational.

Another structure you see on the chart there is the Management Assistance Council. This is a formal structure that I feel is important to the functioning of the organization. We intend to establish the Management Assistance Councils at each VISN, these will be composed of both internal and external stakeholders, to ensure that the needs of the patients, the communities, and others, are incorporated into our decision-making process and that there will be a formal structure by which that input will be attained.

Let me conclude my comments on field reorganization with some brief comments on how we will achieve accountability in the more decentralized Veterans Health Administration system that this reorganization plan would create. Concern about accountability led us to devote an entire chapter of the plan to performance measurement and assistance monitoring—although I would add that there was a lot more that could be said, and that we could have written on that.

The cornerstone of the accountability system will be a performance contract between each VISN Director and the Under Secretary's Office. Each contract will cover three general areas: first, the systemwide tasks and needs that all VISNs will be expected to complete; second, the VISN-specific service delivery and efficiency objectives directed by Headquarters; and third, VISN-specific objectives developed by VISN management. Performance contracts will include support of education and research, as well as our fourth mission, emergency preparedness.

Key areas of focus for the performance measures will be patient satisfaction, ease of access to care, the quality of care, and efficiency. Performance measures will focus primarily on outcomes,

rather than on processes, and will be selected to allow for comparison to national and private-sector measures.

In summary, field units and senior managers will be held accountable for measurable improvements to the veterans' health care system. The resulting efficiencies should allow the Veterans Health Administration to invest in new ways of providing high quality, efficient ambulatory, as well as inpatient, care to better meet the needs of our veterans as well as to better meet their expectations.

Mr. Chairman, I would note that in an effort to move as expeditiously as possible, we have begun to make preliminary plans for implementing the field reorganization. These, of course, are subject to compliance with current law and input that we receive as part of this hearing process. We are establishing a steering committee to oversee the many activities that will be involved; and we are creating a number of technically-oriented work groups that will handle detailed actions such as activation of the VISNs, development of performance measurements, executive performance contracts, employee education, resource allocation, and a number of other areas. We understand that the 90 days in session provided to the Congress for review of the plan under the current law—unless earlier legislative approval is provided—will be completed in late July or early August of this year, depending upon the recess schedule of the Senate.

Let me conclude my comments with just a brief note on restructuring of VHA's Central Office.

In order for the field reorganization to be successful, and for the VISNs to be empowered to make appropriate operational decisions, headquarters must change its focus from micro-managing operations to the critical role of governing and leading the system overall. Offices in the future will be organized by function or product line, whenever possible, rather than in the discipline-specific stovepipe nature that they currently are organized. Headquarters must focus much greater attention, in the future, on achieving system-wide quality improvement, information management, cost management, and strategic planning.

Mr. Chairman, that concludes my general, introductory comments on our plan to restructure the veterans' health care system. I certainly would be pleased to answer any questions that you or any other members of the subcommittee have at this time.

[The prepared statement of Dr. Kizer appears on p. 60.]

Mr. HUTCHINSON. Thank you, Dr. Kizer. And, again, I appreciate your efforts to address, I think, what all of us recognize as a need for reorganization and better services at a more local decision-making level.

I have met, as I know you have, with many of the veterans' service organizations, the veterans groups, and you have included their input in designing this reorganization. Many of them express concerns about the relative autonomy of the VISN Directors and were concerned as to what guarantees there might be to ensure that hospital and VISN Directors would not arbitrarily eliminate specialized services because of the high cost involved. Could you comment on the need to address that, whether any statutory language might

be needed to ensure and to guarantee the continuation of those specialized services.

Dr. KIZER. Certainly, sir.

Of course, what really characterizes the veterans' health care system, indeed the hallmarks of the system, are our specialized services. However, you cannot have specialized services such as spinal cord injury and blind rehabilitation without having a full-service complement of health care services to support those. It would really make no sense for this system, though, to eliminate, to denigrate or to de-emphasize what are our hallmark programs, and what characterizes us as a system. So, sir, I think that within the organization there is widespread recognition that these programs deserve special recognition and that they will continue to require that focus in the future. Yes, while they are costly and often labor-intensive, and they would not be, quote-unquote, competitive in the private sector, they are the essence of what the veterans' health care system is all about.

So, one, I think that denigrating these programs would not be wise for the system, and I think that our managers recognize how foolish it would be to do something that would work to the detriment of the system such as undermining these programs. Second, I would note that while we intend to decentralize, we certainly are not abandoning our oversight responsibility. We have had this discussion with many of the veterans' service organizations, as well as others. We recognize the need to develop performance criteria and other measures that we can use to track these programs in a way that will not only guarantee their ongoing survival and functioning, but which will really improve the quality of service that is provided through these programs in the future. And, third, I guess I would point out that there continue to be considerable provisions already in the law for Congressional oversight of these programs that require notification of not only the headquarters, but also Congress, if any such substantive changes are to be undertaken at the local level. I recognize the concern, and perhaps nervousness, if you will, that some entities may feel about this change anyway, I think it is very understandable that they would have some anxieties. I think, if anything, what we hope will come out of this is a strengthening, not only of the specialized programs, but the system overall.

Mr. HUTCHINSON. Thank you, Dr. Kizer.

Mr. Quinn, you are recognized. We will be under the 5-minute rule, and we will give an opportunity for a second round of questions if so desired. You are recognized.

Mr. QUINN. Thank you, Mr. Chairman. And thank you, Dr. Kizer, for your comments. I might mention also that I am a member of the Joint Economic Committee where Mr. Hutchinson is going to testify so I will leave to hear his testimony. Maybe we would save some time if we just stay here and traded, Tim, and we could all stay with all of you this morning.

I read your testimony, Doctor, and appreciate your comments this morning; and we have a meeting scheduled, I think, over here in the first part of May with my veterans staff to talk about this and other matters. Just a couple of general questions: I like the concept, first of all. I think it is a step in the right direction. Just a question on the MACs, the big MACs as I called them when I

read through here, the Management Assistance Councils: Did I read it correctly that for each VISN there will be a council to sort of advise? And you know the chart that you listed for the councils did a pretty good job of including everybody, local officials, state officials, hospital officials, and so on, and so forth. Do we envision a council for each of the 22 VISNs that you are talking about?

Dr. KIZER. That is correct, sir.

Mr. QUINN. So some of Tim's concern, which is a concern I shared and the organizations mentioned to you and to us, about making certain that whether it is Congressional oversight—which is a little bit removed in Washington, DC from the actual operations—some of the concerns that the organizations may have could be discussed and could be reviewed in the council.

Dr. KIZER. Absolutely. Indeed, that is one of the reasons why I am including this formal structure, which would include representation from the veterans' service organizations. These MACS would provide a forum where these issues could be discussed at a very early stage. And if there are problems, they would be brought to the attention of management and hashed out at that level. But the idea is to provide a formal forum for stakeholder input to occur at the local level.

Mr. QUINN. And I think as important as the concerns early on would be that ongoing that you mentioned. I mean, we need to walk before we run with this thing; I think we would all agree. As the process evolves, there may be additional concerns that the veterans' organizations—and they are going to need a place to air that. They are going to need a place to have some feedback and some response, not only by calling their local Congressmember or whoever it happens to be, but I think that local level of input is key to all of it. So I will be looking with you at that as it evolves.

Thank you for your answer. There is no question that this is a change, dramatic change. How much discussion—we are talking about late July, early August as a possibility to be operating here; you think?

Dr. KIZER. As we have looked at all of the steps that need to be taken internally, our goal is to have this system fully operational by October 1, 1995—concomitant with the new fiscal year, with the hope that we would be phasing it in starting in the early fall—i.e, August or September.

Mr. QUINN. Okay. And how much discussion has gone on in the field, I mean, at local VA Hospitals and some of the other assets that you talk about when you try to get to these 22 VISNs? Is there communication back and forth with hospital directors and staff out there already, and how much?

Dr. KIZER. Yes, sir, there has been considerable field involvement. Just to give you some idea—when we floated some of these concepts out to the field last November, we got about 1,500 pages of response back from our field facilities. With the draft versions of the plan that were sent out, we got additional response. The plan has been discussed in numerous different forums both in the field and in VACO. I do anticipate also that we will, over the next several months, be making considerable efforts to actually visit a wide array of these facilities, particularly ones where there may be

some potential problems, to see what we can do to facilitate the process from a headquarters point of view.

Mr. QUINN. That is a good idea. I was at the Buffalo, NY center this weekend and talked with our director on Saturday. And I think we are going to be pleasantly surprised at those out in the field who want to help. And the reaction has been somewhat positive so far. So thanks for your answers and your comments. I look forward to working with you.

Dr. KIZER. Thank you. And I would just add also that the response that we have gotten from the field overall has been very, very positive; they are chomping at the bit to get going.

Mr. QUINN. Thank you, Dr. Kizer.

Mr. Chairman.

Mr. HUTCHINSON. Thank you, Jack.

Mr. Tejeda, the gentleman from Texas is recognized.

Mr. TEJEDA. Thank you, Mr. Chairman.

Dr. Kizer, I want to commend you for stressing in your testimony the plan's emphasis on outpatient care and primary care. You know, many Texans, many veterans living in South Texas, have very little access to ambulatory care; and they have to drive hundreds of miles to reach some crowded centers. Let me just ask you: What are your thoughts on the prepared testimony of William Schuler of Columbia HCA, recommending the VA to develop contractual relationships with private sector health care providers? Would such a contract be cost effective for the VA?

Dr. KIZER. We would want to look at that and see what the specifics are within the specific community that was involved. Under the scenario that we have outlined here, what I would hope our managers would do would be to review the opportunities that might exist, whether it be contracting with a private provider or using VA assets, or using an academic affiliate, or contracting with a DoD partner, or whatever; look at the cost; look at the access; look at the quality of care; look at the needs of the veterans identified with the system, and a number of other things; and then come up with plans that would work best to serve the needs in that specific community; and also involving entities like the management assistance councils.

Mr. TEJEDA. Just one other question: How will the new VISN Networks affect VA medical research carried out at several facilities within one network? Will the plan have a negative impact on individual VA medical facilities associated with some of the universities within their—particularly on the medical research aspect of it?

Dr. KIZER. It is hard for me to envision how it would have a negative impact. I do see the potentialk for some very—potentially—some very positive impacts and some opportunities, particularly opportunities for our academic partners to look at service-delivery issues and primary-care issues and some other things which historically have often been hard for academic institutions to focus on because of the lack of a partner that has a service-delivery network that would provide those opportunities to do that type of research. So I see really no negative effects, and a number of potential positive benefits to this.

Mr. TEJEDA. Thank you very much.

Thank you very much, Mr. Chairman.

Mr. HUTCHINSON. Thank you.

Our good friend from Florida, Mr. Bilirakis, is recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I, too, want to welcome Dr. Kizer and his colleagues with him to our hearing.

I have an opening statement and I ask unanimous consent that it be made part of the record.

Mr. HUTCHINSON. Without objection.

[The prepared statement of Congressman Bilirakis appears on p. 51.]

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Kizer, Mr. Tejeda brought up, of course, the point of research; and I had not planned to get into that. But his point is well taken. And research, medical research, is something that has always concerned me that there may not be adequate coordination, if you will—that may be a lot of duplication of effort in all that. I am sure that there is in all research. And that concerns me as far as the private sector is concerned, NIH, our universities, et cetera, et cetera. So I guess the same thing applies to VA research. And I know VA research is a good research. It is something we should all be very proud of and should retain. So I am not really going to raise a question in that regard, but I would hope that that is not going to be interrupted, maybe even enhanced, as a result of your plan. But, you know, you do worry that when you have a splitting up like this—which makes sense in general, as far as I am concerned—but when you have a split up like this, does that mean that you have a chance of less coordination, if you will, between the research groups.

Specialized services were brought up. And that is a subject close to my heart. And I guess you answered it pretty well. But in terms of the medical center directors, you know, the authority that they may have to reduce these services in order to save money—I mean, part of the bottom line is obviously going to be important in our lives for ever and ever. Will they have the authority to reduce those services to save money? And they are very expensive, as you already indicated.

Dr. KIZER. Under this concept, the VISN Director, or the VISN, becomes the basic budgetary unit, as opposed to the individual medical center. With this we see some potential, real positive attributes for our specialized services. As we change our focus from that individual institution to a population of veterans over a geographic area, how we can pool the resources within that area to better serve the needs of the veterans that are within that VISN catchment area and we actually can enhance, or potentially enhance, those specialized services by changing the focus from what one institution can do, to what five or six or seven institutions or medical centers combined with various other facilities, long-term care facilities, and clinics, working in coordination can do to actually enhance those services. So again, while I recognize the concern, I would go back to the fact that these specialized services are the hallmarks and really characterize the veterans' health care service. They are at the core of the system.

And I see some very good potentials for strengthening specialized services and for making them better than what has existed in the

past. And while I am cognizant of those concerns, I do not think they are realistic concerns.

Mr. BILIRAKIS. Well, I appreciate it. I trust that it will work out the way you intended in that regard. And as you have just said, they are the hallmark of our VA system health care and health care system.

And really I use them; I have been contacted—maybe we all have—by the press and by others regarding this idea of the VA health care system being eliminated and veterans given vouchers to buy care in the private sector. And, or course, I find a lot of fault with that. But certainly a part of that fault is the fact that the hallmark of our system is these specialized services. And there is not any way they could get those same specialized services in the private sector.

So, but let me ask you then your opinion—if I may put you on the spot—regarding the voucher idea.

Dr. KIZER. Well, sir, I believe that we have the potential; and within 2 or 3 years, we will have the proof that the system that we are proposing will not only be better than the voucher system but, I think it will be much better than any sort of system that would be proposed or conceived of, such as a voucher system. I, frankly, do not think that vendors are the way to go for veterans' health care. I think that we have tremendous potential, to make the VA health care system the flagship health care system of the 21st century. With some polishing, this somewhat raw diamond can indeed be such.

Mr. BILIRAKIS. So your thinking is that in spite of the budgetary constraints that we not only have now but will continue to have, and the fact that we are—certainly this committee is—going to be in the forefront of the eligibility reform process which conceivably—and maybe hopefully—will bring in a larger number of veterans, if you will, that you do not think that that might be part of our future, vouchers?

Dr. KIZER. I do not see that at this point sir. I do not rule out the possibility that we may work in new ways with private sector entities. But as far as turning the system over, vouchering it or whatnot, I really do not see that as a viable alternative. I think that we can show quite well, and even more so in the future, that we are not only more cost effective, but that we will provide better service than would be achieved in such a scenario.

Mr. BILIRAKIS. Well, thank you, sir. Good luck.

Mr. HUTCHINSON. Thank you, Mike.

The gentleman from Illinois, Mr. Gutierrez, is recognized.

Mr. GUTIERREZ. Mr. Chairman, I ask unanimous consent to have my opening statement put into the record.

Mr. HUTCHINSON. Without objection.

[The prepared statement of Congressman Gutierrez appears on p. 54.]

Mr. GUTIERREZ. Thank you, Chairman.

And thank you very much, Mr. Kizer, for being here. I just have one question for you. It is apparent from your testimony that you plan to put a renewed emphasis on outcomes and results. You are going to establish performance contracts, for example. What are some of the criteria you are going to use to judge the performance

of a facility or a group of facilities, or even individuals? And is there any chance that we would put a commodity on things like timeliness or efficiency? And when we do that, do we end up creating a system that rewards quantity over quality? For instance, what happens if we ask: How many patients did you see today? rather than: What did you do for each patient to make them better?

Dr. KIZER. Thank you, sir. As noted in Chapter 4 of the document, we have given various examples of those different areas and exactly the areas that you are talking about. We would see timeliness as one of the areas that we would be looking at. We also see quality of care, customer satisfaction, and a number of other things that would be specifically looked at. I think that your concern is an appropriate one if you only looked at a very narrow slice. But if you look at a comprehensive performance assessment where, yes, timeliness is an issue; but quality is also measured; patient satisfaction is also measured; efficiency is measured; complications are measured; and you put those together, then you have a balance system where you are not just achieving quantity over quality or the scenario that you had expressed.

I think that our approach is a very balanced approach. We have a number of different menus that we can choose from as far as looking at performance measures. One of the things that we would anticipate starting work on in the near future would be developing those specific contract measures for the VISNs, looking at their performance historically in these different areas, looking at the evidentiary base that we have in these things that has accumulated in recent years, and then coming up with measurements by which the management of the various VISNs would be held accountable.

Mr. GUTIERREZ. Thank you, Dr. Kizer. And the concern is simply that as I have watched health care reform during the last—I do not know—maybe 10 to 12 years in my own personal life, it seems like every time I get a health care provider, a new one, whether I am working in the Chicago City Council or moving to Congress and have to change health care providers, or they change, it seems like there is more of an emphasis on efficiency but not really quality in terms of the doctors that you see and the relationships that you develop with those doctors. And those medical institutions seems to be simply saying: We are going to be more efficient. And more efficient has not exactly meant better health care or more personalized health care—at least not in my own personal life. And it has not seemed to work that way. So I want to make sure that as we look at the health care system in the VA, that we maintain that kind of personalized health care where people feel that they have a doctor, they have a relationship with the medical institution.

Chairman Hutchinson, Thank you very much.

Dr. KIZER. Let me just add one brief remark, for your point is very well taken. I think with the increased emphasis on primary care and ambulatory care that is envisioned under this scenario that you will see the personal nature of care increase in the future in the VA.

Mr. HUTCHINSON. Thank you.

And, Dr. Kizer, in reading the summary of the reorganization plan, I know that one of the goals is to provide the best quality

care as possible and to meet the patients' needs. But there was one statement on Page 17, that troubled me, but I would like you to expand on it. It says to be successful, the integrated health care system requires management of total costs, a focus on populations rather than individuals, and a data-driven, process-focus customer orientation. Well, it seems paradoxical to me that we talk about total costs and populations rather than individuals, and then talk about customer orientation.

I am wondering if each of the VISNs has, in effect, a kind of global budget under which they operate? And if the goal then is going to be the management of total costs, where does the the focus on the individual come? And how can we be assured that the individual veteran will not be lost in the greater scheme of the budget?

Dr. KIZER. Indeed, I think that if you were to look at it purely as a budgetary exercise, that might be a concern. But again, the business that we are in is taking care of individuals. We can do that, I think, in a better way when we look at populations and how we can serve the needs of the populations. But at the cornerstone of that are the individuals. So the two really are not exclusive, or they are not contradictory, because health care is basically a one-on-one business between a doctor and a patient, a nurse and a patient, etc. And that is what will continue in the future. But from a planning point of view, we are looking at managing it, so that how we can serve more patients, and provide better care to those individual patients within the system. If we focus on a population, a geographic area, then we can start to achieve some economies, some efficiencies. We can start out-stationing facilities that make it more convenient for the patient to get care in a way that has not been the case in the past in this system.

Mr. HUTCHINSON. Do you see that there would be more rationing of medicine under the reorganization or less? And when you use the term protocol in the reorganization plan, exactly how do you define the word protocol. And how does that fit into the overall scheme of the reorganization?

Dr. KIZER. In the protocol, are you referring to political protocols?

Mr. HUTCHINSON. Yes. If you had a recipe that would be used.

Dr. KIZER. One of the things that many health entities have found useful is defining clinical benchmarks, best practices, or clinical protocols—they go by a variety of different names. And while that is not a specific recipe that everybody falls into, if you can define those best practices or protocols for patients and, as a system, you strive to use them, then experience outside the VA has shown them to have been beneficial for individual patient care, the quality of that care and also the efficiency with which that care is provided. Protocols help clinicians answer such questions as—Do you have to get x-rays for this condition? How many times do you need to get a laboratory test? And a number of other things. Depending on the condition that is under consideration, what many health entities have found is that using best practices, or the protocols, has improved the quality of care, as well as in many cases reduced the cost by avoiding unnecessary testing that really does not have any value in making the patient better.

Mr. HUTCHINSON. Thank you, Dr. Kizer.

The gentleman from Georgia, Mr. Bishop, do you have any questions you would like to pose?

Mr. BISHOP. Not at this time, Mr. Chairman.

Mr. HUTCHINSON. Okay, thank you.

Do any—okay, Mr. Doyle.

Mr. DOYLE. Good morning.

Mr. HUTCHINSON. We will let you warm up and then come back to you. Do any of the members have another round of questions?

Mr. BILIRAKIS. I have just a quick one, Mr. Chairman. I guess maybe it is not all that quickly answered.

Construction: How would the new plan affect the construction plan in terms of planning and that sort of thing?

Dr. KIZER. One of the tasks that I would expect our VISN management to complete within the first year, would be to develop a 5-year, strategic plan for the facility needs they might have in their service area. And then we would be looking at that from headquarters. So that, without speaking specifically about any facility, would be a planning process.

However, perhaps more to your point, where I see the system going in the future is toward becoming an outpatient-based system, looking at lease arrangements, looking at joint venturing, looking at a number of other ways that we might get more return on our dollars as opposed to necessarily building facilities ourselves. And what I would hope is that our field managers would have the flexibility to look at what the needs are, what those needs might be in the future, and how they could best serve those in the most efficient way possible. And it may be that this can be best accomplished by situating a small clinic or a larger clinic or a number of clinics, but I would see much less emphasis in the future on traditional hospital construction.

Mr. BILIRAKIS. And they would be—their responsibility would be really a recommendation responsibility, suggestions, recommendations to headquarters; and headquarters would make the final decisions as far as any construction goes, and that sort of thing.

Dr. KIZER. VISN Directors would have to come to VACO for projects that are above limits that are specified. Projects below the threshholds could be done locally subsequent to process of notification.

Mr. BILIRAKIS. I see.

Dr. KIZER. It might be possible to situate some small clinics or access points.

Mr. BILIRAKIS. Sure.

Dr. KIZER. That made sense without——

Mr. BILIRAKIS. So they would have the authority——

Dr. KIZER. They would still have to notify us and——

Mr. BILIRAKIS. Sure.

Dr. KIZER (continuing). As well as Congress. But in many cases, when it is being done within existing resources, they could do that, certainly.

Mr. BILIRAKIS. Thank you.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mike.

Do other Members have questions of Dr. Kizer?

I would recognize Minority Counsel, Mr. Ibson, for questions.

Mr. IBSON. Yes, sir. I would like to expand on the questions that the Chairman asked you earlier, and related questions from Mr. Bilirakis. In responding to their questions, you have expressed confidence that the integrity of specialized medical programs would be preserved. I think, veterans' service organizations have very real concerns regarding integrity of those programs. And I think those service organizations may have raised those concerns because historically during periods of budget constraints those programs sustained cuts. Given the confidence you expressed that those programs would be protected, would you have any objection to legislation to ensure such protection?

Dr. KIZER. Recognizing that we are not talking about any specific legislation, I can only comment in the abstract. I would hope that we would exhaust all other means first before it were necessary to enact statutory changes. For example, one of the things that has struck me about this is that some of the groups who have complained or who have voiced, I think, some legitimate concerns about where some of these services have gone, have never met with the directors, or met with them collectively, to try to work out what the problems and solutions might be. It occurs to me that in the absence of having that sort of dialogue, it would be premature to effect legislation. And certainly the direction, the tack that I am taking, or would like to take, is that we explore all these other common sense approaches, that we talk about this, that we work together to achieve our common purposes, and that we reserve statutory mandates to when that is absolutely needed.

Mr. BILIRAKIS. Would the Chairman yield just for a quick moment?

Mr. HUTCHINSON. Sure, Mike, you are recognized.

Mr. BILIRAKIS. Dr. Kizer, did you—have you read—the next witness is Mr. William Schuler. He is President, CEO of Portsmouth Regional Hospital, Columbia HCA system. Have you read his written testimony?

Dr. KIZER. I do not believe I was provided his testimony, sir. But I have not read it, to answer your question.

Mr. BILIRAKIS. I would like to recommend, Mr. Chairman, that a copy of that might be given to Dr. Kizer; and if he has any rebuttal or any comments regarding it, he may possibly furnish to the committee in writing.

Mr. HUTCHINSON. The staff will provide Dr. Kizer a copy of the testimony; and if you would give us a written response then.

Dr. KIZER. Sure. I would note that I have met with representatives of Columbia HCA and have discussed where we are going and getting some of their thoughts in the past. I do not know whether Mr. Schuler is aware of that or not.

(Subsequently, the Department of Veterans Affairs provide the following information:)

Mr. William Schuler, President and Chief Executive Officer of the Portsmouth Regional Hospital and Portsmouth Pavilion, Columbia HCA Healthcare Corporation relayed the positive impact on his medical system after a corporate decision was made to decentralize operational decision making. It was instructive to us as we restructure the VHA healthcare delivery system. By decentralizing operational decision making we will increase the autonomy of field management in making operational decisions.

First, Mr. Schuler's company is pursuing an organizational strategy similar to what we have proposed for the veterans' health-care system. We believe this reflects the understanding that health-care is fundamentally a local enterprise and larger health-care organizations function best when operational aspects are decentralized.

Regarding the reference made in Mr. Schuler's remarks to a proposal that would have VA contract with the Clinch Valley Medical Center (a Columbia/HCA hospital located in Clinch valley, Virginia) to obtain certain services for veterans living in the local area, I understand that the proposal is still being reviewed by the regional staff, and a contract has not yet been approved. Further, I understand that the intent of the proposal is to establish a VA clinic that would operate half days, Monday through Friday, staffed with personnel contracted from the community. The clinic would provide an access point for primary medical and psychiatric care only. All additional modes of care, other than acute emergency, would be referred to the Salem VA Medical Center.

This arrangement is the kind of innovative arrangement with the private sector that will be facilitated as a result of VHA's planned restructuring. This is an example of the "virtual organization" referenced in *Vision for Change*. I applaud Columbia/HCA's interest in contracting with the VA to improve veterans' access to care, and I envision many other opportunities for sharing with the private sector in the future.

Mr. BILIRAKIS. Thank you.

Mr. HUTCHINSON. Thank you, Mike.

Do any other Members have questions?

Dr. Kizer, I want to thank you for your time. I thank you for your effort in this reorganization plan. We appreciate it very much. We will excuse you at this time.

Dr. KIZER. Thank you, sir.

Mr. BILIRAKIS (presiding). We will ask the second panel, Mr. Schuler, President, CEO of Portsmouth Regional Hospital in Portsmouth, NH, representing Columbia HCA.

Mr. Schuler, I welcome you to this hearing, very important hearing, and would ask you if you would try to keep your oral remarks to 5 minutes, or as close thereto as possible. But obviously your entire written statement is a part of the record. So if you do not mind the gentleman being in front of you, if that will not bother you, I would appreciate if you would start. Take your time, sir. Please start, Mr. Schuler.

STATEMENT OF WILLIAM J. SCHULER, PRESIDENT, CEO, PORTSMOUTH REGIONAL HOSPITAL, COLUMBIA HCA

Mr. SCHULER. Fine. My name is Bill Schuler. I am a——

Mr. BILIRAKIS. I have been corrected. It is 10 minutes, rather than 5 minutes. We do 5 minutes in Commerce. Sorry. So you have 10 minutes, apparently.

Mr. SCHULER. Okay. Thank you.

My name is Bill Schuler. I am a former U.S. Marine Corps Infantry Platoon Leader, a Vietnam veteran. I did receive a Purple Heart and a Bronze Star as a Marine Officer in Vietnam. And I am pleased and honored to appear before this subcommittee today.

I am presently—currently president and Chief Executive Officer of Portsmouth Regional Hospital and Portsmouth Pavilion. As President and CEO, I am responsible for all internal and external services at the 144-bed medical surgical facility and the 65-bed psychiatric hospital in Portsmouth, NH, where both facilities are located. We have approximately 900 employees, 125 members of our medical staff, and a $75-million-plus budget.

Portsmouth Regional Hospital and Portsmouth Pavilion are both owned and operated by Columbia/HCA Corporation, based in Nash-

ville, TN. Pending a planned merger with another health care company, Columbia will own and operate more than 315 acute care and psychiatric hospitals, more than 100 ambulatory surgery centers, and dozens of home health agencies in 35 States and 2 foreign countries.

In 1944—1994, Columbia employees and facilities provided more than $1 billion in uncompensated and charity care; and the company paid more than $1.2 billion in local, state, and Federal income taxes.

I am pleased—taxes—I am pleased that this subcommittee is seeking information from the private sector as the veterans' health system reorganizes. And I appreciate being part of that process.

Columbia has been an agent of change sweeping in health care. The company's strategy is to have local management make nearly every key decision regarding the operation of that hospital. Local managers are responsible for all personnel decisions, for local marketing programs, for negotiating and signing local contracts, and for establishing and requesting our own levels of capital funding. The corporation is now a service entity to these hospitals, helping my hospital become a stronger local competitor. The corporate offices negotiate national purchasing contracts, suppliers with suppliers, to reduce significantly the cost of supplies to my hospital. The corporate office is also responsible for operations and installation of computer information services which help track financial data and ease the paper flow burden at the hospital on the hospital employees and are instrumental in tracking medical outcomes that enable us to measure and improve the quality of our care. Finally, the corporate office is responsible for capital formation, which it does by issuing shares of stock or borrowing in public debt markets.

The decision to decentralize has provided my hospital and community with many benefits. But make no mistake, the decision was based on how to best compete and survive in today's rapidly changing health care environment. As many of you know, hundreds of hospitals have closed over the past 5 years. More than 10,000 hospital beds were taken out of service in 1994.

In my view, this type of local autonomy is suited to the veterans' health system. Having just listened to Dr. Kizer's proposals, I was encouraged by the fact that the VA is beginning to take a look at decentralization; and I think it is a good move on their part. As this subcommittee examines the restructuring of the veterans' health system, I would like to make some other suggestions as well.

I believe this is an ideal time for the veterans' health system to expand contractual relationships with private-sector health care providers. This will enable the VA to use the excess capacity in the private sector to provide improved ambulatory access to veterans, especially to elderly and chronic patients with limited ability to travel. I am pleased to learn of a public/private initiative in Virginia that may offer future alternatives to the VA veterans who seek to restructure and reform itself to better serve both veterans and taxpayers.

Veterans living in a rural area around Richlands, VA now must travel 2½ hours to the nearest veterans hospital, which is in Salem, VA. Clinch Valley Medical Center, the local hospital, which

is owned and operated by Columbia/HCA, has excess capacity of 42 percent. The management of the Salem VA Hospital has agreed to contract with Clinch Valley Medical Center to provide certain services to veterans living in the area. This experiment will likely demonstrate the cost-effectiveness of public and private partnerships in the provision of health care to rural areas of declining population.

In this agreement, the VA will contract with a local internist, nurse, and secretary. The hospital will lease an on-campus site to the VA. And the hospital will provide necessary ancillary services, such as diagnostic procedures and pharmacy, to the clinic for service-disabled veterans. Once the success of this phase has been established, the local hospital hopes to expand the program to include elective procedures and emergency care for service-connected and nonservice-connected veterans.

In brief, I believe this arrangement will ensure that area veterans receive consistently high quality care delivered locally and efficiently on a timely basis. In my opinion, it does not make sense for the Veterans Administration to compete with organizations such as Clinch VAlley Medical Center. Clinch Valley pays taxes, provides jobs, and delivers quality care to patients regardless of their ability to pay. It makes sense for them to work together. I know this proposal will come before the appropriate Appropriations Subcommittee, and I encourage its passage.

By decentralizing the authority of VA centers, local administrators can make decisions like these to contract with regional private hospitals to provide veterans with care they need in their own communities. It makes sense for the VA; it makes sense for private sector hospitals with excess capacity; and most importantly, it makes sense for veterans.

And speaking as a veteran, and not as a health care professional, I would like to receive my care in my community when I become ill, just as Medicare and Medicaid patients can. I recognize that this change is dramatic and cannot come quickly, but I encourage you to lay the groundwork for that change now. I believe these hearings can lead to that process and other veterans—and I and other veterans seek. So I thank you, Mr. Chairman, for the opportunity to address this subcommittee.

[The prepared statement of Mr. Schuler appears on p. 63.]

Mr. BILIRAKIS. Thank you, Mr. Schuler. Well, Mr. Schuler, you are a veteran; and I commend you for your service to this country. You may know that the veterans have been very zealously guarding separate veterans' health care over the years. The mainstreaming—I think that is the right term; is it not—that is something that they really have not really been willing to accept over the years. I realize that over the years some things may be changing. Ideas and thoughts may be changing because of budgetary constraints and maybe some common sense and that sort of thing. But in your experience, whether you have had personal experience, or whether you were talking about other Columbia/HCA Hospitals or other private facilities, has this idea been welcomed by the veterans, the privatizing; if you will?

Mr. SCHULER. I—I believe so. There was a discussion here of vouchers. My personal opinion, not as a hospital CEO now but as a veteran, is that a voucher system basically puts the power into

the hands of that individual veteran. If, in fact, the veterans' services and hospitals provide the finest quality of care and accessible and easy for them, then I believe veterans will use that. And by the way, I do not think—I am not one that thinks that the voucher system should close the VA system at all. I think it simply puts the power into the hands of that individual veteran to let him make a choice. If, in fact, the veterans hospital or health care service in that area is, as Dr. Kizer mentioned, one of the finest there is, the veterans will clearly use it. And if, in fact, it is not, you have a choice for the veteran to get that care elsewhere. And to me that is the benefit I see of the vouchering and decentralization. I think the decentralization concept which Dr. Kizer had mentioned—and as I was listening to it—was really a very good start. It really puts decision making closer to where the tire hits the road. As a former Infantry Platoon Leader, one of the early examples I got was that the decisions made closest to where the action was was usually the best decision making. And it seems to me that the VA is moving in that direction, and I would encourage that type of——

Mr. BILIRAKIS. Well, all right. Let me sort of play Devil's Advocate, because that is really what I am trying to do. All right if the situation determines that most of the veterans in a particular area do not find the services at the VA as adequate as maybe they would maybe a private facility and switched over, you were basically probably leading up to closing down that facility. I mean, you are not going to keep it open if there is hardly anybody to serve, which maybe based on what you say is maybe what should take place. But then we get to the specialized care. And they are the only ones who could offer that particular specialized care. So do you envision maybe sort of a two-tiered type of a voucher system where there would be veterans facilities for specialized care would somehow be preserved in spite of the fact that maybe the others—and I should not maybe even be going into this because I do not mean to put anybody in fear of closing down health facilities. But I guess that is the real world, and it is being talked about, and we better explore it.

Mr. SCHULER. I—again, as a veteran, along those lines, I would think once decentralization occurs and it becomes more market driven, I would have the confidence that some of these veterans hospitals in areas can begin to dramatically improve their services. It becomes competitive. They have a vested interest in developing a highly competitive, high quality product. And I think that would result somewhat from a voucher system.

I think what you may see is a consolidation of some of these specialized services that may allow veterans to maybe more cost efficiently consolidate these services and make it more accessible to other veterans and improve the quality of it. I would not dismantle the veterans system, by any means. But I would think potentially a voucher system and public/private partnerships would make the veterans systems presently more competitive and more motivated encouragement to become more attractive to those veterans who now have that voucher ability to get their service anywhere. And I view that as a system that could become more competitive and better for the veterans and better for the VA.

Mr. BILIRAKIS. I would hate to be a party to something like that that did not work out. We may as well never run for re-election.

Well, it is something—that is something that is part of our real world. It is being talked about. And I do not see any large amount of interest among the members of the Veterans' Committee thinking towards that end. But at the same time, we should be open minded. And people like your opinions, and people like you.

Mr. SCHULER. I think you need to be open minded in terms of where you could go. Would I recommend that tomorrow? Probably not. But I think the decentralization and reorganization of the veterans is a good step in a direction that makes it more competitive and the ability to develop those kinds of quality services that Dr. Kizer was talking about. And if, in fact, they are successful in developing a more decentralized, quality-driven service that is, as he said, one of the diamonds in the rough in health care delivery, then I think, frankly, a voucher system would fit into their needs because people would love to go there. I might even want to get my care there. And if they are not, you have provided an avenue for veterans to seek care elsewhere.

Mr. BILIRAKIS. Well, thank you, sir.

I will turn now to the ranking member of the subcommittee, Mr. Edwards of Texas.

Mr. EDWARDS. Mr. Chairman, thank you very much. And I will be brief. I have no questions at this point. I would like to submit my opening statement if I could in writing for the record.

Mr. BILIRAKIS. No objection.

[The prepared statement of Congressman Edwards appears on p. 56.]

Mr. BILIRAKIS. The opening statement of Mr. Edwards will be part of the record of this subcommittee.

Mr. EDWARDS. I just want to say I apologize for being late. I would like to say I just forgot to move my watch ahead an hour this weekend, but we had a meeting of Southwest House Members, Democratic Members, at the White House this morning. So we were keeping Presidential time this morning, Mr. Chairman.

Mr. BILIRAKIS. And that explains your tardiness.

Mr. EDWARDS. That is correct. So thank you very much. And I know we have a lot of other witnesses, and I will wait to listen to those.

Mr. BILIRAKIS. Thank you, sir.

Mr. TEJEDA. No questions.

Mr. BISHOP. Thank you, Mr. Chairman.

Just a couple of brief questions, very brief. I am intrigued with the idea of the voucher system and decentralization from your point of view, particularly in areas that are underserved for veterans. Access is a problem in a number of areas in the country for veteran services. And I could see the decentralization to the extent that vouchers would be allowed so that veterans could utilize local facilities such as yours rather than have to travel 3 or 4 miles to a veterans hospital.

On the other hand, if there is a veterans facility available, it has been my experience in talking with veterans, that they enjoy the esprit de corps and the camaraderie of meeting with veterans who have similar backgrounds and experiences while waiting for their

services. And to some extent that has a therapeutic effect. And they would choose if they had a choice to get that care at a veterans facility as opposed to a private facility because they know that they will be able to talk with other people who have similar backgrounds and concerns and who may have even similar problems.

I want to commend you for the innovative idea but also express the concern that the Chairman expressed that we do not want to put veterans hospitals out of business. But I think that it is a very, very innovative idea for utilization of vouchers, for example, in contracting with local hospitals for the provision of services when veterans are not located where there is access. Because I have a lot of complaints in my district that we do not have a convenient veterans hospital for veterans medical services. And many times they have to go from Georgia to Tuskegee, Florida or from South Georgia to Atlanta, which is a great, great deal of inconvenience. The veterans' service organizations do a fine job in trying to assist in providing transportation, but it can really be a lot of wear and tear on a veteran to make that long trip. So I just want to thank you for that. And I just note those comments in the caveat.

Mr. BILIRAKIS. Thank you, Mr. Bishop. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

Mr. Schuler, thanks for your testimony this morning. I represent a district in western Pennsylvania with one of the highest veterans populations in the country, and we have 3 VA hospitals in my district. I have met with all of the directors in those hospitals and toured them. And they have been asking for this decentralization. They want the flexibility to be able to make some decisions locally. So I think many of us are welcoming Dr. Kizer's *Vision for Change* plan. And it is good to hear someone in the private sector to opine that it is a step in the right direction. Thank you for your testimony.

Mr. BILIRAKIS. I am going to do something a little unusual, if I may.

Mr. Bishop, your veterans who now have to travel such long distances to get health care and in spite of the fact that transportation is being provided for them or efforts are being made towards that end, how would they feel if the VA contracted with private facilities in the area as is being done in some areas of the country as Mr. Schuler shared with us? How would they feel about something like that?

Mr. BISHOP. That is a very interesting question, and I certainly will want to explore that. But what I have gathered from the conversations with the veterans' service organizations has been that they would prefer a separate veterans' health care system, specifically designed and specifically targeted for veterans, probably because of the esprit de corps and the common background and experiences and the camaraderie that they have when they pursue those services. And then they get to exchange those ideas and information during the course of their visits and their travel to and from. So I do not know. And I think that it certainly would be a worthwhile survey for the VA to determine what the attitudes of veterans would be toward that.

Mr. BILIRAKIS. That is very important. I know I would ask Mr. Schuler at this point how much of this contracting out is being done; do you know? I mean, you know, to what extent?

Mr. SCHULER. I am really not aware of it. I am just aware of that one incident in Richlands. I believe there are others. And I think, again, the distance, the access issue is probably a good start to see if that works and get feedback from those veterans involved.

I agree there are veterans who would prefer to get—who have the camaraderie—although frankly, there are a lot of veterans who do not have to use the system who are using our hospitals. We are in an area where there is a military base, a concentration of veterans, and I have to admit we share stories now at the local level as well and services. And I, again, I think the voucher system—if, in fact, the veterans feel strongly about that—you have simply empowered them to do that.

And I have no—I do not think the veterans system would go away. I think there is a use for it and a need for it in these particular areas where a 2½ to 3 hour drive could wear somebody down, especially depending on the amount of care that they need, that that sometimes can be a significant benefit to them that they are not wasting 4 to 6 hours in an automobile. But they are, in fact, able to use that more productively in their lives. And so that may be an excellent example where a decentralized VA can negotiate these things, get immediate feedback from their veterans in that area. And it is a good starting point for people to begin to gauge whether——

Mr. BILIRAKIS. In these outlying areas.

Mr. SCHULER (continuing). In these outlying areas. It is, again, Clinch Valley in Richlands, VA is probably a good point that ought to be measured and surveyed after a while and find out how these veterans feel about that.

Mr. BILIRAKIS. Great.

Mr. Bishop, I know you are chomping at the bit. There is something you wanted to add.

Mr. BISHOP. No. I just think that that is a very interesting subject that ought to be explored through surveying veterans' attitudes toward it. I have heard lots of complaints at hearings with this very subcommittee across my district and Atlanta. The veterans complain about having to travel long distances and how inconvenient it is when they have to do that, particularly when they are ill to start with. And it is a burden on families. It is a burden on them in terms of time, and it physically has wear and tear on them. So it certainly should be an option.

Mr. BILIRAKIS. I agree with you. I think we better be open minded to it, maybe try to find out more about it. I do not know, maybe with the demonstration projects in areas such as Richmond and maybe your area and whatnot might be a good idea.

Mr. Tejeda, Mr. Edwards, any further questions of Mr. Schuler?

Thank you very much, sir. We appreciate your coming here today and sharing your expertise with us.

Mr. BILIRAKIS. The next panel, we would like to invite them up at this point. Dr. Daniel Winship, who is the Dean of the Stritch School of Medicine, Loyola University of Chicago; Dr. Samuel Spagnolo, President of the National Association of VA Physicians

and Dentists; Lynna Smith, President of the Nurses Organization of the VA; and Louis Jasmine, National President, National Federation of Federal Employees, welcome.

We have 10 minutes. Your oral testimony, your prepared statement, obviously is made a part of the record. We will start out with Mr. Winship. Doctor?

STATEMENT OF DANIEL H. WINSHIP, M.D., DEAN, STRITCH SCHOOL OF MEDICINE, LOYOLA UNIVERSITY OF CHICAGO; ACCOMPANIED BY DANIEL SPAGNOLO, M.D., PRESIDENT, NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS; LYNNA SMITH, PRESIDENT, NURSES ORGANIZATION OF THE VA; LOUIS JASMINE, NATIONAL PRESIDENT, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

STATEMENT OF DR. DANIEL H. WINSHIP

Dr. WINSHIP. Good morning, Mr. Chairman and members of the subommittee. I am Dr. Daniel Winship, Dean of the Stritch School of Medicine, Loyola University of Chicago. I am pleased to present the testimony of the Association of American Medical Colleges, as you consider the proposed reorganization of the Veterans Health Administration.

AAMC represents the 125 accredited United States medical schools; nearly 400 major teaching hospitals, including 74 VA medical centers; over 90 professional and academic societies; and the Nation's medical students and residents. Together, the members of the AAMC work together to improve the Nation's health through the advancement of academic medicine.

I personally have devoted my professional life to research and academic medicine, having held appointments at several medical schools and hospitals within the AAMC's membership. In addition, I have cared for veteran patients in 4 medical VA medical centers, directed a VA medical center, and served in VA central office.

Currently, I am an attending physician at the Edward Hines, Jr. VA Medical Center, with which Loyola University is affiliated. The Hines VA, you may know, was the first VA medical center to affiliate with a school of medicine. Back in the 1940s, VA medicine suffered from bureaucratic constraints, a shortage of physicians, and a less than sterling reputation.

As thousands of veterans began returning home from the second World War, President Truman signed a 1946 law that allowed VA hospitals to enter into affiliation agreements with accredited medical schools. Affiliations helped staff VA hospitals with top-notch medical school faculty physicians, residents, and interns, and provided medical schools with new venues in which to educate young physicians, including military doctors returning home to seek specialized training.

These affiliations have allowed VA to achieve its goal of affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service. Today, nearly 10,000 VA clinicians have academic appointments with one or more academic institutions; and a similar number of faculty from these academic affiliates care for veteran patients and teach residents and students at VA medical facilities.

Contrary to popular belief, the VA medical system offers veterans excellent health care and a range of specialized services that many veterans desperately need but might not find elsewhere.

VA medical centers consistently score well on the reports of the Joint Commission for the Accreditation of Hospital Organizations, comparing favorably with their private sector counterparts. A 1992 *U.S. News and World Report* article on AIDS cited four VA medical centers among the facilities that offer the finest AIDS care in the United States. The vibrant VA health care research program, based on the health care needs of veterans, attracts top physicians and scientists to VA careers and contributes positively to the quality of medical care received by patients in affiliated VA medical centers.

Since 1982, VA has also been required by law to serve as a backup to the military medical system during war and other national emergencies. During the Persian Gulf War, many VA medical centers developed contingency plans to treat casualties in concert with their academic partners. The Hines VA and Loyola University, for example, crafted a plan that would have used my institution's entire specialty structure to provide medical care for wounded soldiers. These cooperative efforts in support of military medicine are particularly vital since the number of beds operated by the military has declined from 80,000 to 16,000 over the past 25 years.

VA also plays a major part in educating today's physicians. In 1994, VA supported more than 9,100 medical resident positions, or close to 10 percent of all the residency slots in the country, and over 33,000 medical residents from affiliated institutions rotated through VA facilities. More than one-half of the Nation's physicians have received some part of their training in VA facilities.

After nearly 50 years of close partnership, academic medicine cannot envision an educational environment that does not somehow include VA. Severing or even diminishing the symbiosis that has benefitted both parties is particularly unimaginable when one considers that many VA medical centers are situated on the same grounds or located in the same building complexes as their affiliated medical schools.

Academic medicine looks forward to working with VA and the Congress in reinventing VA to face the challenge of caring for the Nation's veterans while adapting to changes in the health care environment and marketplace. The proposal before you is an important first step toward transforming VHA into a more comprehensive, responsive, and efficient medical system. Secretary Brown, Under Secretary Kizer, and their colleagues in Washington and in the field should be commended for tackling the awesome task of reorganizing the largest integrated medical system in the United States.

The AAMC and its member institutions will continue to support VA's efforts to provide the best possible care for our Nation's veterans. We are concerned, however, that the reorganization proposal mentions only in passing VA's missions to educate health professionals and conduct health research. We would like to think that the reorganization can strengthen, rather than imperil, the arrangements between VA medical centers and schools of medicine

that are essential to the high quality of care provided to veterans by VA.

Under the proposed reorganization, basic budgetary and planning responsibilities would shift from individual medical centers to the VISNs, which would coordinate health care for eligible veteran beneficiaries in defined geographic areas.

This move carries potential ramifications for the long-standing relationships between individual VA medical centers and their academic partners. For instance, the proposed shift in planning responsibility from the VA medical center to the VISN signals the potential for dramatic changes in the role of Deans Committees.

Every medical school that conducts medical education programs in cooperation with a VA medical center must organize and nominate a Deans Committee, subject to the approval of the VA medical center director. These Deans Committees are composed of medical school deans and senior faculty members from appropriate medical school departments and divisions. The Deans Committee has a primary advisory responsibility regarding all aspects of a VA medical center's education and research programs. These committees also nominate faculty and trainees from the medical school for appointments to meet VA's staffing needs.

Under the reorganization plan, each VISN would establish a management assistance council to assure input from VHA's internal and external stakeholders. The plan foresees a role for VHA's academic affiliates as consultants to these councils, providing recommendations regarding the operating of and planning for the VISNs. Although we believe the close interaction between VA medical centers and affiliated medical schools warrants involving academic medicine and other important stakeholders as more than simply consultants, we also realize that adding representation from every conceivable external interest would make these councils rather unwieldy.

Notwithstanding this concern, the AAMC appreciates VA's interest in the views of its partners, and we believe these councils would provide an avenue for the dialogue and constructive collaboration that is essential to the success of the reorganization.

The interplay between the VISNs and the Deans Committees within each network will almost certainly create tensions that will buffet the affiliations. Since each proposed VISN would also incorporate more than one VA medical center with a strong academic partnership, the reorganization plan harbors the potential for additional conflicts within the VISNs themselves. I believe VA and academic medicine should work together to create a structure through which the VISNs can work with the Deans Committees, either individually or through consortia, to devise systems for staffing VA facilities, educating students and residents, and conducting health research in the best interests of veterans and each partner. As the subcommittee considers the reorganization plan, the AAMC would welcome the opportunity to discuss this issue further.

We understand the need for VA to restructure its health care system to provide health care to its patients more effectively and rationally. Medical schools and nonfederal teaching hospitals with educational and research missions are also beginning to form integrated networks and to incorporate ambulatory and community-

based service points into expanded continuums of care. However, as VA reinvents itself, the directors of the 22 VISNs must take care not to sunder unnecessarily the ties between individual VA medical centers and medical schools. I believe that VHA headquarters should provide the field with national policy, direction, and oversight to ensure that the benefits of these affiliations are preserved and enhanced.

In my view, the transformations in health care delivery that are spreading across the country present VA and academic medicine with new possibilities for cooperation that would benefit both partners and, ultimately, the veterans we serve. For instance, VHA, medical schools, and teaching hospitals can join together in finding ways to enhance primary care education and to provide students and residents with more experience in outpatient settings. These types of collaborations between VA medical centers and academic medicine would make sense for both partners, providing academic medicine with new educational opportunities and helping VA improve veterans' access to health care by promoting appropriate delivery systems. Together, medical schools and VA can implement necessary changes, yet protect what is good in the current system.

Based on my experience as a physician and an administrator, I believe that the proposed reorganization, although an important first step, should not be considered a panacea by this subcommittee. As the subcommittee discusses the future of VA health care, it should also consider reforming the convoluted and dysfunctional eligibility criteria to allow VHA to provide a comprehensive range of care to all eligible veterans; allowing VA to retain third-party collections; urging appropriators to provide adequate funding for VA medical care and research; and allowing VA medical centers to treat non-veteran patients, as long as the high quality of care for eligible veterans is not compromised and VA is reimbursed properly for all care provided to non-veterans.

Thank you for allowing me to present the views of the Association of American Medical Colleges today. I would be pleased to answer your questions.

[The prepared statement of Dr. Winship is on p. 69.]

Mr. BILIRAKIS. Thank you very much, Dr. Winship. Dr. Spagnolo.

STATEMENT OF DR. SAMUEL SPAGNOLO

Dr. SPAGNOLO. Thank you. Good morning, Mr. Chairman and members of the subcommittee. My name is Samuel Spagnolo, and I am here today as President of the National Association of VA Physicians and Dentists, better known as NAVAPD. For the past 20 years, I have served as the Chief of Pulmonary Diseases at the Washington, DC VA Medical Center, having come here after finishing my training at Harvard and the Mass General Hospital.

I have also been for the past 20 years, serving as the Director of the Pulmonary Division at George Washington University; and I am currently Professor of Medicine at George Washington University.

With me today are two of my colleagues. They are sitting behind me, Dr. Rhonda Lee Travaglino-Parda, who is Chief of Plastic Surgery at the Washington VA and Dr. John Burton, Chief of Dental

Service at Columbia, SC; and we hope they will have an opportunity to answer your questions.

I thank you for the opportunity to comment today on the recent proposal to restructure the Veterans Health Administration. We come before the Committee today to address what we believe is the single most important issue facing VHA. That is maintaining and improving the quality of patient care for our Nation's veterans.

At the outset, let me emphasize that NAVAPD does not oppose change in the VA system. On the contrary, continuous change is necessary to meet the needs of any dynamic business or organization. The VHA must now contend with ongoing changes affecting the demands for its services, such as an aging veteran population, a marked decline in inpatient and acute care, and major shifts in the geographic locations of veterans, to mention a few. The VHA must address these issues in a timely and effective way without compromising quality health care. Therefore, it is not whether the VHA changes, it is how it changes that concerns us.

We applaud the VA for proposing to eliminate unnecessary bureaucratic layers in the management system and shifting operational decisions to the local level. The concept of decentralization is not inherently bad, provided the new structure significantly involves doctors in the management process.

Before I address our concerns, I want to stress that NAVAPD seeks to continue a constructive dialogue with the VA and Congress as we debate this reorganization plan. As always, we stand ready to answer any questions and to work with the VA and Congress.

We would also like to briefly point out that the reorganization plan fails to address the difficult issue of simplifying veterans' health care eligibility criteria. Without knowing who our patients are and what they need, how can we effectively plan for their care? We know there is a Bill recently put forth before the House, and we urge Congress to address this important issue before any attempt is made to reorganize the system.

NAVAPD has four areas of concern, and let me briefly tell you what they are. We are concerned that quality health care is not the focus of reorganization. Although the plan endeavors to address the quality of health care, its primary goal is managed care, now commonly known as best value care, as the plan states. Let me quote from the plan: The new VISN structure places a premium on improved patient services, rigorous cost management, process improvement, outcomes and best value care.

Congressman Hutchinson, I think, has already addressed this. The plan goes on to say that an integrated health care system requires management of total costs; a focus on populations rather than individuals; and a data-driven process-focused orientation, which is a long sentence.

I am personally aware of managed care organizations where patients are scheduled in 8-minute intervals. I do not consider that quality care. When you restructure a system as unique as the VA administration health care system, the question really should be: What is best for the Nation's veterans, not: What is the best value for the VA system? We are concerned that managed care will effec-

tively—adversely affect the quality of care delivered, especially in specialized services.

For example, NAVAPD has consistently taken the position that the VA should improve patient care by creating centers of excellence. These centers would provide treatment, research, postgraduate education in special areas, such as organ transplant perhaps, early diagnosis of cancer, cardiac surgery, spinal cord injury and rehabilitation.

To accomplish this goal, there must be a strong commitment at the management level. There must also be significant input from doctors.

Let me just digress for a minute. As a physician, I am acutely aware that the ultimate responsibility for my patients' care rests with me. I am trained to make decisions on the quality of care that my patients receive. All of you know, the practice of medicine is centered around the doctor/patient relationship, and decisions about treatment must be based upon the professional judgment of the doctor. This relationship must not be compromised by managed care. I ask you: Under managed care, who is the patient's advocate? Who will protect clinical outcomes? Furthermore, courts have consistently upheld my accountability in the doctor/patient relationship. Who is accountable in a system that inserts a non-medical administrator into that relationship?

Now, this leads me to my second point. NAVAPD is concerned that under this plan, doctors will not have substantial decision-making authority regarding the development and implementation of administrative policies within each VISN. The plan proposes that each VISN be headed by a director, who would be expected to have expertise in medical management, finance, budgeting, planning. There is no mention of expertise in patient care. If a doctor cannot advise the VISN director as to the clinical outcome of decision, and if that advice does not carry real authority, then the doctor has no real input into the management process.

Policy decisions made without clinical justification will fail and will have serious adverse impacts on the quality of patient care.

Our third concern is that the plan's main emphasis on decentralization of authority will adversely impact the quality of patient care. By the year 2010, our information is that one third of all veterans will reside in six States: California, Pennsylvania, Texas, Florida, Arizona, and New York. What does that mean for facility management, staffing, expansion and the allocation of technology resources? It is not clear to NAVAPD how the new VISN management structure will address the allocation of these resources among the VISNs and what criteria will be used in the allocation of these resources.

Finally, one of NAVAPD's primary goals has always been to improve patient care by maintaining special medical expertise within the system. The VHA must adopt policies that are aimed at retaining senior, experienced personnel and recruiting new quality doctors.

This reorganization plan fails to address how the VA would modify academic affiliations and resource opportunities for doctors. The opportunity to be actively involved in medical education and re-

search has long been one of the most attractive features in employment. I personally have trained nearly 100 lung specialists.

In this important opportunity for growth and professional development, if that is closed off to VA doctors, you can rest assured that senior physicians and dentists will leave and the recruitment of new, high quality doctors will suffer.

Let me summarize our position. First, the focus of any reorganization of the VHA must be the quality of health care for veterans and not managed or best value care. Second, physicians and dentists should be directly and effectively involved in management decisions affecting patient care. Third, decentralizing management functions in the VHA should not negatively impact resource allocation. And finally, the reorganization should maintain specialized medical expertise in this system.

Mr. Chairman, that concludes my remarks. Thank you for the opportunity; and I, along with my colleagues, would be more than welcome to answer any of your questions.

[The prepared statement of Dr. Spagnolo is on p. 76.]

Mr. BILIRAKIS. Thank you so much, Doctor. Ms. Smith.

STATEMENT OF LYNNA SMITH

Ms. SMITH. Thank you, Mr. Chairman. I would like to introduce myself. I am Lynna Smith, a nurse practitioner at the American Lake Veterans Affairs Medical Center in Tacoma, Washington. As president of the Nurses Organization of Veterans Affairs, I am testifying on behalf of Nova, and I speak for the more than 40,000 professional nurses.

It is an honor and a privilege for me to represent NOVA here today and to testify on the Veterans Administration's Reorganization proposal. This testimony will focus on the effect of this on veterans' health care and on nurses. NOVA strongly supports the Veterans Health Administration and an independent health care system providing a full range of services enhanced by education and research programs benefitting both veterans and the Nation. The VHA functions in concert with major trends in the health care profession and reflects those changes in its care of veterans. NOVA also supports the recognition—reorganization goal to transform the VA into a responsive, decentralized, customer-driven organization providing high quality, cost-effective, accessible service for all veterans. NOVA applauds Secretary Brown for his leadership in this undertaking.

NOVA is also committed to providing quality health care for the veteran. We believe that the health care must shift from the illness/cure model of care to a focus on the wellness/health promotion model. NOVA asserts that an increased utilization of nurses as primary providers will promote accessibility and quality care, that the increased use of nurses as case managers will decrease fragmentation of health care, that research-based clinical practice will promote increased standardization of health care and promote quality of care. That education and training will assist nurses in moving toward ambulatory care, hospice or home care and long term care settings.

The following comments are on components or reorganization. In September, 1994, the Nursing Program's Board of Directors initi-

ated an organizational structure to support decentralization by providing opportunities for grass roots input in policy development and decision making. The Board includes chairs of five constituency centers: Clinical, Administrative, Research, Education, and Informatics. Task forces with representatives from nationwide VA have been developed to work on elements of the strategic plan.

This innovative program has generated interest and enthusiasm from all levels of nursing service. As with all programs, outcome measures need to be tracked. For example, an Advanced Practice Advisory Group was appointed in 1994 and subsequently aligned with the Clinical Constituency Group. The Advanced Practice Advisory Group guided the development of a new directive related to establishing prescriptive authority for Advanced Practice Nurses, Clinical Pharmacy Specialists and Physician Assistants. This Group has also begun the development of Scope of Practice guidelines for Advance Practice Nurses and has initiated identification of issues and information necessary to create a national database for Advance Practice Nurses in the VA. NOVA strongly commends these innovative programs as essential for nursing in the VA.

In late 1994, the VA announced each medical center can now realign Chief Nurses to the position of Associate Director for Nursing Services Patient Care Services. This realignment positions our nursing services to assume a greater scope of responsibility and accountability for the governance and operation of each VHA medical center.

NOVA applauds Nancy Valentine, the Assistant Chief Medical Director for Nursing Programs and the Task Force on Reorganization of the Chief Nurse with the support of Secretary Jesse Brown and Deputy Secretary Hershel Gober in achieving this NOVA goal.

The Veteran Integrated Service Network restructuring proposal would abolish the VHA's current 4-region system and replace them with 22 VISNs. These VISNs will allocate resources among the medical centers and use contract services with the private sector as well as sharing agreements with the Department of Defense. NOVA believes this reorganization will lead to an increased quality of care as well as cost managements. NOVA recommends that nursing representation be at the VISN level.

NOVA also supports the goals of the recent organizational integration in which 16 VA medical centers were realigned into seven facilities. This allows for expansion of services to veterans and the improves the management of the VA's network of health facilities. This integration is commendable and, in our opinion, exactly what the VA needs to accomplish.

However, at one or more facilities, this process appeared very abruptly, with both staff and veterans voicing feelings of uncertainty about their programs and health care. The process of integration, which should have begun prior to merger, must now begin. Issues of concern include communication with the veteran consumer and the hospital staffs about this integration process; continuity of health care programs; consolidation and integration of information systems; and integration of clinical services. NOVA recommends that these integrated facilities be monitored to ensure the achievement of the stated goals, and that the veteran consumer

and the staff of the various clinical programs within these facilities have representation in this process.

NOVA continues to have significant concern regarding veteran eligibility issues and access to care. For example, in Tacoma, Washington, there are three new private health care plans actively marketing veterans.

One of my veterans that I see, after attending one of these sessions stated to me: The plan sounds too good to be true. He decided to return and hear the presentation a second time, and subsequently, signed up for the plan. He selected a family doctor, believing that he will receive total health care, including medications in exchange for his medicare deductible and a $5 visit co-pay. There was a proviso with his plan, though; and that was that he was not to receive health care from any other provider, including the VA.

NOVA believes that eligibility reform is critical to a viable VA. Unless the reorganization plan includes simplification eligibility reform, those veterans, especially those less than 50 percent service connected, may well go elsewhere for their health care.

Our country has a responsibility for the men and women who have put their lives on the line and made our country and the world a safer place. Veterans deserve quality, efficient and effective health care. This is the VA challenge. NOVA is committed to working with the VA and with Congress to achieve this goal.

In closing, Mr. Chairman, NOVA would like to thank you and this subcommittee for your work with the legislation to amend Title 38 to exempt full-time professional nurses from restrictions on remunerated outside professional activities. This regulation has long been an issue for NOVA members, and we are truly grateful for your support.

Thank you.

[The prepared statement of Ms. Smith appears on p. 83.]

Mr. BILIRAKIS. Thank you very much, Ms. Smith. Mr. Jasmine.

STATEMENT OF LOUIS JASMINE

Mr. JASMINE. Thank you. Good morning, Mr. Chairman and members of the subcommittee. My name is Louis Jasmine. I am the president of the National Federation of Federal Employees. On behalf of the National Federation of Federal Employees, otherwise known at NFFE, I appreciate the opportunity to appear before you today to offer our comments on the plan to reorganize the Veterans Health Administration.

NFFE represents over 150,000 fellow employees throughout the country. I would like to take a moment to reaffirm the commitment of all NFFE VA employees to constructing a VHA that is more responsive and provides high quality health care to those individuals who have given so much to this Nation, the veterans. NFFE has wholeheartedly embraced the VA's call to put veterans first and is willing to work with the VHA as it restructures its health care delivery system to put patients first.

I must say also that NFFE applauds the VHA for developing a reorganization plan that is correctly focused on systematic changes intended to improve service delivery rather than on a massive job cuts intended to provide only monetary savings. In today's cut and

slash reform environment, this is certainly a refreshing change and we want to applaud you on that.

As you know, you already know the current, the proposal for reorganization which is going to transform the current field operations to 22 Veterans Integrated Service Networks, or VISN. What is more important to NFFE is the—that in the reorganization plan, that it would lead to a net reduction of 157 FTE positions. NFFE is certainly pleased to see that VHA intends to achieve these reductions through the use of reassignments, early retirement, and special placement initiatives instead of the more draconian reduction-in-force, one thing that we all really do not like to see as a means of reduction. And we certainly want to applaud you for taking these steps at reducing the number of FTEs.

While NFFE is generally supportive of the VHA's reorganization plan, we do have a few concerns. Leading the list in the potential impact is the plan on the labor-management partnerships in the VHA. As you may know, many VA facilities already have, or are in the process of completing, a partnership agreement with resident employee unions. These partnership agreements envision accountability at the facility level. The partnership may be undermined if the facility management is required to defer to the VISN director instead of being able to reach an agreement with its partner at the station. Throughout the Federal Government, partnership agreements have shown by working together Federal workers and management can dramatically improve the quality of service while reducing costs. The VHA reorganization plan should reflect the success of this philosophy.

As I travel through different parts of the country visiting VAs, those that have partnerships, and certainly those partnerships have worked toward improving quality service and reducing cost; and I think the reduction of cost and money is the bottom line throughout this whole operation and your reorganization plan.

Another concern is the potential for micro-management of the medical centers by the VISN directors. In the 1980s, the regions were too large and contained too many medical centers for Regional Director to manage human or fiscal resources effectively. The danger in the present plan is that the VISNs are small enough for the VISN Director to micro-manage the medical centers; and this is a concern that the unions have, NFFE has. To avoid this problem, the VHA should emulate some of the Nation's largest private sector multi-hospital systems, which basically allowed the medical center director the freedom to locally manage the human and fiscal resource departments, but also make them accountable for their actions. And we think the committee should look at that, as well.

Finally, in conclusion, Mr. Chairman, I would like to reaffirm that NFFE's commitment to reform the VHA so that it provides our Nation's veterans with a health care delivery system that is both effective and of high quality. NFFE believes that this proposal has the potential to realize this goal as long as it is adjusted to reflect the success of labor management partnerships and safeguards are added to ensure that local directors are allowed to manage effectively. The local directors having that autonomy and that authority is the key to successful relationships.

That concludes my testimony, and I would like to thank you for allowing me the opportunity to come before you today.

[The prepared statement of Mr. Jasmine appears on p. 89.]

Mr. BILIRAKIS. Thank you, sir. Thank you for your input. Mr. Hutchinson has just come in. But Ms. Smith, Mr. Hutchinson introduced the piece of legislation that you referred to. But you gave me credit. So I guess I am going to have to seriously consider co-sponsoring it.

Ms. SMITH. Thank you.

[Laughter.]

Mr. BILIRAKIS. I am always impressed with the fact that even though during these veterans hearings—this does not really take place in too many other committees when the VA is usually asked to testify first—in other committees, when you ask basically the administration to testify first, or early on, they usually get up and leave after they are done testifying. But I am always impressed that the VA always has a representative here to hear the rest of the testimony. Ms. Egan—and there may be others—but I know Nora Egan is here, and I appreciate very much, and I know the others do, too. You got an earful, particularly from Dr. Spagnolo. I would very much appreciate it if you would—you know, your time is wasted if you do not go back with those inputs to Dr. Kizer and to the others.

Dr. Spagnolo, when this was all being worked out, was there not any coordination done with your group? Was your input not requested? Did the VA not work with your people?

Dr. SPAGNOLO. There were one or two phone calls made, but not on a grand scale, Mr. Chairman. We would like to have had a little more input, but we are certainly willing and able to give as much input now as we can.

Mr. BILIRAKIS. Well, the cow is now out of the barn.

Sir, I commend you for being so very concerned about the quality of medical care. As you say, in your opinion, you do not think enough emphasis has been placed on that insofar as this plan is concerned.

Are you sort of being cautious in your concern that the quality of medical care might be adversely affected or do you feel confident that it will be adversely affected under this system?

Dr. SPAGNOLO. No, I think I am more concerned that it could be, and I do think that—I am all for restructuring and simplifying the bureaucracy, which I have been in it for many years. But I think we can improve quality of patient care if we put some trust in those people who are making those quality decisions, such as the doctors and the nurses and the dentists. And I do not see enough of that happening. I have watched the VA over 20 years, longer; and I have watched the separation between the administration and the providers get wider and wider and wider.

Mr. BILIRAKIS. And you feel that it is getting wider yet?

Dr. SPAGNOLO. And I feel that, you know, a lot of people have a lot of criticisms about the VA health care system; and I feel that you have got to put the providers back—let me borrow a phrase from a, perhaps, a famous senator who said: We feel we have been pushing this train for a long time. We would like to have an opportunity to help lead this train. That is really what I am asking.

Mr. BILIRAKIS. That certainly does appear to be reasonable.

Dr. SPAGNOLO. And I think, as a partnership in this reorganization matter, with real input by physicians, nurses, dentists, and all the practitioners, I think we can deliver quality care. But I am a little concerned about this new phrase, best value and managed. I am very concerned about what that means.

Mr. BILIRAKIS. Ms. Smith, you have devoted your life, obviously, to taking care of people in need, and yet you have said some good things about the reorganization. But Dr. Spagnolo does not oppose it, either. Do you sort of agree with him in the fact that maybe there has not been enough emphasis on quality of medical care?

Ms. SMITH. I feel—I agree with him that there needs to be professional medical nursing input in order to keep the system whole, but I also believe that there has to be a business administration. In order for the VA to survive, we have to have a business aspect to it. That is what this is all about. The VA is such a special group, all of the things that have been talked here today—talked about here today, the veterans' camaraderie, the special problems that veterans have related to so many of the events in their lives related to the military, I believe that we have to preserve that; but we have to do it in the economy. And if it takes a CEO to maintain some business aspects in order to bring more income in and to get more money into health care providers to take care of those veterans, that is what is essential.

Mr. BILIRAKIS. Are there not doctors out there or nurses, I mean, practitioners who also can serve? I realize the reputation of doctors. My son is one of them; and I am here to tell you, when it comes to business—but there must be people out there that could serve, basically, both functions.

Ms. Smith, I commend you for your candidness. You are quite right. I think, the real world is we have got to worry about the bottom line, unfortunately. But at the same time, we do not want to hurt the quality of medical care in the process. Can both not be done, in your opinion?

Ms. SMITH. Can a medical or a nurse do both?

Mr. BILIRAKIS. Yes.

Ms. SMITH. I believe so.

Mr. BILIRAKIS. You believe so, right. Dr. Spagnolo?

Dr. SPAGNOLO. Absolutely, and here is one.

Mr. BILIRAKIS. Right. And I plan to go to Dr. Winship.

Dr. SPAGNOLO. And Dr. Kizer, who was here earlier who is a physician. I think there are plenty of physicians who are good managers, and I think the VA should also start a management program for physicians.

Mr. BILIRAKIS. That is a good point. I wish they had started one when my son was still training through the VA.

Dr. Winship, do you have any comments regarding particularly Dr. Spagnolo's testimony?

Dr. WINSHIP. Yes. I would echo Dr. Spagnolo's concerns, but I do not believe that the VA is headed, necessarily, in the direction of plummeting health care. I think a lot of what is going on now and, in fact, the heart of this program is not just to save money, but also really and truly to improve health care. I have long thought, personally, that decentralization of management of VA medicalk care

would be a great benefit and would allow more bang for the buck, if you will, to get decision-making out there where it is really being done. So I think it is not only possible, I think it is likely, and I think there is a strong focus on that in the plan. But at the same time, because it will represent a major change, a sea change in the way VA has done things for many, many years, I think much care has to be given to paying close attention to what the VA is there for; and it is first to take care of patients, the veteran patients. All the other things feed into that, but that is Job One.

Mr. BILIRAKIS. Thank you. Well, I think my time has certainly has expired. On my behalf and the behalf of the committee, I commend you for your courage in saying basically what comes from the heart.

Mr. Edwards?

Mr. EDWARDS. Thank you, Mr. Chairman. And thank you all for being here today. I want to express my special appreciation for your lifetime career commitment, providing better care for veterans. Veterans are getting better care today because of what all four of you have done in your careers and I want to thank you for that.

Dr. Spagnolo and Dr. Winship, both of you, in fact, all of you touched on the issue of eligibility reform and I would like to focus on that and how that ties into this reorganization plan. Now, the mantra in Washington today is decentralize. I think generally that is a good concept, but there is a reason we do not just send block grants back to mayors and county commissioners and governors and say: Spend this on Veterans Programs as you would like. There is a reason for that; and the reason is that we want a certain standard of guarantee care to be given to veterans, so I do not favor full decentralization of veterans programs.

It seems to me, what we need is a balance between decentralized management and some local flexibility in making management decisions. But we need some centralized goal settings. What are the standards? What is the care we want to ensure that all veterans receive wherever they are in the Country, regardless of local managers' personal views on issues.

I guess, kind of a vague question or concern I might have about reorganization before you have eligibility reform is that you then have localized decisions about who is eligible for care. And there is no standard at all about the kind of care, the kind of criteria we use in determining care for veterans.

Dr. Spagnolo, you said we ought to have eligibility reform before we have this management reform. I do not know if that is one of the concerns you might have, but I would like to hear from you and Dr. Winship since you focused on eligibility reform. Is it essential that we have eligibility reform before this management reform? Or is it preferable? Or if we do not have eligibility reform first, is it something that we ought to be concerned about? Could there be some problems resulting from that?

Dr. SPAGNOLO. I will defer for a moment to my senior person on my left, but also, if time permitted, would appreciate a comment from one or two of the people that I brought with me that are very close to the eligibility issue, Dr. Parda and Dr. Burton, please.

Dr. WINSHIP. VA has been functioning for quite a long time with its current eligibility mix. Whether eligibility reform ever takes

place or not, a lot can be gained by carrying out the plan. I think in terms of management structure, in terms of flexibility, in terms of providing the potential, I think we have the potential for providing better care for the veterans even if eligibility reform did not happen. So I certainly do not think it has to happen before reorganization can take place.

On the other hand, I believe that one of the most dysfunctional things about VA system is its eligibility criteria. It is a non-system that has been cobbled together over decades of this rule and that rule and the other. What really needs to happen, I think, for good care for veterans, is to define the population of veterans that the system needs to care for and then care for them. Give them all the care that they need. That seems to be a very simple prescription, although I understand it must be very difficult to make that happen because it has not happened.

So I think those can go along in parallel; and I think if this plan gets put in place before reform, eligibility reform, that is okay. But I do think that eligibility reform ought not to be taken off the books. I think it is terribly important for the future of the system for that to occur.

Dr. SPAGNOLO. I would agree that perhaps they can go hand in hand. I think if you do reorganize and you have not done eligibility, we are going to be in for a lot—just as much confusion as we have. And I know, my colleagues who do plastic surgery, and they are trying to fix a knee, and they are not permitted to fix the foot because the foot is not the service connected part, but it has something to do with making the knee better. The only way to get that done is you have to admit the patient. And I am sure that if Dr. Burton could speak for himself, could tell you all kinds of problems that he has in the dental service with the same phenomenon.

So it is getting back to providing quality care for the individual patient. I would like to see both issues on the table because I think the organization plan will have less chance of succeeding unless you do something with eligibility. Whether you narrow it or broaden it or whatever you do, you have got to simplify it.

Mr. EDWARDS. Could I ask, along those lines, and Ms. Smith, Mr. Jasmine, if you would also like to comment on this on either my first question or my last question here. Several of you referred to your concerns—Dr. Spagnolo, you specifically on maintaining specialty care if we change this system as suggested. What do you specifically recommend that we do to guarantee under this new reorganization that we maintain commitment to specialty care, specialized care, for veterans?

Dr. SPAGNOLO. Are you asking me?

Mr. EDWARDS. Yes.

Dr. SPAGNOLO. Well, I think we should continue to do some of the things we are already doing. I am a strong proponent of organizing some of these specialty centers and making them the best they are in the world. Perhaps that would be able to shrink some resources from some other areas where they may not need to do that, and you could funnel them into these specialized cares. I do not think you should lose that. And I think you should continue to, although I think the focus has got to be on primary care. I am a great proponent of primary care. But you still have to have the

backup of specialty care to go along with primary care; and I do not think you should begin to jettison that, which I have already seen little bits of that already happening. I think you have to have a balance between them both.

Mr. EDWARDS. Do you think we need Federal standards despite this decentralization—Federal standards saying that you have local management flexibility, but you cannot reduce specialized care in certain areas? Do you think we need that kind of protection?

Dr. SPAGNOLO. Well, I tend to be less of a—setting up a lot more laws, but there has got to be some sort of assurances. I am sort of more—the fewer laws, the better, the happier I am. But I do think there has got to be a balance. Somebody has got to put in some criteria for balance.

Mr. EDWARDS. Thank you.

Mr. BILIRAKIS. Thank you, Chet. Are you done?

Mr. EDWARDS. Yes, unless Ms. Smith or Mr. Jasmine wanted—I did not want to cut them off. If you wanted to comment or agree with the comments made, you can.

Ms. SMITH. I want to say that I agree with that. I think there has to be some mandate to maintain the specialty centers or the specialty programs that are particularly, have been developed, for the veterans.

Mr. EDWARDS. Thank you.

Mr. JASMINE. I have been in the VA system for a little over 10 years as a social worker; and I can relate to many of the issues that my colleagues to the left here address, but I do feel that primary care as well as specialty care should be in here somewhere because oftentimes VAs are in facilities where—again, I heard just prior to us coming up, they have got—a gentleman was talking about the length of time that a veteran has to travel to receive services.

Oftentimes, I mean, this whole process is to look at improving care. Rather than sending someone across the state to receive services, then it would be nice to have that service right there; and then the VA can specialize in those various areas. How it is done, I leave that up to the physicians and the administrators; but I can relate to that, being a social worker and in the system for a long time and having to develop transportation resources so that veterans can get to one place to another and oftentimes the places are so far apart, the veteran would have to spend the night in order to get the services. So I am in agreement in that and with that.

Mr. EDWARDS. Thank you. Thank you, Mr. Chairman.

Mr. HUTCHINSON (presiding). Thank you, Chet. Mike has left, but I wanted to thank him for sitting in for me; and I want to thank the panel. Now, I did not get to hear your testimony, but I have surveyed each of your testimony a little bit and scanned it and appreciate the lines of questions that Chet and Mr. Bilirakis had as well.

I think some of the debate, that I have been hearing about how prescriptive the Federal role should be and how many mandates we should have in association with the reorganization really parallel the debate I think the Congress has gone through in giving more authority to the States because we time and time again ran into the concern that if you give too much authority locally, well, it is

not going to be used correctly and how much should we prescribe from Washington. I think I would agree with Dr. Spagnolo that in general, I trust them more than I trust us in making the right decisions.

Dr. SPAGNOLO. I am glad you said that.

Mr. HUTCHINSON. But there are some legitimate concerns; certainly in the area of specialized services and the overall impact of the reorganization.

Dr. Spagnolo, one—when Dr. Kizer testified, I cited for him part of the *Vision for Change* in which in defining integrated health care systems, it states that it requires management of total cost to focus on populations rather than individuals. I think that I have discerned that that is one of your concerns, that there might be a shift away from the individual toward the focus on populations.

When I asked Dr. Kizer about that, basically he said that he thought you could have a management of expenditures and costs and a reduction in overall spending or control of spending, at least, and at the same time improve the quality of the health care for the individual veteran. I am interested in your evaluation of that.

Dr. SPAGNOLO. I do not disagree with that as a principal. I think there sure are places where we can save money and improve services, but I get a little bit concerned about the total management approach from some of the organizations in the private sector.

I am always completely assured that their focus is on quality of care. And I think everybody in this room knows what quality of care is. That is very hard to define. But I think when you see it, you know it. I am not sure that seeing a patient, one patient every 8 minutes is really quality of care. That may be efficient delivery of a service, but I am not sure that is quality of care. That is what I am concerned. I have spoken with Dr. Kizer about this, and he is certainly concerned that we have to be careful about that arena.

Mr. HUTCHINSON. Do you see the reorganization that he has proposed as exacerbating that risk?

Dr. SPAGNOLO. I think it is going to make that one of our major concerns that we have really got to not lose sight of. I think it would exacerbate that risk, but I think if it is done—again, I keep coming back to the partnership. Let us talk to the people that are in the trenches and have them have some input into this.

Mr. HUTCHINSON. Okay. Dr. Winship, if you could, in a sentence, tell us the one great risk or the one great concern that you might have regarding the impact that the reorganization would have upon VA's relationship with medical schools.

Dr. WINSHIP. The one great concern I have is inadvertent dissolution of some very important and complex ties between academic medical centers, medical schools, and VA medical centers.

Mr. HUTCHINSON. Okay.

Dr. WINSHIP. We do not want that to happen.

Mr. HUTCHINSON. Okay. Now I would like—and with this, I am going to end my questioning—but I would like to start with Mr. Jasmine, and if each one of you would give me your evaluation of whether the reorganization plan in general—I know each one of you have specific concerns and you have expressed them in your testimony—but in general, whether it will benefit and help the VA

system, hurt the VA system in general, or whether it is just another reorganization and a reshuffling of the cards again.

We will just kind of go through and let you answer.

Mr. JASMINE. I hope it just is not a reorganization and shuffling, but I——

Mr. HUTCHINSON. In the Arkansas legislature, that happened all the time. We would reorganize and nothing different would happen.

[Laughter.]

Mr. JASMINE. I think overall that it would help the VA system. As I stated throughout my statement, the major concern that I have is that partnership stay intact, that partnership and the philosophy of partnership not be lost in the reorganization. And what is key to partnership is those directors at those individual sites having the ability and the autonomy to deal with those and deal with managing the human—management resources area and the budgetary.

I think without the director having those kinds of authority, that it can affect the overall operation of the reorganization as well as affect the effectiveness of partnerships. Partnerships is one of the key elements, I think, that can make this reorganization more functional.

To answer your question: Yes, I do think that overall it is good for VA.

Mr. HUTCHINSON. Thank you. Ms. Smith?

Ms. SMITH. I have been around a long time; and I know when we moved from 28 districts to four regions, and now it is back to the 22 VISNs, I think that what is different about this organization or reorganization is that there is a business component to it. I think that is a very important element. As we had talked about before, I also believe that there has to be professional nursing and physician input to make sure that this remains patient-centered, veteran-centered. But I think it is a good plan.

Mr. HUTCHINSON. Thank you.

Dr. SPAGNOLO. I am going to give you a 50/50 analysis. I think, unless there are some major changes in the way it is structured, it may not succeed. We may just be reshuffling chairs.

Mr. HUTCHINSON. All right. Dr. Winship?

Dr. WINSHIP. I believe very strongly that this reorganization plan will be positive for the VA, and I believe that it stands the best chance of any of those reorganization plans which I have seen over the last couple of decades to, in fact, be more than just rearranging the deck chairs on the Titanic.

[Laughter.]

Mr. HUTCHINSON. Three out of four. We did pretty good there.

I appreciate your candor, really. I think I can, with confidence assure you that reorganization moving forward will not in any way prohibit or prevent or preclude what this Congress will do on eligibility reform and that eligibility reform will be addressed forthwith.

Thank you very much. Mr. Bishop from Georgia, you are recognized.

Mr. BISHOP. Thank you very much, Mr. Chairman. I appreciate all of your testimony. I had to step out for a moment and did not hear Mr. Jasmine. But I was particularly interested in Dr. Spagnolo when you talked about quality of care. I think that is

what we are all basically concerned about. How do we deliver the best quality of service to our veterans through the veterans' health system with the proposed reorganization and the decentralization? You recommend very strongly the specialty care centers and that there be an emphasis placed on that? Would that then be compatible with providing vouchers or providing the primary care in the locales or the residents of the veterans?

Dr. SPAGNOLO. Yes, I think so.

Mr. BISHOP. If they are not close to a VA hospital, or if they are close to a VA hospital, that the VA hospital shift their focus to specialty care and really emphasize that and then let the primary care be done pretty much close to home? Then they only have to go away from home with it is really, really, really called for?

Dr. SPAGNOLO. I agree. I see no problem with that.

Mr. BISHOP. Economically, do you feel that that would be a better use of the VA resources as opposed to competing on the primary care as well as the specialty care levels within the health care system?

Dr. SPAGNOLO. I think you might look at that as a way of saving some costs.

Mr. BISHOP. I would like to hear the reaction to that from Dr. Winship because you have a particular aspect of academic medicine and the relationship between the academic as opposed to research in the VA, but also the nurses and the social work perspective. I would like to hear the reaction to all of that from all four of you.

Dr. WINSHIP. Shall I start?

Mr. BISHOP. Yes.

Dr. WINSHIP. You know the VA has had a mechanism for doing what amounts to vouchering for quite a long time. It really has a fair amount of flexibility and has for years in terms of being able to provide care locally, where VA care was not available, or to develop sharing agreements or contractual arrangements where they were important. I think, to that extent, what I see in this plan will help that and will help the success of the plan. So I do not see any real conflict.

I think the conflict comes as one says: Well, we will simply do away with the system, and we will not voucher out all of this care to all the veterans. I think that is fraught with a lot of difficulty. But to work out an arrangement that would be, I think, cost effective, but first of high quality, is certainly something that needs to be looked at.

Now, whether it would be more cost effective to do that—if that is the question—that simply has to yield to analysis of the specific situation, the specific locale, and so forth. One of the things that is happening in academic health centers, as well as in VA, is this move toward primary care and delivery of more care in that fashion, rather than just being bastions of tertiary care and specialization and superspecialization. The VA is heading in that direction; we are all heading in that direction.

I think we can do that together; and the future holds for us to be not only delivering more care out there in the community than in the hospital-based program, but to delivering our educational product out there as well, and doing our research there. I think the future holds all that and we can do that collectively together.

Ms. SMITH. I believe that you have to have primary care. I am a primary care provider, and I work in research But you have to have the two working together. If you separate them, you are going to run into a lot of difficulty getting care for the person with the specialty program. At our place, we have a blind rehab. And if those patients become ill or whatever, they are not followed regularly, they are going to end up in the hospital. Even when they are in the specialty program, there has to be an outpatient component to see them.

At the VA—at our VA, we have divided our primary care component into teams where there are physicians, nurses, practitioners, clerks, into different teams; and every patient is assigned a team. This team—this patient then has a primary provider, but should that primary provider not be available, there is somebody else who can see him and will know his problem.

Also, if they have a problem and their medications have run out, in the past, they used to come through a walk-in clinic, long, long lines, long waiting time. Now, they just call their team; and those prescriptions are taken care of. They do not even have to come in. This has really cut down on waiting lines.

We need to look at these sorts of programs and evaluate them and use this material. Primary care and specialty go hand in hand. To separate them would be doing, I think, a disservice to the veteran. It would be fragmenting their care.

Mr. BISHOP. Mr. Jasmine?

Mr. JASMINE. And so, but being a social worker, I am right in the middle. And you are looking at the problems that if yo try to separate primary care from special care—I just see that that work can go hand in hand. And I kind of agree with the Members here.

Dr. SPAGNOLO. If I might just add from maybe the last 2 seconds, the shift toward primary care, though, does not necessarily require total reorganization of the VA. And the shift toward primary care means a lot of different things to a lot of different people. We are going to be training many physicians over the next few years, and I am sure you would agree to deliver things as internists and primary care doctors they were never trained to do before, that is going to take a long time to get that effect. The kinds of changes that you are suggesting are occurring already. That is a better way of organizing the outpatient and providing services. But again, that really does not require total reorganization of the VA. Any individual VA hospital could have done this 10 years ago. But we still do not want to lose sight of the fact of having the people that are providing the care involved in how we make those decisions, bottom line.

Mr. HUTCHINSON. Thank you, Mr. Bishop.

Do any other Members have questions of the panel?

Well, then I will thank you very much for your testimony and your time this morning.

Mr. HUTCHINSON. And if Panel No. 4 would please come up.

And I would ask of the committee unanimous consent that the statements of the American Legion and the Vietnam Veterans of America be included in the record.

Without objection. So ordered.

[The statement of Vietnam Veterans of America appears on p. 109.]

[The statement of The American Legion appears on p. 104.]

Mr. HUTCHINSON. Panel 4 is David Gorman, Deputy National Legislative Director of the Disabled American Veterans; Terry Grandison, Associate Legislative Director, Paralyzed Veterans of America.

Thank you for your patience in waiting around until Panel 4. We appreciate your willingness to be a part of the hearing here today. Mr. Gorman, we will let you go first. You are recognized.

STATEMENT OF DAVID GORMAN, DEPUTY DIRECTOR, DISABLED AMERICAN VETERANS; ACCOMPANIED BY TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF DAVID GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. I am going to try to be very brief. Let me say at the outset, though, that the DAV supports the concept and the framework that has been embodied in Dr. Kizer's plan in his *Vision for Change*. I think what I would like to do—we recognize that as this is the transition, hopefully implementation——

[Sound system interference.]

Mr. HUTCHINSON. This is an unscheduled witness.

[Laughter.]

Mr. GORMAN. That concludes my testimony, Mr. Chairman.

[Laughter.]

Mr. GORMAN. But, seriously, I think that as hopefully the VA is allowed to move into this transition, this change in the way that they deliver health care and they manage their health care delivery system, many issues that have been thought of already—and I am sure dozens, if not hundreds that have not been thought of already are going to crop up. And they are going be addressed in a way that is professional in nature by the cadre of dedicated and talented VA employees.

If I could, Mr. Chairman, let me—I would like to digress from my written statement and simply try to address some of the issues and concerns that we have heard this morning. Although there have been a number of them, I would like to concentrate on just a couple.

I would think first that from reviewing the plan and hearing Dr. Kizer and having been briefed on it and being somewhat involved, that it is not really just another reshuffling of the charts on a piece of paper nor the chairs on a ship. Rather, it is really, as Dr. Winship alluded to, it is really the first meaningful effort that has been made, I think, that has a chance of succeeding and putting the VA on a track toward being able to provide care on a contemporary basis.

I think there is a statement in the plan that sums up the way that this is proposed real well. And that is to think globally and act locally. I think act globally can be done from VA Central Office or Headquarters, as they would like to call it in the future, to manage their system. But I think, also, that even within each VISN the

global aspect of delivering health care is necessary. And it is going to be there. And the local flexibility that is going to be delivered to the individual medical centers and facilities is going to be so very crucial to it, toward delivering that care.

The special programs, we have been involved for a long time. The DAV has, for one; and I know PVA has been involved for an awful long time on this issue. I want to take issue with one thing that Dr. Kizer said. And that is that the people who have complained or voiced concern about the special programs have not really met with any of the service directors. That may be true. I can say categorically that as far as we are concerned, that is not true.

Going back to 1984 when a reorganization of prosthetics and prosthetics sensory aid was initiated, we were involved, as was PVA, very actively. In the late '80s we were involved in a transition of that reorganization in an intimate way with the VA. They brought us into the picture. In June of 1990, your counterpart on the Senate side conducted a hearing that was very fruitful; and it really changed the way the prosthetics services were delivered.

And even today, the DAV, the PVA and the Blinded Veterans Association are actively involved on an advisory committee, not only for guiding prosthetics, but also other special disabilities. I think the concern that has been thrown up about these special programs has really been a—if I could call them—bad apples within the system have taken and really robbed, if you will, prosthetic funds that were meant for that purpose and done other things with them.

That has caused a lot of fury, as is should have. And it caused really the situation that we are in today where the VA has to do the things they do to sort of fence and protect these funds. It would be our hope, at least from the DAV's perspective, that the plan, the VISNs, to move forward would alleviate that. It would be out of the performance measurements and part of the input that Dr. Kizer foresees coming out of his management councils or advisory councils at each VISN would have an eye on that. And it would not be done. It is not in the best interest of, certainly, the veterans, nor the VA for that kind of thing to happen.

We are somewhat confident that with a careful eye, that that is going to be taken care of. The issue of access that Mr. Bishop and others have referred to, if you cannot—if you have got the best facility in the world with the best providers, it does no good if you cannot get to them. I think this plan addresses that in a meaningful way by setting out parameters where VA can expand into the community and can have points of access in the community where veterans can come to. Maybe not for all of their care, but certainly as a point of access, they might be able to be taken care of in that center. And if not, they can be referred as a built in patient base in a medical center.

The issue of vouchers, I will not pretend to speak for the other organizations, but I can say that—safely—the issue of mainstreaming I think this voucher discussion may evolve into has been one that has been around for a long time. It really started in some depth back when Dr. Kussis was Chief Medical Director in the early 1980s. It was opposed by virtually everybody. It is not a good idea. The VA is too good a system and has too many dedicated people within it. It provides good quality care to veterans, and it

is a national asset. Any talk or discussion or thought of doing away with that as a system would meet from all the energy that our organization could muster.

However, having said that, there are opportunities to provide not vouchers but fee basis, which VA is into now, and contractual medical care in the community where veterans cannot access the VA, both from an issue and a standpoint of access of the system if they are too far away from a medical center and when VA cannot provide the care because they do not have the expertise of the specialties.

I would—I think, Mr. Chairman, with that, I would wrap my testimony up and say again that it is—I think I should also recognize that a lot has been said—before I conclude this morning—about eligibility reform. Can you put one before the other? And I think perhaps this kind of an effort that Dr. Kizer and VHA is putting forward now is one that should not wait. It can be done. I do not think it can be done independent of eligibility reform totally. Eligibility reform remains in our minds and our views the most critical, crucial issue facing VA today and has been for some time. The organizations have put together a—which I am sure you have all seen and have laying around—this red booklet Partnership for VA Health Care Reform, put together by 10 of the service organizations. The Independent Budget, which has been released and is on the Hill; and you all should have a copy of it and hopefully you have looked at it as far as the medical care aspect talks about what needs to be done.

There is a plan out there. If that is done, I think it can not only improve care to veterans, it can make the lives of VA much easier. I do not think the VA eligibility clerks could be any more confused in the future than they are right now as far as veterans eligibility for care. And that sometimes drives veterans away from the system.

So there are a lot of things that can happen, a lot of things that are happening. This is one very first bona fide effort to step forward and make the system better than it is today, better for veterans, better for VA, and certainly better for the American taxpayer.

With that, Mr. Chairman, I will conclude. Thank you.

[The prepared statement of Mr. Gorman appears on p. 93.]

Mr. HUTCHINSON. Mr. Grandison, you are recognized.

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Thank you. Good morning, Mr. Chairman, and members of the subcommittee. On behalf of the Paralyzed Veterans of America, we appreciate this opportunity to express our views regarding the Veterans Health Administration reorganizational proposal.

Mr. Chairman, while PVA supports this effort by the VA to streamline its management structure and enhance the efficiency of the veterans' health care system, it is important that we do not lose sight of the VA's primary health care mission. The VA has historically focused on addressing those medical requirements of veterans which are related to their military service. For PVA's members, those services have been provided by the VA system for spinal cord injury and dysfunction care. For other veterans, the VA has

created unique programs focusing on the health care requirements of amputation, PTSD, and long-term mental health services.

As the VA's restructuring is assessed, it is extremely important that these core, specialized services are given special consideration. It is essential that these specialized services are recognized as being the cornerstone of the VA's health care mission. PVA believes the VHA's reorganizational proposal is one of many steps that must be taken to carry the VHA into a new and vital future. PVA is also cognizant of the fact that a missed step along the way could have disastrous implications for disabled veterans.

VA needs to clearly demonstrate that it has the commitment and capabilities to adjust to the change in health care environment. In particular, special care must be taken to nurture and protect those services developed to meet the unique needs of the veterans with spinal cord dysfunction and other veterans requiring VA's specialized services. VA's spinal cord injury and dysfunction care system affords veterans access to a complex comprehensive mix of health care services not readily available in the private sector.

Providing all aspects of necessary medical and rehabilitative services, the VA incorporates acute, sustaining, and long-term services of veterans who experience spinal cord dysfunction. The VA's SCI system brings together a range of medical specialties necessary to address the lifetime requirements of veterans with spinal cord dysfunction.

Mr. Chairman, if the VHA is to preserve the unique quality and integrity of spinal cord dysfunction medicine as well as other specialized programs, then VHA must outline in greater detail the management structure that will ensure system-wide integrity in the context of a decentralized administration. To ensure this end, PVA recommends an organization that would do the following: One, protect the resources essential to sustain strong, specialized service programs; two, develop clinical practice guidelines for specialized programs such as spinal cord dysfunction medicine and develop standards of care; three, monitor performance and quality; four, enforce the coordination of funding, policy, standards, and quality assessment to ensure dependable access and high quality care for veterans within the service network.

While the need for structural change is acute, the cure for VA's long-term success and viability will depend on the following initiatives: eligibility reform, maintenance of VA's core mission of providing specialized services, guaranteed funding for the provision of care—provision of health care services, and retention of non-appropriated funds. These changes will provide the VA health care system with the instruments it needs to provide efficient and quality health care to our Nation's veterans.

Mr. Chairman, PVA will support the reorganization of VHA. We will assist in the process in any way we can to ensure the quality of VHA's program for spinal cord injury and dysfunction, so vital to our members well-being and sustainment. PVA will also insist on excellence in other specialized services for blinded veterans; veterans in need of prosthetics; for those in need of special mental health services, such as PTSD. Like us, these veterans depend on VHA for services that cannot be matched by for-profit providers.

Mr. Chairman, that concludes my testimony. Thank you.

[The prepared statement of Mr. Grandison appears on p. 96.]

Mr. HUTCHINSON. Thank you, Mr. Grandison, we appreciate that. And we certainly appreciate the contribution of both of your fine organizations and look forward to working with you on the issue of eligibility reform as we see reorganization implemented.

Now, one of the recurring concerns that we have heard is the issue of specialized services and whether under reorganization there could be any erosion of resources and support for those specialized services. And I understand that is of particular concern to your organization.

Mr. Gorman, if I understood you correctly, you felt that there is no need for Congressional action or statutory language to protect those resources, that you will have adequate input as the reorganization is implemented to ensure that. And, Mr. Grandison, I am not sure—I want both of you to comment on this in just a moment—I know you emphasized that in reorganization there should be a protection of resources. Do you feel that you will have input in the implementation of the plan sufficient to ensure that kind of protection, or does Congress need to do anything?

And let me stop—or start with Mr. Gorman, and let both of you comment on that.

Mr. GORMAN. I would be hopeful that Congressional action is not necessary. I would not—I do not think that we would recommend that right now that you all of a sudden take a large chunk of funds for the special programs that have been identified and say you set those aside and fence those. I think in a lot of ways that may restrict the flexibility that is needed to manage health care in general.

However, having said that, the issue of specialized services, as I tried to say, has always been near and dear to us. I am a user of specialized services, as is Terry, and a lot of members of our organizations. If they are somehow, because it is a nonprofitable cohort of veterans to treat—if all of a sudden a VISN director or a medical center director says I can better use these funds over here and not use them for their intended purpose or not use them to take care of the veterans that actually need them, then we have got a problem.

I think our focus now is that I think we have to go into this with two premises: one, a good-faith effort on the part of the VA to do the right thing; and two, to keep an eye on the process. And I think that we have been doing that through a variety of ways, particularly the Prosthetics and Special Disabilities Advisory Committee that the VA has established.

And I think that your role is so very crucial and so very important—and has been over the years—to keep a look on and an eye on these various programs and see what has been happening to them. But without any evidence—and I think you need to strengthen and really drive home continuously that these things are the very essence and the fabric of why VA was created many, many years ago to take care of the war wounded and their rehabilitation. And these kinds of special programs and services are very crucial to that. We can never lose sight of it.

Mr. HUTCHINSON. Thank you.

Mr. GRANDISON. Mr. Chairman, I guess I would address this question by first looking at Title 38 in regards to spinal cord dysfunction medicine. Title 30 makes no substantive provisions for protection and for the on-going future of spinal cord dysfunction medicine. In the context of a VISN scenario, as Mr. Gorman stated, spinal cord dysfunction medicine as well as other specialized programs will be especially vulnerable to budget and program manipulations. Without statutory protection, there is no way that PVA can be assured that there will be a viable future for spinal cord dysfunction medicine. I will give an example to illustrate: Five SCI beds were recently closed at the West Roxbury VA. These closures were done at the regional office level. These beds were closed without PVA's consultation, and there is no statutory obligation to come before Congress with plans to close SCI beds. So we are very concerned about that, and so we are looking for some assurances. We would also like to thank Mr. Edwards for introducing his legislation, which does make greater protections for specialized programs. We would like to thank him for including that language in his Bill. And we would like the opportunity to work with you to make it even stronger. Although good-faith promises and good-faith efforts are all well and good; but when it comes down to the actual dollars and cents and making tough decisions, our membership cannot afford to just wait and rely on that. We need more than that. Because, again, our members' future medical care depend substantially on SCI medicine's viability.

Mr. HUTCHINSON. I think Dr. Kizer's point was that it would be very short sighted and counterproductive for local directors to divert funds because that is the strength of the VHA. This is one of the unique services and that that in itself would be a strong disincentive for them to diminish the role of the specialized services. I would think also that your organization, if you have adequate input during the implementation stage, that for us to act now might really be counter to the whole goal of decentralizing.

Mr. GRANDISON. I agree in context with Dr. Kizer's statement. Yes, it would be counterproductive to the system. It would basically compromise the whole VA health care system, in that regard. But, again, there must be assurances because, spinal cord dysfunction medicine is a high cost and labor-intensive program. A VISN director faced with making certain budgetary decisions may view spinal cord dysfunction medicine as a ripe target for reduction in program services. This is a chance that PVA and other disabled veterans should not have to face. And as I said earlier, in Title 38 there are no substantive protections that Title, to protect spinal cord dysfunction medicine. We need strong legislative language in line with Mr. Edwards' legislation.

Mr. HUTCHINSON. Okay. Thank you.

Mr. GORMAN. If I could, Mr. Chairman, just one other comment. It is sort of on the other side of the coin. I think, too, that it is very important that when you have these kinds of specialized programs like spinal cord injury service, for example, and probably the best example, you have to have that concurrent with an ongoing viable acute care program. You cannot have the two isolated from each other. So it is okay to get a real strong assurance that they are going to have and SCI center. But on the other hand, when they

take away the acute care capabilities, it does you very little good to have the SCI. So I think there is a whole, integrated piece of the puzzle that you have to have here. I think that is a big part of it.

Mr. GRANDISON. And I certainly agree with that. They are integral to each other.

Mr. HUTCHINSON. Thank you.

Mr. EDWARDS. Thank you, Mr. Chairman. I will be very brief. And I apologize for leaving. The Texas delegation is having a photograph taken at 11:45, and I do not want to hold up the entire delegation. This is certainly far more important substantively.

I just will be brief in my comments in saying that I hope you will do two things. One is as this reorganization is put in place, I hope you will pay special attention to whether there is a good enough information system in place so that we will know if specialized care—and we will know quickly—if specialized care is being compromised. I think you are right to be concerned when managers are faced with limited, finite resources. And the kind of constituencies you represent, the veterans you represent are very high-cost care recipients in many cases. And it will be tempting for a manager, not out of ill will, but out of pragmatic decision making to just slowly erode those specialized services. So the first thing we have got to be sure of is that there is an adequate, timely information flow. And I hope you will take a look at that.

Secondly, we are just beginning this process. But I know that the Chairman, Chairman Hutchinson, is pushing very quickly to have eligibility reform on the front plate, front burner, and in high gear with this committee. He is putting together legislation now, and I am going to be supportive of his legislation, work with him. My Bill is kind of a first step. And let us get the debate on the table. But as we work together on a bipartisan basis with him and Mr. Stump, I hope you will work with us and help us put language in that eligibility reform bill that does protect specialized care. I think if we do not have some direct protections over time, not through ill will but just local management decisions, we are going to see the specialized care erode. And I think that would be a real tragedy. And I think that would be a first step toward eventually losing the unique role of the VA health care system. So please work with the Chairman and me on that. We look forward to working with you.

Thank you, Mr. Chairman. And I apologize for walking out before the end of the hearing.

Mr. HUTCHINSON. Not at all. Thank you, Chet.

Did you want to make any comment on Mr. Edwards' statement?

Mr. GRANDISON. Well, PVA would definitely look forward to working with Mr. Edwards and you, Mr. Chairman, to effectuate a viable change in the health care system. We look forward to it.

Mr. GORMAN. I think that the effort that was put forth last year in trying to get this committee reporting on a bill that was—that treated VA and veterans so very, very well in the area of eligibility reform and how services would be delivered, I think hopefully that effort is going to carry over and we can all work together toward that common goal which I think we all recognize and share. I look forward to it.

Mr. HUTCHINSON. Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman.

Let me say how much I appreciate Mr. Gorman and Mr. Grandison's testimony. I was interested. You did comment on the issue that arose earlier regarding the attitude of veterans toward decentralization and having local service and vouchers as opposed to getting treatment, primary care, from the VA facilities. I would like to hear from both you and Mr. Grandison again on that as there is some thought probably outside of this committee in Congress, some of the budget-cutting committees that are more concerned with trying to streamline the services, the health care services, that veterans are getting. And they would like to perhaps see a voucher system which would ultimately either eliminate, greatly reduce, the primary care that is being provided by the VA system and make the VA compete with other health care providers. And the survival of the fittest is sort of the attitude out there. But it seems to me that my concern from the veterans that I represent, many of whom do not have access, they have distance problems in getting primary care as well as specialized care, assuming that we hold onto the primary care in veterans hospitals where they exist. But in the areas where veterans do not have access, do you feel that this decentralization would be aided by the use of vouchers and contracting of services in local communities with other health care providers to serve the needs of veterans in their communities so that they do not have to endure tremendous travel burdens that many have to endure now?

Mr. GRANDISON. Mr. Bishop, in regard to spinal cord dysfunction medicine, it poses a very delicate question because spinal cord dysfunction medicine cannot operate efficiently without the backup of primary care, tertiary care system. Spinal cord dysfunction medicine's lifeblood and viability is predicated on that backup. So in that view, we cannot see how veterans with spinal cord dysfunction can get consistent medical care, the close nexus between VA's tertiary care system spinal cord dysfunction centers must continue.

Also, even if vouchers were to be used, particularly in the case of spinal cord dysfunction medicine, there would be no way to monitor the performance and the outcomes and quality of care, efficiency, and even access that the veteran with spinal cord dysfunction will receive from one VISN Network to the other. We would find fragmented and compromised, a breakdown in the whole specialized service regarding spinal cord dysfunction medicine. We do not see an operable way for vouchers and specialized programs, such as spinal cord dysfunction, to operate in a harmonious way.

Mr. BISHOP. But I assume that that is not the case with primary care, though, for the veteran that does not have the need of the special, highly specialized, services of spinal cord dysfunction but just the general internal types of things that all of us will eventually need if we continue to live.

Mr. GRANDISON. The veteran who has a spinal cord injury or spinal cord dysfunction, there is no provision within the proposal with how that veteran will receive access to the spinal cord injury center outside his VISN or even within his VISN area, if the distance is very remote. So there has to be some kind of mechanism even within this proposal to provide a referral mechanism to get that spinal

cord dysfunction veteran to that particular spinal cord injury center.

But there is no viable option in the private sector regarding spinal cord dysfunction medicine because there is no private sector facilities that provide the care that VA spinal cord injury centers provide. Again, spinal cord injured veterans are not only dealing with the spinal cord and paralysis, but they also have problems with kidneys; they have problems with the bladder; they have problems with skin ulcers; they have respiratory problems. So our injuries are not necessarily confined or different from a veteran who may have an amputation, but still it is the holistic approach to caring for that veteran and the tertiary backup is needed.

Mr. GORMAN. If the concept in which you talk about a voucher, if I understand it correctly, is to give to a disabled veteran—VA give to a disabled veteran—a piece of paper that entitles that veteran to, say, $1,000 worth of health care in the private sector. If that is the definition that you use to frame your question, then I would say it is not a good idea. Then what you do is you disenfranchise that veteran from the VA system, and the veteran becomes the indemnifier of that care. If that is the case, you might as well do away with the VA and do what Medicare does, just pay for the care.

There are too many good things the VA does to do that. I use the VA system; and quite frankly, I would be very apprehensive, if not scared, to be given a voucher like that to go to the private sector. No one has convinced me, number one, that the VA care is inferior to the private sector. No one has convinced me, on the other hand, that the private sector can take care of my general medical needs and my specific medical needs adequately. And I do not think they can, to be frank with you. I am an amputee, and I have been using the VA for 25 years, and I am satisfied with it. I would not like to go to Dr. Jones cold and present him with my problem. He may be an excellent physician, but I do not think he understands my problem with my knees.

Again, once—sometimes once you let a contractor or low bidder, which perhaps the voucher system would be, and it may be good for the life of that contract, which could be short term, maybe a year. At the end of that year, what happens when that provider comes back to the VA and says: I am going to continue to take care of your veteran, but not at the cost I did last? So you have no control, as Terry says, either with the quality of the care, which is more critical as far as we are concerned, or the management and cost of the care.

In your scenario that we are trying to get to is: When a veteran is so distant from VA and there is no VA identity there in the community, should that veteran have to travel X number of miles to the VA to get care. And the answer, I think is: No, he should not have to or she should not have to. The VA has a very vital ongoing fee-basis program where they do that on a monthly basis. The veteran is allowed, if you will, without question to use X number of dollars to purchase care from a—I am blocking the word I want—from a provider that has already been approved by VA.

If the need is for more care, for more dollars to purchase more care as they need it, that can be approved by the VA on an ongoing

basis. But there is that monitoring system in the process. But I think to simply hand the voucher and the dollars to the veteran does not do the veteran any good. It may, in fact, do the veteran a lot of harm.

Mr. HUTCHINSON. Thank you, Sanford.

I want to thank Mr. Gorman, Mr. Grandison and all of the witnesses today for their contribution to the hearing.

This hearing is adjourned.

[Whereupon, at 11:58 a.m., the subcommittee was adjourned.]

APPENDIX

THE HONORABLE MICHAEL BILIRAKIS
THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

APRIL 6, 1995

THANK YOU, MR. CHAIRMAN.

FIRST, LET ME COMMEND YOU FOR SCHEDULING THIS TIMELY HEARING ON THE VETERANS HEALTH ADMINISTRATION'S REORGANIZATIONAL PROPOSAL, VISION FOR CHANGE. THIS IS AN IMPORTANT ISSUE THAT DESERVES THE SUBCOMMITTEE'S ATTENTION.

I WOULD ALSO LIKE TO WELCOME DR. KIZER AND OUR OTHER WITNESSES TO THE SUBCOMMITTEE. I LOOK FORWARD TO HEARING YOUR TESTIMONY.

IN RECENT YEARS, THERE HAS BEEN A DRAMATIC SHIFT IN THE WAY MEDICINE IS PRACTICED WITH A GREATER EMPHASIS ON OUTPATIENT CARE. IF THE VA IS GOING TO REMAIN A VIABLE HEALTH CARE PROVIDER IN THE FUTURE, IT MUST ADAPT ITS HEALTH CARE SYSTEM TO REFLECT THE NEW REALITIES OF MODERN MEDICINE.

I AM PLEASED THAT THE VA IS MAKING A CONCERTED EFFORT TO IMPROVE THE EFFECTIVENESS OF THE VA HEALTH CARE SYSTEM AND CORRECT ITS CURRENT DEFICIENCIES. THIS PROPOSAL IS A STEP IN THE RIGHT DIRECTION.

I STRONGLY SUPPORT EFFORTS TO STREAMLINE GOVERNMENT PROGRAMS TO MAKE THEM MORE EFFICIENT AND COST-EFFECTIVE. HOWEVER, AS WE IMPLEMENT THESE REFORMS, WE MUST MAKE SURE OUR EFFORTS ARE IN THE BEST INTEREST OF THE INDIVIDUALS THESE PROGRAMS ARE MEANT TO SERVE.

I AM CONCERNED ABOUT THE IMPACT THE REORGANIZATIONAL PLAN WILL HAVE ON THE VA'S SPECIALIZED SERVICES SUCH AS SPINAL CORD INJURY MEDICINE, LONG-TERM CARE SERVICES, READJUSTMENT COUNSELING, ENVIRONMENTAL MEDICINE, REHABILITATION AND PROSTHETICS.

MANY OF THESE SPECIALIZED MEDICAL PROGRAMS ARE UNIQUE TO THE VA SYSTEM. CONSEQUENTLY, THE VA HAS DEVELOPED NATIONALLY-RECOGNIZED EXPERTISE IN SEVERAL OF THESE AREAS. IN MANY INSTANCES, IT IS DIFFICULT TO FIND COMPARISONS OR EVEN A SIMILAR LEVEL OF SERVICE IN THE PRIVATE SECTOR.

THEREFORE, SPECIAL CARE MUST BE TAKEN TO ENSURE THAT THOSE SERVICES DEVELOPED TO MEET THE UNIQUE NEEDS OF VETERANS ARE ADEQUATELY MAINTAINED IN ANY RESTRUCTURING OF THE VETERANS HEALTH ADMINISTRATION. I HOPE DR. KIZER WILL ADDRESS MY CONCERNS DURING HIS TESTIMONY.

AGAIN, I LOOK FORWARD TO HEARING THE TESTIMONY OF OUR WITNESSES. THE VA'S REORGANIZATIONAL PROPOSAL IS JUST ONE STEP IN THE REFORM PROCESS AND I AM EAGER TO LEARN OF ANY OTHER RECOMMENDATIONS THEY MAY HAVE ON WAYS TO IMPROVE THE VETERANS HEALTH CARE SYSTEM.

AS ALWAYS, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE ON ANY SUGGESTIONS THE WITNESSES MAY HAVE ON THE ISSUES BEFORE THE SUBCOMMITTEE TODAY.

THANK YOU, MR. CHAIRMAN.

Opening Statement
Rep. Luis V. Gutierrez
Subcommittee on Hospitals and Health Care
April 6, 1995

Mr. Chairman, thank you for calling today's hearing.

When we organized the Veterans' Committee at the beginning of the 104th Congress, we were surprised to find that a few subcommittees were suddenly gone.

One of those was the Oversight & Investigations Subcommittee which, under Chairman Lane Evans, played a valuable role in insuring that Congress took an active role in the VA programs in which we are all interested.

I was pleased to serve on that subcommittee, and I hope that some of the work that it performed will be addressed by other panels.

I was also pleased to serve on the Hospitals & Health Care subcommittee in the previous Congress, and was relieved to see that it, at least, was spared in the transition.

By serving on this subcommittee again, I feel fortunate that I am able to work on issues that are somewhat familiar to me. More importantly, I look forward to working on issues which I know are crucial to the day-to-day lives of constituents in every district throughout the country.

We find ourselves in an environment in Washington that is changing quite rapidly-- maybe too rapidly. Therefore, I think it's appropriate that we are dealing today with another important institution that seems to be on the verge of change: the VA's health care system.

I, for one, hope that the changes that the VA makes are little bit more appealing-- from my point of view-- than some of the changes I have seen take place here in Congress lately.

And just as I have found a way to voice my opposition, whenever necessary, to the changes that I have seen proposed in this new Congress, rest assured-- or be forewarned-- that if I see something that strikes me as slightly irregular or unwarranted in these upcoming changes at the VA, I'll raise similar objections.

That's not a prejudice against change. It's not a distrust of the VA.

It's simply the role that I think I was sent here to play on behalf of my constituents. They want change not for the sake of change, but for the sake of veterans who depend on the VA for their health care.

So, Mr. Chairman, and ranking member Chet Edwards, I look forward to today's hearing, and to working with you in a constructive manner to eventually make the changes we need to make, but first to question and examine those proposed changes.

Opening Statement
for
Honorable Chet Edwards
Ranking Member
Subcommittee on Hospitals and Health Care

Hearing on the Reorganization of the Veterans Health Administration

April 6, 1995
Room 334, CHOB

Mr. Chairman, thank you for holding this hearing on VA's proposed reorganization plan. The importance of this hearing is underscored by the title of the VA proposal -- "Vision for Change: A Plan to Restructure the Veterans Health Administration." Those are bold words, which connote more than a mere reorganization.

I salute the broad goals underlying this proposal. Change is certainly needed, and Dr. Kizer's vision and leadership are very, very welcome. At the same time, given the plan's relative lack of specificity, it is critical that we take this opportunity to raise questions

AND HAVE A DIALOGUE WITH THE PLAN'S ARCHITECT AS WELL AS WITH THOSE WHO WILL BE AFFECTED BY IT.

MR. CHAIRMAN, AMONG THE GOALS OF THE PLAN ARE TO DEVELOP A MORE PATIENT-FOCUSED VA THAT WOULD INCREASE ACCESS TO AMBULATORY AND PRIMARY CARE SERVICES. I HEARTILY SUPPORT THAT GOAL. AS SEVERAL WITNESSES NOTED IN THEIR TESTIMONY, HOWEVER, THE VA PLAN DOES NOT INCLUDE A SPECIFIC PROPOSAL TO REVISE ELIGIBILITY CRITERIA AS NEEDED FOR VA TO PROVIDE PRIMARY CARE. DR. KIZER HIMSELF HAS TESTIFIED THAT VA NEEDS "ELIGIBILITY REFORM" LEGISLATION. ALL THE VETERANS ORGANIZATIONS WITH WHOM I'VE SPOKEN THIS YEAR CITE "ELIGIBILITY REFORM" AS THEIR HIGHEST LEGISLATIVE PRIORITY.

WITH THAT IN MIND, MR. MONTGOMERY AND I INTRODUCED A BILL TUESDAY (H.R. 1385) WHICH I BELIEVE WOULD TAKE A GIANT STEP TOWARD ACHIEVING OUR VETERANS' GOALS FOR

REFORMING VA HEALTH CARE ELIGIBILITY. I KNOW THE CHAIRMAN IS MOVING TOWARD THE SAME GOAL. I LOOK FORWARD TO WORKING WITH HIM ON THIS IMPORTANT SUBJECT AND HOPE WE CAN SCHEDULE AN ELIGIBILITY REFORM HEARING IN THE NEAR FUTURE.

AGAIN, I THANK YOU FOR CONVENING THIS HEARING, MR. CHAIRMAN, AND LOOK FORWARD TO OUR WITNESSES' TESTIMONY.

PREPARED STATEMENT OF HON. BOB CLEMENT

Mr. Chairman, thank you for holding this hearing on this very important and encouraging proposal. I want to join you in welcoming Dr. Kizer, the VSO representatives and our other witnesses today.

When Dr. Kizer first arrived, Secretary Brown told us that he was a man of considerable experience and expertise—a man of vision. And now, just a short time later he has made good on the Secretary's word. He has shared with us his vision—his Vision For Change. I want to congratulate Dr. Kizer and his staff for their work.

Vision For Change is a significant move in the right direction. A move many of us have been advocating. This proposal will improve the quality of care, provide greater access to care, enhance current successes and preserve the veterans health care system.

The plan will enable the VHA to make the necessary changes to remain competitive and provide services comparable to those available through private providers and non-governmental facilities.

In short, Vision For Change will allow the VA to continue to deliver the quality health care veterans deserve for years to come.

I am encouraged by this proposal and look forward to hearing from our witnesses.

Statement of
Kenneth W. Kizer M.D., M.P.H.
Under Secretary for Health
Department of Veterans Affairs
to the
Committee on Veterans' Affairs
Subcommittee on Hospitals and Health Care
April 6, 1995

Mr. Chairman and Members of the Subcommittee, I am pleased to have this opportunity to discuss my plan to restructure the Veterans Health Administration (VHA).

As you know, copies of the plan, "Vision for Change," were sent to the Committee on March 17, 1995, in accordance with the requirements of Section 510 of Title 38. That report describes our plan to change the way we provide health care to veterans. In brief, this reorganization is designed to improve the delivery of health care to veterans, improve the quality of this care, increase the efficiency with which we provide it, and establish accountability for outcomes and bottom-line results. I would add that the reorganization plan is also designed to retain or continue those things in the system that are functioning well, as well as to complement our several statutory missions.

Perhaps the first issue I would comment on this morning is "why change VHA?" There are a number of reasons.

As a result of technological advances, economic factors, the rise of managed health care systems, and a variety of other forces, there have been profound changes in recent years in how health care is delivered in this country. There has been a marked shift away from inpatient care and a dramatic rise in ambulatory or outpatient care. For example, the majority of surgery is now performed on an outpatient basis. Likewise, chemotherapy for cancer is now routinely administered on an outpatient basis. Many complex medical conditions previously requiring hospitalization for intravenous antibiotics or other treatment are now routinely treated at home or in outpatient settings. And even more dramatic changes will occur in the years ahead. Indeed, it will not be that many years before the traditional general acute care hospital becomes a large ICU taking care of only the sickest and most complicated of patients. All other medical care will be provided in ambulatory care settings, at home, in hospices, or at various types of extended care facilities.

The VA must adapt to these changing conditions in the larger health care environment.

In addition, several reports on VA health care in recent years have concluded that structural changes are needed in the system. In the aggregate, these reports have consistently found that the VA needs to become more flexible, more customer-focused, more decentralized, and more cost-effective. Our plan to restructure the veterans health care system should accomplish all of these objectives.

Finally, for a variety of complex and interlinked reasons, there has been a fundamental re-analysis of how government functions in recent years. The National Performance Review and other activities are being undertaken to reinvent government to minimize bureaucracy, to reward efficiency and innovation, and to empower employees to make government work better for citizens. Our plan for restructuring the VHA is consistent with these goals.

The foundation for accomplishing these changes in the veterans health care system involves the dissolution of the current hierarchical central office and regional office structure and in its place create a federation of Veterans Integrated Service Networks (VISN) that is supported by a national headquarters. At this time, the plan calls for 22 VISNs, each including from five to eleven medical centers and various other VA assets. VISN boundaries have been established in accordance with existing patient referral patterns; aggregations of patients and facilities needed to support primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state lines.

It is envisioned that the VISN will become the basic budgetary and planning unit for delivering veterans health care. The individual and historically independent VA medical centers will remain important but less central components of larger, more community-based, interlocking networks of care.

As an integrated system of care, the new VISN structure will emphasize the pooling of resources, outpatient and primary care, partnerships and customer service. A premium will be placed on improved patient services, rigorous cost management, process improvement and outcomes. Emphasis will be placed on the integration of ambulatory care and acute and extended inpatient services to provide a coordinated continuum of care. Redundant administrative structures and processes will be eliminated. Each layer or process in the new organization will be expected to add value to the delivery of services.

Each VISN director will be assisted by a small staff of professional, technical, and support personnel, the number varying with the size and complexity of the individual network. While the

specific numbers and types of employees will be left to the discretion of the director, each VISN management will be expected to include expertise in medical management, finance and budgeting, and planning. Medical management and operations management will be expected to work hand-in-hand to provide "best value" care.

Other areas of expertise may be needed in a VISN from time to time that would not warrant a full-time staff member or collateral assignment. It is expected that the VISN director will draw such expertise on an ad hoc basis from individual facilities within the network, from headquarters, or from the Support Service Centers.

Two other important components of the field reorganization also warrant comment. The first is the Support Service Centers (SSCs). During the transition from where we are now to the new organization, the SSCs will preserve the expertise available in the existing four regional offices in areas such as construction management, finance, planning, and quality assurance. They will ensure continuity of operations while the regions dissolve and the VISNs become operational.

Once the VISNs are fully operational and their support needs more clearly delineated, recognizing the concomitant decentralization that will take place, the SSCs will provide support services as required. We expect they will serve primarily as roll-up, data collection, and technical support centers providing needed information for both the networks and VHA headquarters.

The second structure I would mention is the Management Assistance Councils (MACs), which are conceived to be formal structures to ensure input from VHA's internal and external stakeholders. The MACs will be composed of facility directors, chiefs of staff, nurse executives, union representatives and others from within each VISN. Likewise, MACs will contain external representatives from veterans service organizations, state and local government, academic affiliates, and private sector health care entities, all of whom will serve as consultants to the council. Each council, working in close concert with its external consultants, would formulate plans and recommendations to the VISN director. It is intended that these MACs will ensure that the needs of the patients, the community, and others are incorporated into the decision-making process.

Let me conclude my comments on the field reorganization with some comments on how we will achieve accountability in the more decentralized VHA system that this reorganization will create.

Concern about accountability led us to devote an entire chapter of our plan to performance measurement and systems monitoring. The cornerstone of the accountability system will be a performance contract between each VISN director and the Under Secretary's office. Each contract will cover three general areas: (1) systemwide needs and tasks that all VISNs will be expected to complete; (2) VISN-specific service delivery and efficiency objectives directed by headquarters; and (3) VISN-specific objectives as developed by VISN management.

The key areas of focus for VHA performance measures will be patient satisfaction, ease of access, quality of care, and efficiency. Performance measures will focus on outcomes, rather than on processes. In order to compare our performance to that of the communities we reside in, we will emphasize performance measures that allow for comparison to national and local private sector measures, as well as comparison with current performance evaluation trends supported by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Performance contracts will also address the support of education and research, as these missions and our academic partnerships have been a major factor in VA's achieving excellence in patient care. The fourth mission, emergency preparedness, also will be included in the performance contract with each VISN director.

In summary, field units and senior managers will be held accountable for measurable improvements to the veterans health care system. The resulting efficiencies should allow VHA to invest in new ways of providing high quality, efficient ambulatory and inpatient care to better meet our veterans' needs and expectations.

Mr. Chairman, in an effort to move as expeditiously as possible we have begun to make preliminary plans for implementing the field reorganization, subject, of course, to compliance with the requirements of Section 510. We are establishing a steering committee to oversee the many activities that will be involved, and we are creating a number of technically oriented work groups that will handle detailed actions such as activation of the VISNs, development of performance measurements and executive performance contracts, employee education, and resource allocation. We understand that the 90 days in session provided to the Congress for review of our plan under Section 510 (unless earlier legislative approval is provided) will be completed in late July or early August of this year, depending upon the recess schedule of the Senate.

Let me conclude this opening statement with just a brief comment on the restructuring of VHA's Central Office.

In order for the field reorganization to be successful, and for the VISNs to be empowered to make appropriate operational decisions, headquarters must change its focus from micro-managing operations to the critical role of governing and leading the overall system. In recognition of the changes in patient care delivery patterns in the field, headquarters must be restructured to better support the new delivery paradigm.

The new headquarters will provide support for specific groups of patients or functions rather than advocacy for specific medical or technical disciplines. Offices will be organized by function or "product line," whenever possible, rather than by discipline. Headquarters must focus much greater attention on achieving systemwide quality improvement and the consistency of quality Headquarters also must focus more on cost management and strategic planning.

To accomplish our headquarters restructuring, I anticipate a three-step process. First, the headquarters staff will be reorganized as outlined in Chapter 3 and Appendix 5 of our report, and as schematically depicted on the chart I have shown here. Next, the staff will identify those operational activities that can be decentralized to the field, and they will make the necessary changes to policy manuals and directives. Third, the new core values and behaviors associated with our "Patients First" philosophy will begin to become institutionalized so that the new VHA headquarters can provide the kind of leadership and direction the field will need in the future.

Importantly, a significant part of this process will be to identify new functions the headquarters should perform that have not been done in the past due to a historically misplaced emphasis on operational business. As I mentioned earlier, among these will be a heightened emphasis on strategic planning, development of "clinical benchmark" guidelines and practices, quality improvement, and systemwide information management.

This concludes my general overview of our plan to restructure the veterans health care system, and I would be pleased to answer any questions that you or the other members of the subcommittee may have.

* * * * *

Statement of William J. Schuler, President and Chief Executive Office, Portsmouth Regional Hospital and Portsmouth Pavilion, Portsmouth, New Hampshire

Mr. Chairman and members of the subcommittee:

My name is William J. Schuler. I have served as a First Lieutenant in the United States Marine Corps and as an infantry platoon leader in Vietnam. I have received a Purple Heart and a Bronze Star for my service. As a veteran, I am pleased to have been asked to appear before this subcommittee.

I am president and chief executive officer of Portsmouth Regional Hospital and Portsmouth Pavilion. As president and CEO, I am responsible for all internal and external services at the 144-bed medical surgical hospital and the 65-bed psychiatric hospital in Portsmouth, New Hampshire, where both facilities are located. We have 900 employees, 125 medical staff members, and a $75 million budget.

Portsmouth Regional Hospital and Portsmouth Pavilion are both owned and operated by Columbia/HCA Healthcare Corporation based in Nashville, Tennessee. Pending a planned merger with another healthcare company, Columbia will own and operate more than 315 acute care and psychiatric hospitals, more than 100 ambulatory surgery centers, and dozens of home health agencies in 35 states and two foreign countries.

In 1994, Columbia employees and facilities provided more than $1 billion in uncompensated and charity care, and the company paid more than $1.2 billion in local, state, and federal taxes.

I am pleased that this subcommittee is seeking information from the private sector as the veterans health system studies reorganization. And, I appreciate being a part of the process. Over the last five years, few economic sectors have changed as much as the private sector healthcare system, and these changes have produced lower medical inflation, and in many instances, better quality.

Columbia has been an agent of the changes sweeping healthcare. The company's strategy is to link networks of commonly-owned healthcare providers to

offer patients and large purchasers of care, such as HMOs, one source for all their healthcare needs.

Another part of Columbia's strategy is to have local management make nearly every key decision regarding the operation of the hospital. This strategy is a reversal from the traditional model used by multifacility hospital systems. Before, many decisions were made at the corporate headquarters. Corporate departments were responsible for capital expenditures, marketing programs, staffing patterns, and many other hospital issues.

Today, most local operating decisions are made by hospital chief executive officers. They are responsible for all personnel decisions, for local marketing programs, for negotiating and signing local contracts, and for establishing and requesting our own level of capital expenditures. I now have almost complete autonomy over the operation of my hospital.

The structure of the corporation is such that the corporate office is now a service entity to the hospitals. And the services that the corporate office provides enable my hospital to be a stronger local competitor. The corporate office negotiates national purchasing contracts with suppliers to reduce significantly the cost of supplies to my hospitals. The corporate office is also responsible for the operation and installation of computer information systems which help track financial data, ease the paper flow burden on hospital employees, and are instrumental in tracking medical outcomes that enable us to measure and improve the quality of care.

Finally, the corporate office is responsible for capital formation, which it does by issuing shares of stock or borrowing in public debt markets.

The company's decision to decentralize was made through careful analysis of changes in the private-sector healthcare system. Cost-pressures, new types of purchasing organizations, and increased demands for quality have made it necessary for decision-making authority to be shifted to the local level. It is easier for a local HMO to negotiate with a local hospital administrator than with a far-away corporate officer. It is more convenient for physicians to work with an administrator who has decision-making authority over capital expenditures and methods for improving

quality. And, it is valuable for my employees and for the people in my town to know that decisions about their hospital and their care are being made by people in their own community.

The decision to decentralize has provided my hospital and community with many benefits. But make no mistake--the decision was based on how best to compete, and survive, in today's healthcare environment. As you may know, hundreds of hospitals have closed over the last five years. More than 10,000 hospital beds were taken out of service in 1994.

There is as much as 20 to 30 percent excess capacity in hospitals throughout the country. Having the ability to move quickly and decisively in a local community is critical to competing and surviving.

In my view, this type of local autonomy is suited also to the Veterans Health System. To be more responsive to patients, physicians, employees and other constituents, VA hospitals should have more local autonomy. As this subcommittee examines the restructuring of the Veterans Health System, I would like to make other recommendations as well.

I believe this is an ideal time for the Veterans Health System to develop contractual relationships with private-sector healthcare providers. This will enable the VA to use the excess capacity in the private sector to provide improved ambulatory access to veterans, especially to elderly and chronic patients with limited ability to travel.

I am pleased to learn of a public/private initiative in Virginia that may offer future alternatives as the VA seeks to restructure and reform itself to better serve both veterans and taxpayers.

Veterans living in rural areas around Clinch Valley, Virginia, now must travel two and a half hours to the nearest Veterans Hospital, which is in Salem, Virginia. Clinch Valley Medical Center, the local hospital, which is owned and operated by Columbia, has excess capacity of 42 percent. The management of the Salem VA Hospital has agreed to contract with Clinch Valley Medical Center to provide certain services to veterans living in the area. This experiment will likely

demonstrate the cost-effectiveness of public/private partnerships in the provision of healthcare to rural areas of declining population.

In this arrangement, the VA will contract with a local internist, nurse and secretary. The hospital will lease an on-campus site to the VA. And the hospital will provide necessary ancillary services such as diagnostic procedures and pharmacy to the clinic for service-disabled veterans.

Once the success of this phase has been established, the local hospital hopes to expand the program to include elective procedures and emergency care for service-connected and non-service connected veterans.

In brief, I believe this arrangement will ensure that area veterans receive consistently high quality care delivered locally and efficiently on a timely basis.

In my opinion, it does not make sense for the Veterans Administration to compete with organizations such as Clinch Valley Medical Center. Clinch Valley pays taxes, provides jobs, and delivers quality care to patients regardless of their ability to pay. It makes sense for them to work together. I know this proposal will come before the appropriate appropriations subcommittee, and I encourage its passage.

By decentralizing the authority of VA centers, local administrators can make decisions like these to contract with regional private hospitals to provide veterans with the care they need in their own communities. It makes sense for the Veterans Administration. It makes sense for private sector hospitals with excess capacity. And, most importantly, it makes sense for veterans.

And speaking as a veteran, and not as a healthcare professional, I would eventually like to choose the hospital I go to when I become ill just as Medicare and Medicaid patients can. I recognize that change this dramatic cannot come quickly, but I encourage you to lay the groundwork for change now.

I believe these hearings can lead to the progress that I and other veterans seek. So, I thank you, Mr. Chairman, for the opportunity to address this subcommittee.

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

on

REORGANIZATION OF THE VETERANS HEALTH ADMINISTRATION

Presented by

Daniel H. Winship, M.D.
Dean
Stritch School of Medicine
Loyola University of Chicago

before the

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
United States House of Representatives
The Honorable Tim Hutchinson, Chairman

334 Cannon House Office Building
Washington, DC
Thursday, April 6, 1995

Good morning, Mr. Chairman and Members of the Subcommittee. I am Daniel H. Winship, M.D., dean of the Stritch School of Medicine at Loyola University of Chicago. I am pleased to present the testimony of the Association of American Medical Colleges as you consider the proposed reorganization of the Veterans Health Administration.

The AAMC represents the 125 accredited United States medical schools; nearly 400 major teaching hospitals, including 74 Department of Veterans Affairs (VA) medical centers; over 90 professional and academic societies; and the nation's medical students and residents. Together, the members of the AAMC work to improve the nation's health through the advancement of academic medicine. I have devoted my professional life to research and academic medicine, having held appointments at a number of institutions represented by the AAMC, including the Marquette School of Medicine in Milwaukee; the University of Missouri School of Medicine in Columbia, where I served as professor and associate chairman of the department of medicine and associate dean for VA affairs; and the University of Kansas School of Medicine in Kansas City, where I was professor of medicine and associate dean for VA affairs.

I believe I bring a unique viewpoint to this table today. In addition to teaching medical students and residents, conducting medical research, and administering a medical school, I have served on the staff of four Veterans Affairs medical centers, including stints as medical service chief and chief of staff at the Harry S Truman Memorial Veterans Hospital in Columbia, Missouri, and an appointment as chief

of staff at the Kansas City VA Medical Center. I was also medical center director at the Kansas City VA in 1986 and 1987, before coming to Washington, where I served as associate deputy chief medical director in charge of programs and operations for medicine and surgery in VA Central Office. In 1990, I left Washington for Chicago and my current position as dean of the Stritch School of Medicine and attending physician at both the Loyola University Medical Center and the Edward Hines, Jr., VA Medical Center.

The Hines VA, you may know, was the first VA medical center to enter into an affiliation arrangement with a school of medicine. From that first affiliation, a long-standing partnership has grown. Before embarking on a discussion of the VA's "Vision for Change," I would like to provide a brief overview of VA's relationship with academic medicine.

In 1919, Congress directed the U.S. Public Health Service to operate hospitals to care specifically for sick and disabled veterans of the First World War. By the end of the Second World War, the Veterans Administration, as it was known at that time, oversaw the provision of medical care to veterans in 97 hospitals across the country. Despite this growth in facilities, the VA medical system lacked adequate medical personnel to meet the health needs of returning veterans.

Paul B. Magnuson, M.D., who chaired the department of orthopaedic surgery at Northwestern University Medical School, was one of the individuals called upon to resolve this dilemma. He found the VA medical system was facing a shortage of physicians caused, in part, by bureaucratic red tape and the bad reputation of VA medicine. Dr. Magnuson suggested that affiliations between medical schools and VA hospitals would solve VA's problems by allowing medical school deans to staff VA hospitals with top-notch medical school faculty physicians, medical residents, and interns. These affiliations, in turn, would provide medical schools with new venues in which to educate young physicians, including military doctors returning to the United States and seeking specialized training.

On January 3, 1946, President Truman codified Dr. Magnuson's vision by signing Public Law 79-293, which established a department of medicine and surgery within VA and allowed VA hospitals to enter into affiliation agreements with accredited medical schools. Later that month, VA issued Policy Memorandum Number 2, which decreed that "the Veterans Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts

responsibility for all graduate education and training." Policy Memorandum Number 2 today still guides the affiliations between 130 VA medical centers and 105 of the nation's 125 medical schools.

Affiliations between medical schools and VA medical centers have contributed to attaining the goal set forth for VA in Policy Memorandum Number 2: "affording the veteran a much higher standard of medical care that could be given him with a wholly full-time medical service." Nearly 10,000 VA clinicians have academic appointments with one or more affiliated health professions institutions, and a similar number of faculty from these academic affiliates direct or provide care for veteran patients and teach residents and students at VA medical facilities.

VA medical centers have consistently scored well on Joint Commission on the Accreditation of Hospital Organizations (JCAHO) reports, comparing favorably with their private-sector counterparts. A 1992 *U.S. News and World Report* article on Acquired Immune Deficiency Syndrome (AIDS) cited four VA medical centers among the facilities that offer the finest AIDS care in the United States. The vibrant VA health research program, through which many academic physicians and scientists engage in research projects based on the health needs of veterans, also contributes positively to the quality of medical care received by patients in affiliated VA medical centers.

Since 1982, VA has also been required by law to serve as a backup for the military medical system during war and other national emergencies. During the Persian Gulf War, many VA medical centers developed contingency plans to treat casualties in concert with their academic partners. The Hines VA and Loyola University, for example, crafted a plan that would have used my institution's entire specialty structure to provide medical care for wounded soldiers. This collaboration between VA and academic medicine in support of military medicine is particularly vital since the number of beds operated by the military has declined from 80,000 to 16,000 over the past 25 years.

In addition to providing medical care to veterans, conducting health research, and supporting military medicine, VA plays a huge role in educating today's health workforce, including physicians, dentists, nurses, and allied health professionals. In 1994, VA supported more than 9,100 medical resident positions – close to 10 percent of all the residency slots in the country – and over 33,000 medical residents from affiliated institutions rotated through VA medical facilities. More than one-half of the nation's physicians have received some part of their undergraduate or graduate training in VA

facilities.

After nearly 50 years of close partnership, academic medicine cannot envision an educational environment that does not somehow include VA. Severing or even diminishing the symbiosis that has benefited both parties is particularly unimaginable when one considers that many VA medical centers are situated on the same grounds or located in the same building complexes as their affiliated medical schools! In addition, five of the 125 U.S. medical schools were established in the 1970s through direct support from VA: Marshall University, Wright State University, East Tennessee State University, Texas A&M University, and the University of South Carolina.

For all of these reasons, academic medicine looks forward to working with VA and the Congress in reinventing VA to face the challenge of caring for the nation's veterans while adapting to changes in the health care environment and marketplace. The proposal submitted by VA to the Congress, "Vision for Change: A Plan to Restructure the Veterans Health Administration," is an important first step toward transforming VHA into a more comprehensive, responsive, and efficient medical system. Secretary Brown, Under Secretary Kizer, and their colleagues in Washington and in the field should be commended for tackling the awesome task of reorganizing the largest integrated medical system in the United States.

As I understand it, the VHA reorganization plan embodies a patient-centered approach that would increase access to ambulatory and primary care services, decentralize and localize decision-making authority, and coordinate VA's health care delivery assets to provide comprehensive medical care to the covered and eligible veteran population. The locus of authority and responsibility would shift to the 22 proposed Veterans Integrated Service Networks, or VISNs, which would include from five to 11 hospitals each. Central office management would step away from day-to-day operational involvement, focusing instead on developing system-wide policies and monitoring quality and outcomes. At the same time, individual medical centers would cede budgetary and planning control to the VISNs as the medical centers and other VA facilities become coordinated components of these larger community-based networks.

The framework outlined in the reorganization plan would enable VHA to begin adapting to ongoing changes in health care delivery and financing. Meanwhile, the AAMC and its member institutions

will continue to support VA's efforts to provide the best possible care for our nation's veterans. We are concerned, however, that the VHA reorganization proposal mentions only in passing VA's missions to educate health professionals and conduct health research. For example, the continuation and further development of the historic cooperation between VA and academic medicine in patient care, education, and research is not included in the group of 27 values listed in the reorganization plan as guiding the establishment of the VISNs. We would like to think that the reorganization of VHA can strengthen, rather than imperil, the arrangements between VA medical centers and schools of medicine that are essential to the high quality of care provided to veterans by VA.

Under the proposed reorganization, according to the plan, "the basic budgetary and planning unit of health care delivery shifts from individual medical centers to integrated service networks providing for populations of veteran beneficiaries in defined geographic areas." This move carries potential ramifications for the long-standing relationships between individual VA medical centers and their academic affiliates. For instance, the proposed shift in planning responsibility from the VA medical center to the VISN signals the potential for dramatic changes in the role of Deans Committees.

Every medical school that conducts undergraduate or graduate medical education programs in cooperation with a VA medical center must organize and nominate a Deans Committee, subject to the approval of the VA medical center director. These Deans Committees are primarily composed of medical school deans and senior faculty members from appropriate medical school departments and divisions. The Deans Committee has a primary advisory responsibility regarding a VA medical center's education and research programs, and cooperates with VA personnel in implementing clerkships for medical students, establishing integrated residency programs with the VA facility, and coordinating VA research programs with other facility activities. Deans Committees also nominate faculty and trainees from the medical school for appointments as full- and part-time VA physicians, attending and consulting staff, and residents -- all of whom are crucial to meeting VA's staffing needs.

Under the reorganization plan, each VISN would be expected to establish a "management assistance council" to "assure input from VHA's internal and external stakeholders." The plan foresees a role for VHA's academic affiliates as consultants to these councils, providing recommendations regarding the operating of and planning for the VISNs. However, we believe the close interaction between VA

medical centers and affiliated medical schools warrants involving academic medicine and other important stakeholders in these councils as more than outside advisors.

The interplay between the VISNs and the Deans Committees of the affiliated VA medical centers within the networks will almost certainly involve tensions that will buffet the affiliations. Since each proposed VISN would also incorporate more than one VA medical center with a strong academic partnership, the reorganization plan harbors the potential for additional internecine conflicts within the VISNs themselves. I believe VA and academic medicine should work together to create a structure through which the VISNs can work with the Deans Committees, either individually or through consortia, to devise systems for staffing VA facilities, educating students and residents, and conducting health research in the best interests of veterans and each partner. As the subcommittee considers VHA's reorganization plan, the AAMC would welcome the opportunity to discuss this subject further.

We understand the need for VHA to restructure its health care delivery system to provide health care to its patients more effectively and rationally, and we trust that educating health professionals and conducting health research will remain two of the four missions assigned to VA by the Congress. Like VHA, medical schools and non-federal teaching hospitals, which share these educational and research missions, are beginning to form integrated networks and to incorporate ambulatory and community-based service points into expanded continuums of care. However, as VHA reinvents itself, the directors of the 22 proposed Veterans Integrated Service Networks must take care not to sunder unnecessarily the ties between individual VA medical centers and medical schools. I believe that VHA National Headquarters should provide the field with national policy, direction, and oversight to ensure that the benefits of these affiliations are preserved and enhanced.

In my view, the transformations in health care delivery that are spreading across the country present VA and academic medicine with new possibilities for cooperation that would benefit both partners and, ultimately, the veterans we serve. For instance, the VHA reorganization plan emphasizes health promotion and disease prevention through the provision of primary and ambulatory care services. At the same time, medical schools and teaching hospitals are searching for ways to enhance primary care education and to provide students and residents with more experience in outpatient settings. Collaborations in this arena between VA medical centers and academic medicine would make sense

for both partners, providing academic medicine with new educational opportunities and helping VA improve veterans' access to health care by promoting appropriate delivery systems for the high quality of the care veterans traditionally receive from academic physicians. Together, medical schools and VA can implement necessary changes, yet protect what is good in the current system.

As Under Secretary Kizer points out in his preface to "Vision for Change," "the planned organizational structure merely provides a template upon which new attitudes and behavior will be encouraged and rewarded, and around which a new organizational culture can grow." Based on my experience as a VA physician and administrator, I agree that the proposed reorganization, although an important first step, should not be considered a panacea by this subcommittee. As it carefully considers the restructuring of VHA, the subcommittee should also consider

- reforming the convoluted and dysfunctional eligibility criteria to allow VHA to provide a comprehensive range of care -- including inpatient, outpatient, and preventive services -- to all eligible veterans;
- allowing VA to retain third-party collections, including Medicare payments, and thereby increase its funding base and reduce its reliance upon federal appropriations; and
- urging appropriators to provide adequate funding for VA medical care, which has failed to keep pace with medical inflation, and VA health research, which supports research into conditions that directly affect veterans and provides incentives for top physicians and scientists to choose VA careers; and
- allowing VA medical centers to treat non-veteran patients, as long as the high quality of care for eligible veterans is not compromised and VA is reimbursed properly for all care provided to non-veterans.

Thank you for providing me with a chance to present the views of the Association of American Medical Colleges on reorganization of the VA medical system. I would be pleased to answer your questions.

STATEMENT

of the

NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS

Hearing on

VHA REORGANIZATION PROPOSAL

Presented by
Samuel V. Spagnolo, M.D.
President, NAVAPD

Mr. Chairman and members of the Committee, my name is Samuel V. Spagnolo, and I am here today as President of the National Association of VA Physicians and Dentists (NAVAPD). For the past twenty years, I have served as the Chief of Pulmonary Diseases at the Washington, DC, VA Medical Center and Director of the Pulmonary Division at George Washington University. I am also Professor of Medicine at George Washington University. I thank you for the opportunity to comment on the recent proposal to restructure the Veterans Health Administration (VHA).

NAVAPD represents approximately 15,000 doctors in the VA system. We come before the committee today to address what we believe to be the single most important issue facing the VHA -- maintaining and improving the quality of patient care for our nation's veterans. Any reorganization proposal of the VHA must focus on the quality of patient care as its primary goal if it is to succeed. It is with this overriding priority in mind that we comment on the VA's "Vision for Change" plan to restructure the VHA.

At the outset, I must emphasize that NAVAPD does not oppose change in the VA system. On the contrary, continuous change is necessary to meet the needs of any dynamic business or organization. The VHA must now contend with ongoing changes affecting the demands for its services, such as an aging veteran population, a marked decline in inpatient and acute care, and major shifts in the geographic locations of veterans, to mention a few. The VHA must address these issues in a timely and effective way without compromising quality health care. Therefore, it is not <u>whether</u> the VHA changes, it's <u>how</u> it changes that concerns NAVAPD.

We applaud the VA for addressing the difficult issues confronting the VHA system. Eliminating unnecessary bureaucratic layers in the management system and shifting operational decision making to local levels is a laudable goal that NAVAPD supports. The

concept of decentralization is not inherently bad, provided the new structure significantly involves doctors in management decisions at local levels.

This testimony will address some of the concerns NAVAPD has regarding the reorganization plan. Before addressing those concerns, I want to stress that NAVAPD seeks to continue a constructive dialogue with the VA and Congress as we debate this reorganization plan. As always, NAVAPD stands ready to answer any questions about its position and to work with the VA and Congress at any time.

NAVAPD would also like to briefly point out that the reorganization plan fails to address one of the most difficult issues facing the VHA -- overhauling and simplifying veterans health care eligibility criteria. Without knowing who our patients are and what they need, how can we create an effective plan for their care? The reorganization plan states in its preface that "this reorganization alone cannot heal all the maladies of the veterans health care system," and it mentions eligibility criteria as one of the areas where a remedy is needed. We urge the VA to address the pressing problems associated with eligibility before it attempts the task of reorganizing the VHA.

NAVAPD has four major areas of concern regarding the VA's reorganization plan. These concerns relate to the following objectives: (1) putting quality health care before managed health care; (2) involving physicians and dentists in management decisions; (3) ensuring that decentralization does not adversely impact resource allocation or accountability; and (4) providing for continued specialized medical expertise in the VHA system.

First, we are concerned that quality health care is not the focus of the reorganization. Although the plan endeavors to address quality of health care, its primary goal is managed care, or "best value" care, as the plan states. To quote directly from the plan,

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"The new VISN structure places a premium on improved patient services, rigorous cost management, process improvement, outcomes and 'best value' care." The plan goes on to say that an integrated health care system "requires management of total costs; a focus on populations rather than individuals; and a data-driven, process-focused customer orientation."

NAVAPD maintains that when restructuring a system as unique as the VHA, the question that needs to be asked is not, "What is the 'best value' for the VA system?" Rather, the question should be, "What is best for our nation's veterans?" The VA was created as a subsidized health care system for veterans. It must not only provide a high quality of traditional medical care, it also has the unique role of providing specialized care in such areas as prosthetics and orthotics, spinal cord dysfunction, post traumatic stress disorder and Persian Gulf Syndrome. Moreover, the system must stand ready to respond to national emergencies. NAVAPD is concerned that managed care will adversely affect the quality of care delivered, especially in these specialized services.

For example, our association has consistently taken the position that the VHA should further improve patient care by creating "centers of excellence" for treatment, research and post graduate education in specialized areas such as organ transplantations, early diagnosis of cancer, cardiac surgery and spinal cord injury. To accomplish this, there must be a strong commitment at the management level with significant clinical input from doctors. Managed care, however, tends to promote homogeneity throughout the system , which, in turn, directly contravenes ideas like establishing "centers of excellence."

As a physician, I am acutely aware that the ultimate responsibility for my patients' care rests with me. I am trained to make decisions on the quality of care that my patients receive. The practice of medicine is centered around the doctor/patient relationship, and decisions about treatment must be based upon the professional

judgment of the doctor. This relationship must not be compromised by managed care. I ask you, under managed care, who is the patient's advocate? Who will protect clinical outcomes? Furthermore, courts have consistently upheld my accountability in the doctor/patient relationship. Who is accountable in a system that inserts a non-medical administrator into that relationship?

This leads me to my second point. NAVAPD is concerned that under the reorganization plan, physicians and dentists will not have substantial decision-making authority regarding the development and implementation of administrative policies within each Veterans Integrated Service Network, or VISN. The plan proposes that each VISN be headed by a director, and that VISN management "would be expected to include expertise in medical management, finance and budgeting, and planning." There is no mention of expertise in patient care and clinical practice.

Certain aspects of the VISN management structure are fundamentally flawed and will require substantial revision before the VA medical community will have any confidence in the structure. For example, if a doctor cannot advise the VISN director with real authority as to clinical outcomes of management decisions, then he has no real input into management decision making.

Policies that directly impact patient care, such as decisions on access to care, resource allocation, performance measurement, research, and the development of training programs, must be adopted and administered with the meaningful participation of physicians and dentists. Policy decisions made without adequate clinical justification will fail and will have serious adverse impacts on the quality of patient care.

Our third concern is that the plan's emphasis on the decentralization of authority within VHA may adversely impact the quality of patient care. Any reorganization of the VHA

infrastructure must provide adequate support for service delivery. One of our concerns is that the overall structure proposed by this plan does not take into account demographic data when allocating resources among the VISNs. By the year 2010, one-third of all veterans will reside in California, Pennsylvania, Texas, Florida, Arizona and New York. What does that mean for facility management, staffing, expansion and the allocation of technology resources? It is not clear to NAVAPD how the new VISN management structure will address the allocation of resources among the VISNs and what criteria they will use in resource allocation.

Finally, one of NAVAPD's primary goals has always been to improve patient care by maintaining medical expertise within the system. In other words, it is imperative the VHA adopt policies that are aimed at retaining senior, experienced personnel and recruiting new quality caregivers.

This will not happen if the system undermines morale by relegating caregivers to merely a supportive role. Doctors within the VHA are the foundation of the system. Considering the extent of their expertise in so many critical areas, they should be actively involved in VHA administration.

In addition, the plan fails to address how academic affiliations and research opportunities for doctors in the VHA system will be retained and strengthened. The opportunity for direct and meaningful involvement in medical education and research have long been two of the most attractive features of VA employment. If these two critical areas for growth and professional development are closed off to VA doctors, you can be assured that senior physicians and dentists will leave and the recruitment of quality doctors will suffer.

Allow me to briefly summarize our position:

1) The focus of any reorganization of the VHA must be the quality of health care for veterans and NOT managed or "best value" care.

2) Physicians and dentists should be directly and effectively involved in management decisions affecting patient care.

3) Decentralizing management functions in the VHA should not negatively impact resource allocation.

4) The reorganization proposal should maintain medical expertise in the system.

Mr. Chairman, that concludes my remarks. Thank you for the opportunity to present this testimony. I would be pleased to answer any questions you and other members of the committee may have.

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Statement of

Nurses Organization of Veterans Affairs
(NOVA)

By

Lynna Smith, MN, RN, CS, ARNP
President

Before the

Committee on Veterans' Affairs
Subcommittee on Hospitals and Health Care

On

Veterans Health Administration's Reorganization Proposal

April 6, 1995

Mr. Chairman and Members of the Subcommittee on Hospitals and Health Care, I am Lynna Smith, MN, RN, CS, ARNP, a Nurse Practitioner at the American Lake Veterans Affairs Medical Center in Tacoma, Washington. As President of the Nurses Organization of Veterans Affairs (NOVA), I am testifying on behalf of NOVA, and I speak for the more than 40,000 VA professional nurses.

It is an honor and privilege for me to represent NOVA here today and testify on the Veterans Health Administration's Reorganization (VHA) proposal. This testimony will focus on the effect this reorganization will have on veterans' health care and VA nurses. NOVA strongly supports the VHA as an independent health care system providing a full range of services enhanced by education and research programs benefiting both veterans and the nation. The VHA functions in concert with major trends in the health care profession and reflects those changes in its care of veterans. NOVA also supports the reorganization goal to transform the VA into a responsive, decentralized, customer-driven organization providing high quality, cost-effective, accessible service for ALL veterans. NOVA applauds Secretary Brown for his leadership in this undertaking.

NOVA members are committed to providing quality health care for the veteran. NOVA believes VA health care must shift from the illness/cure model of care to a focus on the wellness/health promotion model. NOVA asserts increased utilization of nurses as primary care providers using a cost effective mix of other health care providers. This will promote increased accessibility and quality care for veterans.

The increased use of nurses as case managers to integrate, coordinate, and advocate for individuals requiring extensive services will decrease fragmentation of health care. It will also provide more holistic care for individuals with complex needs. NOVA supports research-based clinical practice that promotes standardized clinical practice and enhances the quality of care. NOVA supports career development as well as ongoing education and training at all levels. This education and training will promote nurses' increased knowledge in geriatrics which will assist nurses in moving towards ambulatory care, hospice or home care and long term care settings.

COMPONENTS OF VHA REORGANIZATION

Nursing Programs

Implementation of a Field-Based Organizational Structure with a Board of Directors and Constituency Centers.

In September 1994, the Nursing Service Board of Directors initiated an organizational structure to support decentralization by providing opportunities for grass roots input in policy development and decision making. The Board includes chairs of five constituency groups: Clinical; Administrative; Research; Education; and Informatics. Tasks forces with representation from the VHA nationwide have been developed to work on elements of the strategic plan.

This innovative organizational program has generated interest and enthusiasm from all levels of nursing service. As with all programs, outcome measures need to be tracked. For example, an Advanced Practice Advisory Group was appointed in the Spring of 1994 and subsequently aligned under the Clinical Constituency Group. The Advanced Practice Advisory Group guided the development of a new directive related to establishing prescriptive authority for Advanced Practice Nurses, Clinical Pharmacy Specialists and Physician Assistants. This Group began the development of "Scope of Practice" guidelines for Advance Practice Nurses and has initiated the identification of the issues and information necessary to create a national database for Advance Practice Nurses in the VA. NOVA deems the implementation of these innovative programs to be a positive step and encourages their continued support.

Realignment of the Chief, Nursing Service to the Associate Medical Center Director Level.

In late 1994, the VHA through Directive 10-94-096 announced each medical center can now realign Chief Nurses to the position of Associate Director for Nursing Services/Patient Care Services. This realignment positions nursing service to assume a greater scope of responsibility and accountability for the governance and operation of each VHA medical center.

NOVA applauds Nancy Valentine, RN, Ph.D, CNAA, FAAN, Assistant Chief Medical Director for Nursing Programs and the Task Force on Reorganization of the Chief Nurse with the support of Secretary Jesse Brown and Deputy Secretary Hershel Gober in achieving this NOVA goal.

Veteran Integrated Service Networks.

The restructuring plan would abolish the VHA's current four region system in which each region has responsibility for 36 to 45 medical centers. These regions will be replaced by 22 Veterans Integrated Service Networks (VISNs) which will each manage five to twelve medical centers. At each VISN, a CEO would manage a staff of ten individuals which replaces the current staff of approximately 100 at each Regional Office. The 22 VISNs will allocate resources among the medical centers and use contract services with the private sector as well as sharing agreements with the Department of Defense. This should ensure high quality care to all veterans, easier access to VHA services as well as improved cost management. NOVA recommends a continued nursing representation at the VISN level.

Merged Management at VA Medical Centers.

NOVA supports the goals of the recent organizational integration in which 16 VA medical centers were realigned into seven facilities. This allows for the expansion of services to veterans and improves the management of the VA's network of health-care facilities. This integration is commendable and exactly what the VA needs to accomplish.

However, at one or more facilities, the process appeared abrupt with both staff and consumers voicing feelings of uncertainty about their programs and health care. The process of integration, which should have begun prior to a merger, must now begin. Issues of concern include: communication with the veteran consumer and staff about this integration process; continuity of health care programs; consolidation and integration of information systems; and integration of services. NOVA recommends the integration of these facilities be monitored to ensure the achievement of the stated goals, and that the veteran consumer and staff of various programs have representation in this process.

Access programs and issues.

NOVA still has significant concern regarding veteran eligibility issues and access to care. In Washington State, health care plans are being actively marketed to the population in general and specifically to groups of veterans. One veteran stated, "it sounded too good to be true." He went

back to hear the presentation a second time and was convinced. For his medicare and a five dollar co-payment, he can select a doctor and have total care including medications. His wife may participate; however, he was asked not to seek health care from any other source, including the VA. There are two other similar programs within a ten mile radius of this veteran.

NOVA believes eligibility reform must occur. Existing as well as new, innovative programs in the VA are not included in the health care programs identified above. Some of these programs include:

- Respite care programs for patients with disorders such as Alzheimers disease or other terminal conditions requiring supportive care. This care provides a "tune-up" for the veteran and "time off" for the care giver, allowing the veteran to stay home as long as possible.
- Spinal cord injury rehabilitation programs with long term, supportive follow-up.
- The West Palm Beach VA proposes an alternative approach to community-based care. It would establish partnership arrangements with community resources and redesign the roles of existing VA resources for increased efficiency.
- In-patient and out-patient psychiatric care.
- Alcohol and drug abuse treatment which allows for acute detoxification with continued monitored residential outpatient treatment.
- Programs for the homeless which are interdisciplinary, focused plans.

Our country has the responsibility for the men and women who have put their lives on the line and made our country and the world a safer place. Veterans deserve quality, efficient and effective health care. This is the VA challenge. NOVA is committed to working with the VA's Veterans Health Administration and the Subcommittee on Hospitals and Health Care to achieve this goal.

Mr. Chairman, NOVA would like to thank you for your time and attention and pledge to you we will continue to work with Congress in serving our Nation's veterans. I would also like to thank you and this Subcommittee for your work with the legislation to amend Title 38, United States

Code, to exempt full-time professional nurses of the Department of Veterans Affairs from restrictions on remunerated outside professional activities. This regulation has long been an issue for NOVA's members, and we are truly grateful for your consideration and support.

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Statement
of

Louis Jasmine

National President

of the

National Federation
of Federal Employees

on

The Reorganization of the
Veterans Health Administration

before the

Subcommittee on Hospitals and Health Care

Committee on Veterans Affairs

April 6, 1995

Good Morning, Mr. Chairman and Members of the Subcommittee:

My name is Louis Jasmine and I am President of the National Federation of Federal Employees. On behalf of the National Federation of Federal Employees, I appreciate the opportunity to appear before you today to offer our comments on the plan to reorganize the Veterans Health Administration.

Before I begin, I would like to take a moment to reaffirm the commitment of all NFFE VA employees to constructing a VHA that is more responsive and provides high quality health care to those individuals who have given so much to this nation. NFFE has wholeheartedly embraced the VA's call to "put veterans first" and is willing to work with the VHA as it restructures its health care delivery system to put patients first.

First, I must say that NFFE applauds the VHA for developing a reorganization plan that is correctly focused on systemic changes intended to improve service delivery rather than on massive job cuts intended to provide only monetary savings. In today's cut and slash "reform" environment, this is a refreshing change.

As you know, the proposed reorganization plan would transform the field organization of the VHA from the four regions, 33 networks, and 159 independent VA medical centers with 22 Veterans Integrated Service Networks (VISN) that would report directly to the Undersecretary for Health. Under the proposal, the basic budgetary and planning unit of health care delivery

shifts from individual medical centers to the integrated service networks. The networks service areas and the veterans they serve would be defined on the basis of VHA's natural patient referral patterns; the number of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care and factors such as state borders. Importantly, the VHA has stated that the reorganization plan will lead to a net reduction of 157 FTE positions. NFFE is pleased to see that VHA intends to achieve these reductions through the use of reassignments, early retirement and special placement initiatives instead of the more draconian reduction-in-force.

While NFFE is generally supportive of the VHA's reorganization plan, we also have a few concerns. Leading the list is the potential impact of this plan on the labor-management partnerships in the VHA. As you may know, many VA facilities already have, or are in the process of completing, partnership agreements with their resident employee unions. These partnership agreements envision accountability at the facility level. The partnership may be undermined if the facility management is required to defer to the VISN director instead of being able to reach an agreement with its partner. Throughout the federal government, partnership agreements have shown by working together federal workers and management can dramatically improve the quality of service while reducing costs. The VHA reorganization plan should reflect the success of this philosophy.

Another concern is the potential for micro-management of the medical centers by the VISN Director. In the 1980's the regions were too large and contained too many medical centers for the Regional Director to manage human or fiscal resources effectively. The danger in the

present plan is that the VISNs are small enough for the VISN Director to micro-manage the medical Centers. To avoid this problem, the VHA should emulate some of the Nation's larger private sector multihospital systems, which allow their medical center directors the freedom to locally and fiscal resources, but makes them accountable for their actions.

Finally, NFFE questions how shifting budgetary and planning aspects of health care delivery from the medical centers to geographic areas would move decision making authority closer to those affected by the decision. It would seem to have the opposite effect. In fact, if the VISN director is responsible for budget and planning functions, this would seem to severely limit local management flexibility to deal with local issues in a timely and authoritative manner.

In conclusion, Mr. Chairman, I would like to reaffirm NFFE's commitment to reform the VHA so that it provides our Nation's veterans with a health care delivery system that is both effective and of the highest quality. NFFE believes that this proposal has the potential to realize this goal as long as it is adjusted to reflect the success of labor management partnerships and safeguards are added to ensure that local directors are allowed to manage effectively.

This concludes my testimony. I would be pleased to answer any questions you may have.

STATEMENT OF
DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 6, 1995

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf, of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I want you to know how genuinely appreciative we are to have the opportunity to relate our views regarding the Department of Veterans Affairs (VA) Veterans' Health Administration (VHA) proposal to restructure and reorganize its headquarters and field operations.

Mr. Chairman, I would again extend to you the DAV's congratulations on assuming the chair of the Subcommittee and pledge an eager willingness to work with you and your staff toward our shared common goal of improving the manner in which VA health care services are delivered to our nation's disabled veterans. Also, our congratulations and the same pledge are extended to Mr. Edwards as he assumes the position of Ranking Member of the Subcommittee.

Mr. Chairman, I will not attempt to create a bibliography of the various VA commissions, task forces, blue ribbon groups, government and nongovernment audits and reports, studies and recommendations by groups as diverse as the American Medical Association and the Heritage Foundation, or testimony presented to various Congressional committees and subcommittees over the years, by VA management, VA medical center directors, chiefs of staff, medical doctors, nurses, dentists, psychologists, Vet Center Team Leaders, veterans' service organizations, deans of medical schools, or veterans' patients and their families.

Rather, we would offer the opinion that there is virtually no one who would attempt to convincingly argue VHA need not change. Quite the contrary.

All of us interested in preserving a viable VA health care delivery system acknowledge change is required. Frankly, a radical change is needed. That is why we believe this is an extremely timely and critical hearing for the future of VA. And, what must be recognized is that this proposal represents a bonafide, first step exercise whose goal is moving VHA from an inefficient, inflexible delivery system to one which will be consistent with the practice and delivery of contemporary medical treatment in our country.

Mr. Chairman, the document, "Vision for Change, a Plan to Restructure the Veterans' Health Administration," as proposed by the Under Secretary for Health, Kenneth W. Kizer, M.D., M.P.H., is, in our view, the correct prescription to initiate such change.

We have reviewed VHA's proposal and are supportive of the conceptual framework designed to facilitate the major changes that need to occur.

Too often, the system has been designed to do what is best or desirable for the system or individual medical centers and, often times, for individual programs. What has been lacking in

the past has been the existence of a mentality that drives the system to do what is in the best interests of the veteran patient. After all, this is the very essence of what gave rise to VA.

As stated by Dr. Kizer, the proposed reorganization plan embraces a "Patient's First" focus for VA's structure and delivery of services. To do so, VHA will be organized into 22 Veteran's Integrated Service Networks (VISNs) designed as the basic budgetary and planning unit of VHA.

Each VISN will have a director who will report directly to the office of the Under Secretary for Health. The VISN's function will, in large part, be to integrate ambulatory care services with acute and long term inpatient services, and achieve, by greatly enhanced authorities and flexibilities, the "greatest possible health care value for the allocated resources provided."

Mr. Chairman, Dr. Kizer's plan and his vision creates the vehicle to drive the changes absolutely critical for VHA's survival into the next century. We embrace the logic found in the slogan, to, "Think Global, Act Local."

Contained in the reorganization proposal is the following statement which we believe best captures the intent and essence of the proposal:

> "This reorganization is not a simple realignment of 159 independent medical centers, 33 networks and four regions into 22 VISNs. Nor is it a re-shuffling of bureaucratic boxes on a central office organizational chart. Rather, it is a fundamental change in the way responsibility is spread across many decision points in order to imbue the organization with a common sense of purpose. VHA will become less like a mega-corporation and more like a system of federated networks that are bound together by a determination to provide quality patient care. If roles are properly defined and executed, and if power, authority and accountability are balanced and dispersed throughout the organization, then the result will be an interdependent and interlocking system whose whole is greater than the sum of its parts."
>
> "Think global, act local" is a fashionable slogan that embodies how VHA intends to function in the future. Strategic planning will become integrated with quality improvement in order to ensure that the changing demands of the national health care environment are reflected in the consistent delivery of local services. Patient care services, and most importantly VHA's recognized special programs, will benefit from a new way of thinking in which multi-functional teams will collaborate and offer expert consultative services for clinicians at the point of service delivery. Health care delivery will be shifted away from institutional inpatient modalities to network-based ambulatory solutions. And a renewed emphasis on data capture and information management will provide the vehicle for meaningful performance measurement and resultant accountability. VHA also recognizes the importance of maintaining its education and research activities. The responsibility to the next generation of clinicians will be best met if education, training and research efforts are supported by the restructuring of the delivery system.

Mr. Chairman, as previously stated, we believe and endorse the concept of the Under Secretary for Health's proposal. There is no question VHA needs to change if it is to survive in the

competitive, market-driven health care system now taking shape in our country. Without change, VA will be relegated to a system best described as dysfunctional. Continued dysfunction will only lead to the system's demise. Veterans and the American taxpayer deserve better.

The VA's proposal is best described as very general in nature. It will not be until well into the implementation and transition phases of the reorganization that various specific details will be addressed. Obviously, issues will arise that had not been contemplated. We are confident that VA and the talented cadre of professionals it employs will identify these issues and deal with them in a meaningful way.

In order to keep VHA focused, the DAV, and I'm sure our sister veterans' service organizations (VSOs), will be keeping an ever vigilant eye on the progress of the reorganization and the manner in which it is conducted. Of course, we remain confident that this Subcommittee will do the same.

Additionally, we believe the Under Secretary for Health will hold true to his already established behavior of including the VSOs as the reorganization takes place and, hopefully, will directly include us in certain key elements of the restructuring.

Once again, Mr. Chairman, we are extremely pleased that a tangible effort is underway to produce what we all must recognize as overdue changes to the VA's health care delivery system. We are optimistic for the plan's success and eager for it to get underway. Although we all have questions and concerns, we are hopeful VHA will be permitted to move forward with their proposed reorganization and restructuring just as soon as possible.

This completes my testimony and I would be pleased to respond to any questions you may have.

STATEMENT OF

TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE DEPARTMENT OF VETERANS AFFAIRS

VETERANS HEALTH ADMINISTRATION'S

REORGANIZATION PROPOSAL

APRIL 6, 1995

Chairman Hutchinson, Ranking Minority Member Edwards and Members of the Subcommittee, on behalf of the Paralyzed Veterans of America (PVA), I wish to thank you for this opportunity to present testimony today regarding the Veterans Health Administration's (VHA) Reorganization Proposal. PVA commends the Secretary of the Department of Veterans Affairs (VA) Jesse Brown and the Under Secretary for Health Dr. Kenneth W. Kizer for submitting a progressive reorganization plan for VA's health care system. Moreover, PVA would like to praise Dr. Kizer's leadership of VHA and his courage for undertaking the daunting task of realigning VHA's health care delivery system.

PVA views the VHA's plan as a step in the right direction to change the veterans' health care system to a more patient-centered and efficient health care program. To that end, PVA extends its experience and expertise to this Subcommittee and to the VHA to assist in anyway in the realignment of the veterans' health care system to meet the health care needs of all its users, including those veterans with spinal cord dysfunction (SCD).

Mr. Chairman, while PVA supports this effort by the VA to streamline its management structure and enhance the efficiency of the veterans health care system it is important that we do not lose sight of the VA's primary health care mission. The VA has historically focused on addressing those medical requirements of veterans which are related to their military service. For PVA's members those services have been provided by the VA's system of spinal cord injury/dysfunction care. For other veterans the VA has created unique programs focusing on the health care requirements of amputation, PTSD and longterm mental health services.

As the VA's restructuring is assessed it is extremely important that these core, specialized services are given special consideration. It is essential that these specialized services are recognize as being the cornerstone of VA's health care mission. The reorganization of VA must incorporate and maintain these specialized services in order that the VA retains its unique role in meeting the health care needs of veterans.

Veterans Integrated Service Networks

VHA's reorganization proposal would restructure VHA's field operations and its central office management. VHA's field operations would be restructured around the concept of Veterans Integrated Service Networks (VISN). Under this concept, VHA's current field operations (four regional field management offices) will be replaced by 22 Veterans Integrated Service Networks nationwide. A director will manage each VISN area. The VISN directors will be responsible for ensuring the full range of services, including specialized services and programs for disabled veterans. VISN directors will report directly to the Office of the Under Secretary. According to the proposal, VISNs will focus on (1) integrating acute and long term inpatient and ambulatory services, and (2) achieving the greatest possible health care value for the allocated resources provided.

We support the reconfiguration of VHA's field operations because it vests in the VISN directors the authority and flexibility needed to operate VA medical facilities in the context of a rapidly evolving health care system. VISN directors will be tasked with developing and implementing VISN budgets, consolidating and/or realigning functions, and contracting with non-VA providers for medical and non-medical services. Under this proposal, the directors will be able to tailor health care operations to correspond with local needs. VISN directors will be afforded greater latitude in responding to state health care reform initiatives. Moreover, PVA recognizes that the success of VISNs will be intrinsically tied to the individual directors. They will be responsible for ensuring the continuity of medical services within the VISN framework and the viability of specialized programs.

While PVA supports the enhanced authority and flexibility the reorganization plan will give VISN directors, we are concerned about the implications this new authority will have on SCD medicine. For example, a VISN director may view SCD medicine as a high cost, labor intensive program and may decide to cut services. In such an environment, SCD medicine would be extremely vulnerable to budget and program manipulation at the local and VISN level. We strongly recommend that protections be implemented to safeguard SCD medicine and to ensure continuity of services provided to SCD veterans within VISNs.

The structure and function of VHA's central office will also be significantly altered. Central Office's emphasis will change from control of processes to monitoring of outcomes. In short, central office will no longer micromanage field operations. Instead, central office will focus on developing system-wide polices and practice parameters.

VHA's reorganization proposal for field operations and central office management is intended to produce tangible improvements in

the quality and efficiency of care provided to veterans. PVA supports the following goals promulgated in the reorganization proposal: (1) decentralized central office; (2) increased accountability at the delivery level; (3) stream line the veterans health care system; and (4) greater efficiency. In fact, PVA has advocated and urged change in these areas for quite some time. PVA's study, *Strategy 2000 Phase II: Meeting the Special Health Care Needs of America's Veterans,* discussed in detail the need to restructure the VA health care system. The study also advanced the need to safeguard VA's specialized services and programs for disabled veterans.

Implications for Provision of Care to Veterans with Spinal Cord Dysfunction

PVA believes the VHA's reorganization proposal is one of many steps that must be taken to carry the VHA into a new and vital future. PVA is also cognizant of the fact that a misstep along the way could have disastrous implications for disabled veterans. VA needs to clearly demonstrate that it has the commitment and capabilities to adjust to the changing health care environment. In particular special care must be taken to nurture and protect those services developed to meet the unique needs of veterans with SCD and other veterans requiring VA's specialized services.

VA's spinal cord injury/dysfunction care system affords veterans access to a complex, comprehensive mix of health care services not readily available in the private sector. Providing all aspects of necessary medical and rehabilitative services, the VA incorporates acute, sustaining and longterm services for veterans who experience spinal cord dysfunction. The VA's SCI system brings together the range of medical specialties necessary to address the lifetime requirements of veterans with SCD.

PVA is concerned about the quality and viability of SCD medicine as described in the reorganization plan. To illustrate, VHA does not provide sufficient clarity as to how the new central office and

VISNs will interact to adequately assure quality performance and outcomes for specialized services, most notably, care for veterans with SCD. Without system-wide performance indicators, clinical practice guidelines, and treatment outcome measures, central office and VISNs cannot ensure the proper resources and quality of care for effective SCD medicine. In addition, VHA's proposal does not state whether there will be designated coordinators or personnel to monitor the conduct and quality of SCD medicine and other specialized services at the local and VISN level. PVA's membership depends heavily on the unique and specialized services of VA's SCD medicine program. VHA's realignment must be implemented in a manner that will not compromise the SCD medicine program.

The reorganization proposal is remarkably silent on the specifics of SCD medicine and its future configuration. For example, some VISNs will have several Spinal Cord Injury Centers (SCI) while others will have none. The reorganization proposal does not provide information on how services to SCD veterans will be arranged in VISNs without an SCI Center. PVA recommends that VHA create an inter-VISN referral mechanism to ensure the appropriate provision of care to SCD veterans in VISNs without SCI centers. We recommend that VHA thoroughly review the operation of SCD medicine within the VISN scenario to ensure that SCD veterans have access to VA's SCD services regardless of where they live.

If the VHA is to preserve the unique quality and integrity of SCD medicine, as well as other specialized programs, then VHA must outline in greater detail a management structure that will ensure system-wide integrity in the context of decentralized administration. To ensure this end, PVA recommends an organization that would:

- Protect the resources essential to sustain strong specialized services programs
- Develop clinical practice guidelines for specialized programs and develop standards of care;
- Monitor performance and quality; and

- Enforce the coordination of funding, policy, standards and quality assessment to ensure the dependable access and high quality care for veterans within the service network.

Funding for Specialized Services:

PVA recommends that resources for specialized services, including SCD medicine, should be protected and maintained to ensure the integrity of these specialized services.

The current VA system of allocating resources to individual medical centers with spinal cord injury centers has proven inadequate in appropriately recognizing the costs associated with SCD care. The current Resource Planning and Management (RPM) model does not fully account for all services provided veterans with SCD. For example, the cases of outpatient care and longterm care reimbursements do not reflect the resource utilization frequently required. It is incumbent upon VA to ensure that the proposed changes in managerial structure are matched with accompanying changes in their resource allocation methodology assuring that individual centers are not penalized for the provision of SCD care.

Clinical Practice Guidelines for SCD Medicine:

VA should create and/or adopt accepted practice guidelines, policies, and standards of care for SCD medicine. It is imperative to implement practice guidelines for SCD medicine to ensure that SCD veterans are receiving appropriate levels of care and to maintain continuity and consistency of care across VISNs.

Monitor Performance and Quality:

PVA recommends that VHA designate specific personnel or coordinators to monitor the conduct and quality of SCD medicine and other specialized services at the VISN and local level.

We also recommend that responsibility for these functions should reside in the Office of Patient Care Services. In addition, all

specialized programs should be represented in a Specialized Services Unit within the Office of Patient Care Services.

PVA also recommends that VA establish a mechanism that ensures consumer involvement in the reorganized system. Consumers and non-VA experts must be afforded the opportunity to provide the Under Secretary with a broad view of how VHA compares with and compliments similar services outside VA. This will give the Under Secretary independent assessments of how the new management structures are affecting service and how veterans with special needs perceive VHA.

Again PVA applauds Secretary Jesse Brown and Under Secretary for Health Kenneth W. Kizer for their guidance and foresight in taking the first steps toward restructuring the VA health care system. And while the need for structural change is acute, the cure for VA's long term success and viability will depend on the following: **eligibility reform; maintenance of VA's core mission of providing specialized services; guaranteed funding for the provision of health care services; and retention of non-appropriated funds** (e.g., third party reimbursements and medicare payments). These changes will provide the VA health care system with the instruments it needs to deliver efficient and quality health care to our nation's veterans.

Mr. Chairman PVA will support the reorganization of VHA. We will assist in the process in any way we can to ensure the quality of VHA's program for spinal cord injury and dysfunction, so vital to our members' well being, is sustained. PVA will also insist on excellence in other specialized services for blinded veterans, for

veterans in need of prostheses, for those in need of special mental health services such PTSD. Like us, these veterans depend on VHA for service that cannot be matched by for-profit providers.

Thank you for this opportunity to testify. We look forward to continuing to work with you and this Subcommittee in the future.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 6, 1995

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to offer comments on the Department of Veterans Affairs (VA) reorganization proposal for the Veterans Health Administration (VHA).

Mr. Chairman, The American Legion is pleased to recognize the effective leadership that Dr. Ken Kizer has brought to VA in the short time since his confirmation as Under Secretary for Health of the Veterans Health Administration. The VHA reorganization proposal, Vision for Change, represents an earnest effort to improve the effectiveness of the VA medical care system and correct its systemic dysfunctions. Dr. Kizer promotes a progressive posture within VHA and displays a unique understanding of the VA medical care system.

The plan to restructure the Veterans Health Administration connotes progressive movement toward streamlining VA medical care services and decentralizing administrative functions. The proposal sets out to build on VHA's many strengths and to successfully correct the existing fragmentation of VA health care assets. The American Legion views the proposal as necessary to advance and solidify VA's role as the health care provider of choice by the veterans' community. Currently, many veterans are confused by complex eligibility criteria. Veterans are "locked" out of the system because they can afford to pay for health care services, or because they are unable to gain access to the system due to various eligibility restrictions. The proposed Vision for Change will help lay the foundation toward necessary and comprehensive reform of the VA health care system.

Mr. Chairman, the VHA reorganization proposal can serve as a foundation for subsequent improvements in the delivery of VA medical care services. In the past dozen years, VA has experimented with many different field structures. VA had 28 medical districts and six medical regions; then all medical districts were abolished and replaced with seven medical regions; and most recently the system has been structured into four medical regions. The American Legion views the existing field alignment as unmanageable. The VHA reorganization proposal of 22 Veterans Integrated Service Networks (VISNs) is a more functional system.

There are certain advantages to the VHA reorganization proposal. It represents the first step in the complex process of creating a more efficient, patient-centered health care system. The VISNs will place management decisions closer to patients and their needs. The Networks will also streamline and consolidate services and administrative activities, and encourage and promote management innovations. The plan also provides a template upon which future adjunct developments can occur, i.e., eligibility reform, and enhancing both the access to care and the quality of care provided. Recent technological changes, economic factors, demographic changes, and the rise of managed health care, among other things, have caused a dramatic shift from hospital care to a corresponding increase in outpatient care. The VHA reorganization proposal will allow VA to adapt its service delivery systems to align with the changes occurring in the delivery of modern medicine.

In addition to the benefits of the proposal, we caution that the plan should be viewed only as a first step to greater system reform. The proposal does not facilitate the treatment of greater numbers of veteran patients nor does it propose to improve equity of access to health care for veterans. The American Legion is also interested in

further exploration of how the proposed "lines of authority" will work between the medical centers, the Network Chief Executive Officer and the VA Central Office.

While The American Legion supports the broad outlines of the VHA reorganization proposal, there are several issues which require further amplification. These include the role of the Office of Policy, Planning and Performance and the functions of the Medical Inspector in VA Central Office. The function and product of the office of Assistant Secretary for Policy and Planning has historically been somewhat obscure. It needs to be determined if VA Central Office is duplicating functions or is there a plan for greater integration of the VHA Office of Policy, Planning and Performance and the office of Assistant Secretary for Policy and Planning.

In regard to moving the functions of the Medical Inspector into the Quality Improvement area, we should be sure that the investigative arm of VHA doesn't have its authority diluted by such a move. We need some oversight function to remain or be assumed by the Office of Inspector General. Which ever change is made, there must remain some arm of the organization with the ability to investigate allegations of mistreatment, malfeasance or medical negligence.

Mr. Chairman, although VA Voluntary Services are not directly addressed in the Vision for Change, volunteers provide an invaluable service to veterans and to the smooth running of many VA medical centers. In addition, the VA Voluntary Service is an arm of the public, community and guest relations functions of the medical center. As such, Voluntary Services should report to the directors of individual medical centers and centrally through the Administrative Programs Officer. Volunteers give freely of their time and effort and should be treated in a special way. They serve across all institutional product lines and should not be arbitrarily assigned under the responsibility

of clinical services, or other services such as recreational services. The American Legion feels that the title Voluntary Services should remain.

The American Legion strongly advocates the maintenance of a separate and direct line of reporting and a separate funding stream for the Readjustment Counseling Service. The services the Vet Centers provide are clearly multi-functional and multi-disiplinary and, as such, should continue in this unique reporting system from the Vet Centers to the Director, Readjustment Counseling Service (RCS) through a structure to be designed and implemented by the RCS to carry out the functions currently performed by the RCS Regional Offices.

The American Legion supports the intent of the recent decision by VHA to administratively consolidate a number of VA medical centers. This action will amplify VA's goal of incorporating reforms which revitalize the VA and make it more efficient. To that end, the VHA reorganization proposal can contribute to reducing duplicative services within a defined geographical area. A challenge inherent within the reorganization plan will be to further review individual medical center missions to develop a coherent system of treatment and patient referral patterns within each of the 22 Veterans Integrated Service Networks. **A fundamental concern of The American Legion with regard to the increased efficiency fostered by the VHA reorganization plan, is that VA not be penalized for improving its health care product through reduced health care appropriations.**

Mr. Chairman, The American Legion remains ready to assist in any organizational activity which will aid Secretary Brown in his quest of "Putting Veterans First." The VHA reorganization proposal is important to the future

of the Veterans Health Administration. The American Legion is hopeful that Congress will speedily approve the proposal and waive the mandatory legislative period required for implementation of the proposal.

Mr. Chairman, that concludes my statement.

Statement of

Submitted to the

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE
ON HOSPITALS AND HEALTH CARE

Regarding

"Vision for Change: A Plan to Restructure
the Veterans Health Administration"

April 6, 1995

"VVA, At Work in Your Community"

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INTRODUCTION

Chairman Hutchinson and members of the Subcommittee, Vietnam Veterans of America (VVA) appreciates this opportunity to present views on the VHA reorganization plan. VVA has long advocated for many of the progressive and prudent changes described in "Vision for Change" proposed by the Under Secretary for Health. We are especially heartened to see the strategy for accountability, standardization of a quality of care, and emphasis on maximum utilization of resources and services available to veterans. Because community-based delivery systems and decentralization of responsibility and budget functions have proven to be effective and efficient in the private sector, these changes will better prepare VA to be a contender in today's highly competitive health care environment.

"Veterans health care reform" has been advocated by many veterans including the ten veterans service organizations participating in *The Partnership for Veterans Health Care Reform*. While many components of such reform – eligibility criteria and the state pilot programs – require enactment of legislation, some program improvements can be made through administrative actions. VA Under Secretary for Health, Dr. Kenneth Kizer, has put forth a proposal to reorganize the Central Office and field structure of the Veterans Health Administration (VHA), in such a way as to increase efficiency and responsiveness to patient needs.

The reorganization would change VHA middle management from four regions to 22 Veterans Integrated Service Networks (VISN), to facilitate process improvement, outcome management, cost reduction, and value engineering. The hospital, while still an important component, is no longer the center of the health care delivery system, and the reorganization plan provides incentives for expanding community-based access points and primary care. The basic budgetary and planning unit will no longer be independent and often competing medical centers, but populations of veteran beneficiaries in geographic areas. As VVA has recommended for some time, the plan represents a major shift of management philosophy from bricks-and-mortar to quality-driven patient services.

LOCAL ADVISORY COMMITTEES

One point within the reorganization plan that merits particularly favorable comment is the requirement that each VISN establish a "management assistance council" to solicit information and guidance from internal and external stakeholders. VVA has witnessed the success of veterans advisory panels at the local level, and wholeheartedly supports this concept. By working directly with VISN management, VSOs and other interested parties -- especially the patients -- will provide assistance in identifying program successes and addressing problems. This consumer input will provide accountability, as well as informed management.

Like other veterans service organizations, VVA has monitored individual VA facilities when our members have voiced concerns about the quality of care or the responsiveness of VAMC Directors. Dialogue on the local level between facility administrators, professional staff, and members of the veterans community is a very effective means of identifying local problems and organizing the resources to solve them. When these groups are formalized into an advisory committee or task force, veterans and VA personnel develop energetic partnerships which engender a real spirit of shared purpose.

These local advisory committees provide an opportunity for veterans to communicate with staff, to be accorded the status of a consultant in the development of policies and services. Just as in the traditional "community hospital," advisory committees give patient-veterans a sense of ownership, which translates into concern and commitment to assist the VA facility in good times and bad. These partnerships are vital to survival in these critical times of dwindling resources.

OTHER VHA ADMINISTRATIVE CHANGES

Dr. Kizer has also moved forward with two administrative initiatives to push the VA health care system toward the more patient care-oriented, decentralized structure outlined in the plan. VVA favors the policies recently implemented, which will attempt to shift scarce staff

resources from purely administrative functions to direct patient care.

In seven areas of the country, VHA will integrate the administrative functions of the multiple VA Medical Centers (VAMC), in order to eliminate duplication and inefficiency. By creating "economies of scale" in the administrative functions, VHA will be able to focus more resources on patient care. The 16 VAMCs involved in these facility integrations will maintain health care delivery functions. The only changes, it is hoped, that veteran patients should notice are improvements in service.

VHA has established the following patient service goals for the integrated facilities: providing a full continuum of care to patients, including primary care to every patient; expanded clinic hours; additional points of access for care and decreased waiting times; more timely admissions processing; reducing travel for veteran patients needing specialized care by transporting relevant staff among the facilities; better coordination of patient transfers and referrals; speedier availability of patient medical files at each integrated facility; and establishment of a single phone number that veterans can call for care, information and appointments. VVA views these goals as an excellent starting point for the changes contemplated in "Vision for Change."

A second VHA initiative will allow all VAMC directors to make administrative reorganizations with the approval of the next higher authority (currently the Regional Office; after implementation of the reorganization plan, the VISN). The goals of this policy change are similar to that of the facility integrations: to improve efficiency and enhance patient services. This policy change will provide facility directors with greater flexibility to respond to changes in the local health care delivery market, and to coordinate patient services with other VAMCs. Other laws and regulations regarding reduction-in-force (RIF), Title 38 staffing adjustments, specialized medical services, and various labor-management relations policies remain in effect. Facility directors are responsible for communicating appropriately with all effected stakeholders, including VSOs.

VA Voluntary Service

One concern raised by VVA and other VSOs regarding both new administrative policies and the VHA reorganization as a whole, is the importance of maintaining a special focus on VA Voluntary Service (VAVS). Through the VAVS program, volunteers contribute millions of work hours and other resources to VA facilities. VA stands to loose significant resources, it is noted, if VAVS volunteers become disillusioned through the reorganization process.

VAVS advisory boards also serve as a forum for discussion with veterans advocates and other community leaders, and resolution of problem areas. Through the VAVS program, VHA is provided with significant cost-free personnel resources, as well as in-kind contributions of money, supplies and medical equipment. Given the emphasis of the 104th Congress on voluntary and charitable organizations to solve shortfalls in federal government programs, the significant contributions and importance of the VAVS programs cannot be overlooked.

Readjustment Counseling Service

The reorganization plan incorporates the Readjustment Counseling Service (Vet Centers program), and maintains RCS's separate authority structure and budget. Our members, at the national convention in 1993, adopted a strong resolution that the Readjustment Counseling Service continue in its present configuration as a community-based service provider with locations separate from, and outside the budgetary and managerial control of the VA Medical Centers. VVA has urged the Senate and House Veterans' Affairs Committees to approve this VHA Reorganization plan, including the provisions to maintain the distinct budget and line-authority of the Vet Center program.

The unique community-based nature of Vet Centers is a distinct asset to the future planning of VA health care. Expanding access points is one of the primary objectives of VHA reorganization and reform. This is critical to VA's ability to provide more cost-effective care and to reach out to those veterans who do not currently access VA services. The Vet Centers can serve as a model for this growth. The geographic distance separating many veterans from

the nearest VAMC makes the community-based Vet Centers an important point of contact for veterans in their first attempts to access VA services. The benefit of coordination already being done between Vet Centers and VAMCs around the nation, conducting preliminary health screening and referrals, will be critical to VA's expansion of outpatient and primary care access points.

Perhaps the most important point VVA presented in our comments to Dr. Kizer is that the Vet Center program's effectiveness would be significantly *diminished* if the Vet Centers were brought under the budget or management authority of the VA Medical Centers. The community-based aspect is critical for VA to achieve its mission of readjustment for veterans of all eras. Veterans who use the Vet Center program insist that these centers continue to be community-based and not fall within the threatening, bureaucratic environment of the VAMCs.

These community-based walk-in assistance and referral centers have proven to provide efficient and cost-effective treatment for veterans seeking help for PTSD, its secondary symptoms of substance abuse and homelessness, as well as more basic VA benefits information and employment and training referrals. One of the Vet Centers' greatest strengths has always been that of veterans helping veterans. VVA remains a strong proponent of the Vet Center program, as this issue is critical to our membership.

Measuring Success of the Vet Centers

One point which must be considered in evaluating the Vet Centers, whose primary mission is PTSD counseling, is the intangible nature of mental health services generally. When trying to measure success or failure or determine the most cost-effective treatment, mental health is distinguished from other specialties because there are numerous factors which influence outcomes that the health care professional cannot control. It is easy to measure success, for instance, when treating a patient for infection. It is more difficult to measure the distance from illness to complete recovery in the realm of the human mind. Relapses and/or secondary problems may be ongoing even when significant treatment successes can be noted. For instance, a veteran may be in recovery from a substance abuse problem, but the root problem of PTSD continues to cause readjustment problems.

Measuring success is an ongoing challenge for mental health professionals, as noted in the context of the national health care reform debate. Dr. Kizer has noted that RCS will need to justify the continuing need for the Vet Center program, by more clearly defining what the Vet Centers do, and how this success can be measured and verified. VVA is soliciting anecdotal data from our membership which may be beneficial in this regard. (Attachment 2 of this testimony includes highlights of the material submitted thus far.) Such information should provide insight into the very basic reasons veterans utilize Vet Centers and how the Vet Centers serve veterans -- thus, the consumers perspective on success of the program may be ascertained. VVA looks forward to working with VA and the Congress to address this important issue.

Vet Center counselors are recognized as very committed, selfless healers who often sacrifice much personal time to the cause of evening and weekend counseling sessions, group therapy, and outreach activities. The only problem with this scenario is the ultimate staff burnout that results from over-commitment. While workload has grown, staffing of the Vet Centers has remained stagnant. The program was once on the cutting edge of PTSD counseling, developing many creative approaches and strategies to treatment. The Vet Centers continue to innovate but are generally operating in a survival mode rather than continuing to develop cutting-edge techniques.

The Vet Centers have been a highly successful, cost-effective method of treating veterans for PTSD. Increased use of these "help without hassles" counseling centers is testimony to their effectiveness in providing care in a setting the veterans are comfortable with, and which saves the VA's sparse resources by precluding the need for costly inpatient care. When one considers the minimal cost of procuring community-based office space and hiring three to four counselors, the Vet Centers provide substantial "bang for the buck." VVA advocates that additional resources be allocated to the Readjustment Counseling Service in order to better meet demand for these services and to enhance VHA's community-based points of initial access.

OTHER SPECIALIZED PROGRAMS

In reviewing the "Vision for Change" document, one concern which arose is the future of the "Counseling and Treatment for Sexual Trauma" program. This is not listed as a "VHA Special Program." VVA asks that additional consideration be given to the unique nature and service delivery systems involved with this program. Sexual Trauma Counseling correlates to the criteria for one or more of the special programs listed in the plan. However, the scope of services and criteria for care are not exclusive to any one of these categories.

The law governing this program extends a special eligibility for treatment to any veteran -- man or woman -- which does not require them to file a claim in order to receive care. Additionally, this care can be delivered by professionals in either the Readjustment Counseling Service, or through VAMC outpatient facilities. Since significant resources have been invested in educating VA professionals about the special needs and treatment modalities appropriate for patients in these programs, VVA urges the Under Secretary for Health and the Congress to add this important program to the "VHA Special Programs" list.

CONCLUSION

VVA supports the principles put forth by Dr. Kizer in the reorganization plan, and is confident that these changes will move VA toward the goals of consumer-orientation, responsiveness, accountability, and provision of high quality care to American veterans. The future of the VA health system, and the unique care it provides to veterans, depends upon changing the way VA delivers its services. The concept put forth of "empowering patients" is critical, because any efforts to make patients equal partners in treatment and the development of policy will strengthen VA's capacity to better serve the veteran community.

Again, VVA appreciates the opportunity to present this statement for your review. We look forward to working with this committee and with VHA officials, to achieve these common goals. We would be pleased to provide any additional information you may need.

Attachment 1

VVA's Comments

to

DVA Under Secretary for Health
Dr. Kenneth W. Kizer

regarding the

Draft VHA Reorganization Document

February 27, 1995

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183
Telephone (202)628-2700 • General Fax (202)628-5880 • Advocacy Fax (202)628-6997 • Finance Fax (202)628-5881

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

"VVA, At Work in Your Community"

February 27, 1995

Dr. Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Dr. Kizer:

On behalf of Vietnam Veterans of America, Inc. (VVA), I would like to thank you for the opportunity to provide comments on the draft VHA Reorganization your office has prepared. As a veterans' advocacy organization, this is one of the most critical issues facing our constituency. We commend you for the process you have undergone in deliberating these issues, and for the vision you have shown in planning for the future of the VA health care system.

The reform, improvement and ultimate survival of veterans health care is of paramount importance to millions of veterans who depend upon VA services. Millions of other veterans do not currently use VA health care, but would if the VA were accessible to them. Another group of veterans does not currently want to access VA health care because of negative impressions, but if the system provided the services they need in a user-friendly and cost-effective manner, these veterans might be attracted to VA. As the largest single group of veterans, Vietnam veterans fall into each of these categories.

The reorganization plan you have put forward would move VA forward into the future, with clear goals and objectives toward improving access and quality of care, maximizing VA's existing assets, and creating the premier health care system for veterans. As you have noted both in the document and in briefings to VSO representatives, VA has significant assets which will guide it through the challenges of reform. Your leadership, experience and insight have given our organization confidence that VA can capitalize on these assets, and adapt to the changing health care delivery environment into the 20th century.

We agree with your assessment that the specialized programs, generally, need more development in this proposal. Those veterans currently utilizing VA care are in many cases dependent upon these specialized services. VA has created Spinal Cord Injury treatment, blind rehabilitation, prosthetics, geriatrics, environmental illness, homelessness, mental health and substance abuse program expertise based upon the specific and unique needs of the veteran population. We encourage you to more clearly define how these programs will fit into the VISN structure, to ensure that these unique VA specializations do not fall victim to local management and budget restructuring.

As VVA has noted before, our membership is very pleased to see that you have maintained the separate authority structure and budget of the Readjustment Counseling Service (Vet Centers program). The very unique community-based nature of the Vet Centers program is certainly an asset to the future planning of VA health care. Expanding access points is one of your primary objectives, and we would agree that this is critical to VA's ability not only to provide more cost-effective care, but also to reach out to those veterans who do not currently access VA services. The Vet Centers can serve as a model for this growth.

Perhaps the most important point VVA's membership would like to present to you in this regard, is that the Vet Center program's effectiveness would be significantly diminished if the Vet Centers were brought under the budget or management authority of the VA Medical Centers. The community-based aspect is critical for VA to achieve its mission of readjustment for veterans of all eras. Veterans who use the Vet Center program insist that these centers continue to be community-based and not have the threatening, bureaucratic environment of the VAMCs.

These community-based, walk-in assistance and referral centers have proven to be an cost-efficient and effective treatment for veterans seeking help for PTSD, its secondary symptoms of substance abuse, homelessness, as well as more basic VA benefits information and employment and training referrals. VVA is a long-time proponent of the Vet Center program, and this issue is critical to our membership. At our most recent National Convention in Norfolk, Virginia, August 4-8, 1993, VVA adopted a resolution urging that the Readjustment Counseling Service continue in its present configuration as a community-based service provider with locations separate from, and outside the budgetary and managerial control of the VA Medical Centers.

VVA believes that statistics would show that Vietnam veterans, as well as World War II and Korean War vets, veterans of the Persian Gulf War, and other veterans continue to utilize Vet Centers in even larger numbers than in the past, and many return for additional counseling. Post traumatic stress disorder affects veterans in many different ways and at varying times during their lives. And the Vet Center program provides a host of supplemental services, such as employment information, job referrals, etc. Again, one of the most beneficial points for you to consider in your efforts to expand VA health care access points, is the coordination already being done by Vet Centers around the nation, to conduct preliminary health screening and referrals.

You have noted that RCS will need to justify the continuing need for the Vet Center program, by more clearly defining what the Vet Centers do, and how this success can be measured and verified. We are currently soliciting anecdotal data from our membership which may be beneficial in this regard. Such information should provide insight into the very basic reasons veterans utilize Vet Centers, and how the Vet Centers help these veterans -- thus, the consumers perspective on success of the program may be ascertained.

One point which must be considered when evaluating the Vet Centers, whose primary mission is that of PTSD counseling, is the intangible nature of mental health services generally. When trying to measure success or failure, or determine the most cost-effective treatment, mental health is distinguished from other specialties, because there are perhaps greater factors beyond

the health care professional's purview or control which influence outcomes.

When treating a patient for infection, for instance, it is easy to measure success -- the infection is defeated and the patient is again healthy. It is more difficult to measure the distance from point A to point B, so to speak, in the realm of the human mind. Relapses and/or secondary problems may be ongoing, even when significant treatment successes can be noted. Measuring success is an ongoing challenge for the field of mental health professionals, as noted in the context of the national health care reform debate, and VVA would be pleased to work with you and your staff to address this issue.

The issue of accountability in VA health services is and has always been a concern for our membership. We note your presentation in Chapter Four of the draft document and urge you to continually consult VA's consumers in the ongoing development of performance measures. Many veterans and Congressional leaders may be cautious of decentralization efforts, because of the fear that accountability will disappear. Accountability has been a long-standing problem for the VA health care system. Perhaps the most visible example of this problem is that of women veterans health services. Efforts to develop a decentralized decision-making structure should bring this accountability down to the most local level. And it is our feeling that your proposed central office realignment will provide more control over conflicting directives and objectives to the field.

VVA is very supportive of the goals and objectives put forth in this draft reorganization document. This proposal should allow VA to allocate resources based upon demand for services, and to evaluate system performance based upon overall outcome and consumer satisfaction, rather than on obscure bureaucratic culture which does not lend well to the changing private sector health care environment. Your outside perspective brings fresh ideas into the VA health care system, and does not show bias toward a specific background or concern. Your perspective is global in nature, and the changes you advocate are for the long-term wellbeing of veterans and the health system developed to serve them.

Again, VVA appreciates your work on behalf of our nation's veterans, and we look forward to working with you to continue the development of this plan. Please do not hesitate to contact me or my staff at any time.

Sincerely,

/signed/
Paul E. Skoglund, CAE, CMP
Executive Director

PES:krw

Attachment 2

Testimonials Submitted

to

Vietnam Veterans of America, Inc.

regarding the

Readjustment Counseling Service (RCS)
Vet Centers Program

MINNESOTA STATE COUNCIL
VIETNAM VETERANS OF AMERICA
Veterans Service Building
20 West 12th Street, #121
St. Paul, MN 55155
(612) 224-6345

March 9, 1995

Vietnam Veterans of America
Government Relations Department
1224 M Street, N.W.
Washington, D.C. 20005-5183

Attn: Vet Center Testimonials:

Many members of Vietnam Veterans of America here in Minnesota, have availed themselves of the excellent counseling services available through the Vet Center System.

I have heard numerous favorable comments from individual veterans about the understanding attitude of Vet Center staff members and the valuable assistance that the centers dispense.

Because of the nature of the Vietnam War, many returning veterans have had reservations about participating in more formally organized and directed programs. For that reason, centers located in the communities in which the individual veteran resides and staffed by veterans with similar experiences, have proven to be particularly effective in reaching the sometimes isolated Veterans of the Vietnam Era.

Also, peculiarities of the Vietnam War have exacerbated what has in prior conflicts been called combat fatigue and which Vietnam Veterans identify as Post-Traumatic Stress Syndrome or PTSD.

Captured U.S. soldiers faced torture (being skinned alive), both sides sometimes threw away the "rule book" during brief, brutal jungle engagments, civilians were friendly and just as often as not were also the enemy, the measure of success was the body count (which unexpectedly proved to be morally and psychologically corosive), the soldiers were young, their transition from the field was abrupt and often executed with no counseling prior

to their discharge (sometimes in as little as 48 hours from the depths of the swamps to the indifferent streets) and the welcome home was sometimes hostile (which prevented the psychological reintegration of many veterans with the society that they had thought they were protecting with their blood).

Vet Centers have proven especially proficient in attracting this type of combat numbed, "outsider" veteran. When the Vet weakens emotionally from his struggle, when he tires of his personal nightmares and painfully constant memories, when he has exhausted the energy necessary to maintain his equilibrium, when his encroaching nightmares threaten to overwhelm him and when he turns to embrace alcohol and drugs as a coping and survival mechanism, A Vet Center has been readily accessible to that veteran.

Sincerely,

Bruce T. Branigan
State Legislative Coordinator
Vietnam Veterans of America
Minnesota

March 4, 1995

Dear Whom It May Concern,

I am a Vietnam veteran having served there in 1968-1969. My duties were Infantry (11B20) in a Forced Recon Unit of the 1ST Division and later as a Communications NCO in the Mobile Riverine Force of the 9TH Division. My total service to my country was four (4) years active duty and one (1) year Active Reserve.

When I came back to the states from Nam it was to a very confusing state of affairs. Not only was I suffering from survival guilt but was met with indifference from a nation that blamed me for the Vietnam War.

I withdrew to escape reality through constant moves and the inability to hold a job. Nightmares and the inability to adjust pushed into the depths of alcoholism and drug addiction.

After a period of homelessness and deep despair I sought help. Through the efforts of a Rehab and AA I have been in recovery since October 1983. My life changed dramatically but there was still something missing.

During my efforts to save a marriage I sought help at the Vet Center in Lake Worth, Fl. in 1989.

One of the greatest attributes of this Center was that it doesn't have the look of bureaucracy and being government issue. It gave me a feeling of being truly home. Being in relaxed surroundings with a group of trained individuals that understood where I was at which I had no earthly idea. They supported and guided me with whatever was necessary.

Through individual counseling I grew to understand why I have difficulty in trusting people, isolation, inability to have close relationships, insomnia, nightmares, memory loss, etc. and was given the life saving tools to cope. They have helped me to deal with the guilt of surviving.

I attend group twice a month with other veterans at the Center now which a tremendous help that I still need. Also since the Vet Center has opened to veterans of all conflicts I've noticed more veterans reaching out for help. These include veterans of World War II and Korea. What I've learned since being diagnosed with PTSD that this is a never ending disorder that must be constantly acknowledged through help and medicine in most cases.

When I went into the service for my country I was promised Health Care for life and as years have gone by the Congress has slowly stripped away those benefits. The only time Congress seems to stand up for veterans is when the country needs them and when all is calm they fade away.

I agree cuts need to be made but why do you take away from those who have served to insure that America would be safe and free. Why do you care more for those who have never served their country than the veterans who sacrificed their lives and careers to insure World Peace? Don't we deserve more? Because of the inability to properly care for veterans we make up 40% of the homeless population, VA Medical Centers have empty beds is because of staff and fund reductions. How many of the over 50,000 suicides among Vietnam Era vets been saved had the government been more supportive?

Why doesn't Congress stand up for those who have stood up for you!!!

Yours truly,

BEN L. HUMPHRIES
SSGT U.S. Army
1967-1973
Vietnam Veterans of America
Fl State Council

331 Tequesta Dr #214

Tequesta, Fl. 33469

March 10, 1995

Vet Center Testimonials
Government Relations Department
1224 M St., NW
Washington, DC 20005-5183

Dear Sirs;

I am writing in support of retaining the Vet Center program in its present configuration and as a separate program apart from the VA Medical Centers. Over the previous sixteen years, this program has proven to be a world leader in providing care to Vietnam-Era veterans, those theater veterans from subsequent wars, and their families. In comparison of expenses, the Centers are run in a cost efficient manner and are only a small portion of the overall DVA budget. It is a model of efficiency and helps reduce the drain on resources at VA Medical Centers by providing a place for ambulatory mental health care in an atmosphere of warmth and caring. Each of the professionals that I have had the pleasure of meeting across this state have one goal in common: providing the best possible care to those who have borne the brunt of battle.

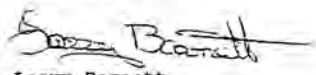
Many of our veterans are suspicious of government programs and would not receive any help at all if not for the Vet Centers. On numerous occasions, I have been personally involved in crisis situations with veterans, only to have them refuse to go to the VA hospitals for help. Yet almost to a man they will go to the Vet Center, due to the positive remarks they have heard from other veterans and due to the diligence of the staff of these Centers. There is an immediate response to each and every request for assistance. I have personally gone to a VAMC, only to be told I would be able to get an appointment with mental health in thirty days or more. This is totally unsatisfactory. I realize that this is not the fault of the VA staff, but due to the overload of cases they are required to handle. I have truly seen remarkable instances where individuals, whom many had given up on, have turned their lives around and become contributing members of society, directly related to the assistance rendered by the Vet Centers.

The majority of Vet Center staff are veterans from many different eras and backgrounds. This has been very important in assisting veterans. Many veterans will not work with a non-veteran, as many of the staff of VAMC mental health clinics are. Once again this is not an attack on their professionalism, but rather a symptom of the problems of the Post-Korea veteran population.

As a combat veteran who has seen the horror of war, I can truly say that I will never forget the impact of combat upon an individual. To raise the question that any veteran should now be "okay" and will never again need assistance shows a basic misconception of the trauma of war. For those of us who fought America's wars the memory is forever burned into our minds. I implore you to continue to fight to retain this program.

The DVA is attempting to change from its previous bureaucratic complexity and we applaud this change. But the direct line authority of the Vet Center program allows it to be more efficient and accountable to the veterans and the DVA. Is this not the goal of the realignment of the Department of Veteran Affairs? Maybe the Vet Center program should be utilized and enhanced as a model of the efficiency of a government program, rather than as target for those with other agendas.

Sincerely,



Larry Barnett
President

March 10, 1995

Vietnam Veterans of America
Government Relations Dept.
1224 M Street N.W.
Washington, D.C. 20005-5183
Attn: Vet Center Testimonials

Dear Reader

My husband, Lester L. McLaughlin, is a Vietnam veteran with three Purple Hearts. He has been receiving counseling from Jan Sparks at the Vet Center in Charleston, W Va. for approximately 15 months. Jan is a wonderful lady and she understands and identifies with the male vets who are in my husband's group. She guides them and encourages them to talk about home life, work, Vietnam, drug abuse, everything. The guys feel they can be totally free with her. She makes no judgments. He looks forward to the weekly meetings at the

Vet Center because he feels at home, wanted, cared for, listened to. On his first trip to the Center, he was met by two Vets and with tears streaming down their faces, they shook his hand and said, "Welcome home, Brother". He has more of a family relationship with the staff and members of the Vet Center than he does with his parents and 11 brothers and sisters.

As for placing the Vet Center in a VA Hospital, I say no. Have you ever been to a VA Hospital? Well, I have. Countless dollars were spent at the Hospital in Beckley to beautify it and I must say it does look nice. However, the staff is still inconsiderate and even rude. They leave you with the impression that you are asking for welfare assistance and the money you want is theirs personally. The

staff spends a lot of time, walking around with cups of coffee ignoring the long lines of patients waiting for assistance.
My husband makes a 200 mile round trip drive every two months to the Beckley VA Hospital for mental health counseling with Dr. Faheem. I also go because I must do all the driving as my husband does not have the confidence to drive in heavy traffic as he did in pre-Vietnam days. Dr. Faheem, on the average, spends no more than 2 minutes with my husband and that is used to write out prescription for drugs. Instead of counseling my husband to get at the source of his problems, Dr. Faheem gives him drugs to cover them up. On the other hand, when he goes to see Jan at the

Vet Center, he finds he has a friend who listens, cares and encourages. He has made a lot of mental progress because of Jan Sparks, the Vet Center, and his new friends.
It would be a great loss if the Vet Center was transferred to a VA Hospital. My husband would not be able to go because the closest hospital is 100 miles one way. My husband has not come far enough mentally or emotionally to make it on his own.

Thank you.

Priscilla M. McLaughlin
SR 3 Box 298
Drydale, WV 25113

304-286-2114

March 10, 1995

Vietnam Veterans of America
Government Relations Dept.
1224 M Street N.W.
Washington, D.C. 20005-5183
Att Vet Center Testimonials

Dear Reader

I am writting about the pending closure of the Vietnam Outreach Centers. This issue concerns me and others very much. I hope the outreach centers can be kept going. The outreach center in Charleston has been the best thing that has happened to me in a long time, for the past fifteen months I have been receiving one on one counseling from ~~what~~ I believe a very good counselor. I also go to group counseling. There is no doubt the outreach center has helped me with my anxiety and temper problems. I went to the closest Va Hospital which is over a hundred miles away for help. I get very nervous and angry when I drive so my wife drove me. We did this ~~three~~ three time and I was served with the mental health doctor two minutes. I think he (Dr. Faheem Beckley Va Hospital) is a joke. Dr Faheem is cheating the government, the tax

paper out of money and me out of the help I need and deserve. The doctor only wants to give pill that will cover up the [redacted] problems of Vets. I think that the Vietnam Outreach Center is of much more help to me. I just know the two hours I spend there benifets me more than the two minutes I spend with Dr Thum. I would like to continue the group meetings but if the outreach centers ~~not~~ moved into the Va Hospitals it will be to far to drive making it impossible for me to continue. I was wounded three different times in Vietnam, I have three purple hearts and sometimes become very angry and nervous. I do not want the Va Hospital to make me dependent on drugs. I will not become a Zombie. There pills make Zombies of Vets.

Thank you.
Lester L McLaughlin
Rt 3 Box 298
Ivydale, WV 25113

304-256-2114

VIETNAM VETERANS OF AMERICA
Captain Candido E. Molinet
Miami Chapter 620
P.O. Box 527568
Miami, FL 33152-7568
(305) 667-1787
(FAX) 667-1868

09 March 1995

Vietnam Veterans of America
Government Relations Department
1224 M Street, N.W.
Washington, D.C. 20005-5183

Attn.: Vet Center Testimonials

Dear Sir/Madam,

The purpose of this letter is to emphasize the importance of maintaining the Vet Centers, a separate entity from the VAMC. The need of this arises from the difficulty that a great majority of Vietnam veterans have in dealing with the VAMC'S.

This breaks down to two basic problems encountered by vets, seeking help at the VAMC'S. First is the bureaucratic run around so well know to Vets. Second is the lack of Vets serving Vets, regardless of the attempts made by non-vet staff to intergrade with the veterans, it is much more productive when the vet encounters another vet. For the simple reason that the trauma associated with combat or the problems with readjustment to civilian life can not be fully realized by anyone that has no true reference point.

In contrast the experience of going to a Vet Center, is almost as familiar as going home, to a family reunion of sorts. I myself have used both avenues only to fine in most cases the VAMC in Miami to be lengthy in waiting time (average 2-4 hrs.) And that is for medical care intake only. As opposed to the personal attention and care seen at the Vet Center.

Please as a vet and one appointed to speak on behalf of many other vets, lets leave something that is working well alone. See attached copy of executive summary report from the Miami Vet Center.

Respectfully,

Daniel L. Peres (357-52-4599)
Legislative & Governmental
Affairs coordinator
VVA Chapter 620, Miami FL.

EXECUTIVE SUMMARY

MIAMI VET CENTER
2700 SW 3RD AVE
SUITE 1A
MIAMI, FL 33129
(305)859-8387

- ESTABLISHED IN MARCH, 1980

- STAFF:

TEAM LEADER	ED CALVO, M.S., LPC
THERAPIST	DOMINGO SANTANA, MSW
VOCATIONAL COUNS.	ULSYEE WILLIAMS, B.S.
OFFICE MANAGER	KATHY CARTER

- PRIMARY AREA SERVED: DADE AND MONROE COUNTY

- VETERAN POPULATION:

MIAMI CATCHMENT AREA - 490,000 VETERANS/ALL ERAS
- 142,000 VIETNAM ERA VETERANS
- 47,000 IN-COUTRY VIETNAM
- 4,000 PERSIAN GULF
- 100 LEBANON
- 100 PANAMA
- 50 GRENADA
- 14,523 ESTIMATED PTSD CASES (30.9% RTI STUDY)

- CASELOAD:

CLIENTS SERVED TO DATE = 8,224

ACTIVE CASES = 225

NEW CLIENTS PER MONTH = 45 (AVERAGE)

CLIENTS VISITS PER MONTH = 250 - 300 (AVERAGE)

MAJOR DIAGNOSIS/PROBLEMS (APPROXIMATE)

PTSD	= 25%
DRUG/ALCOHOL	= 10%
MARITAL/FAMILY	= 05%
PSYCHOLOGICAL/OTHER	= 15%
EMPLOYMENT	= 35%
BENEFITS	= 03%
BASIC NEEDS	= 04%
MEDICAL	= 01%
LEGAL	= 01%
OTHER	= 01%
TOTAL	= 100%

- STAFF COMPOSURE:

IN-COUNTRY VIETNAM VETERANS	3
IN-COUTNRY PERSIAN GULF	0
VETERANS STATUS	3
BLACKS	1
HISPANIC	2
WHITE	1
MALE	3
FEMALE	1
DM&S CREDENTIALS	0
PSYCHOLOGY INTERNS	0
DVOPS	2
PRACTICUM STUDENTS	0
VOLUNTEER/WORK STUDY	0

- CLIENT DEMOGRAPHICS:

BLACK	18%
HISPANIC	11%
WHITE	70%
OTHER	01%

VIETNAM ERA VETERANS	89%
VIETNAM THEATER VETERANS	70%
OTHER ERA VETERANS	3%
PERISAN GULF VETERANS	7%
LEB/GRA/PAN/VETERANS	1%

MALE VETERANS	98%
FEMALE VETERANS	02%

March 9, 1995

Vietnam Veterans of America
Goverment Relations Department
1224 M Street, N.W.
Washington, D.C. 20005-5183

Attn: Vet Center Testimonials

Dear Sirs/Madam,

As a Vietnam Veteran I am appalled that the politicians and the overpaid bureaucrats at the Veterans Administration are once more engaged in a nefarious campaign to close the Vet Center Programs.

Since 1981, I have availed myself of the professional and compassionate sevices at numerous Veteran Outreach Centers. Notably, the Vet Centers of San Diego, San Francisco and Concord, California. Because of the very existence of the Vet Centers, I am fortunate enough to lay claim to the title of **"One of the walking wounded instead of one of recently deceased."** The Vet Centers deliver the services and they have always been there for this Veteran, whereas, the same can not be said for those cowards who would call for the downsizing and reorginization of our Vet Centers. Or is this just another sleazy attempt to abolish existing services while laying the groundwork for compleatly denying any and all services for U.S. Veterans and their families.

Just this past Tuesday, I was accompanying a good friend to a hearing at your new multi-million dollar building in downtown Oakland. I must say I was very impressed. However, I did note that outside of what looked liked an excessive number of V.A. staff, sadly very few vets were seeking services at this mammoth office complex.

I walked just a few blocks away and there I saw a line of veteran's waiting patiently, (no surprise) at the V.A. Outpatient Clinic. Not far from the Oakland O.P. clinic are a set of nondescript buildings that are being used by 20 or more veteran's for transitional housing at a V.A. funded community based program. Just like the Vet Centers this facility is under the direction of a hard-working, two tour Vietnam veteran and one volunteer who proved his mettle as a Platoon Commander in charge of one of those forgotten hilltops outside of Khe Sahn, namely Hill 861 (South).

These two men, just like their collegues at the Vet Centers are addressing just one of the issues of our homeless veterans population that continues to swell as we add to their ranks the numbers of veterans that

Page 2, (con't)

have recently been discharged from the Persian Gulf War and the humanitarian Somalia relief operation. Statistically speaking, it's no secret that anywhere from 30% to 35% of our nation's homeless are men and women who have been released into our communities after serving their duty in the U.S. Armed Forces. No doubt, they were magnificently trained for their respective missions but they are totally unprepared for the degeneracy and degradation of the streets and by God, they shouldn't have too. On the other hand, they have at least a fighting chance if the Vet Centers and V.A. community based programs are there to keep them from falling thru the ever shrinking social safety net.

You can forget about reorganizing the Vet Centers with the regional Veterans Health Administration. It didn't work 25 years ago and its not likely to work now. Many of us still remember the insufferable bureaucracy and the condescending attitudes of the regional center employee's. Having to spend an entire day of getting shuffled from one clerk to the other, only to be told by the other clerk that you are in the wrong place and then to be sent downstairs to see another clerk that no, you must see the receptionist and to start your unsuccessful journey all over again. A waste of time for the Veteran not to mention, the taxpayers who is footing the bill for this little exercise in futility. The Vet Centers have proved their worth time after time, saving not only lives of countless Veteran's but restoring the Veteran to his family and so much more. All of this is done at a comparative cost of what the V.A. would spend if we are forced to return to the days of the V.A. Jurassic period sometime prior to the 1980's.

What becomes of the staff at the Vet Centers in the wake of all this reorganizing and downsizing. In my book, the most dedicated talented and compassionate professionals that God saw fit to put on this planet. Their generosity and devotion is only exceeded by their wit,warmth and first hand knowledge of the unresolved issues that still plague a rather sizable number in the Veteran's community throughout this nation. The Staff at the Vet Centers are the best that you have and they should not be left to twist in the wind while waiting for a pink slip from the V.A. or worse being consigned to a lavish office only to shuffle papers from file cabinet to another until boredom forces them into an early retirement. Their selflessness and dedication to those they serve is more than just serving, it is nobility and unconditional love that drives the Vet Center offices. When will the Washington insider's finally understand this simple refrain? "If it works; don't fix it."

It saddens me to think that my message may be thought of as glib, sentimental and without merit. But, you see I remember my Vet Center provider's. Their names and all they did, for me and my family over the last 14 years.

Page 3, (con't)

Men and women, a few like myself, expatriates from the City of Brotherly Love, racially and culturally divirse but all of them dedicated to one simple idea, that love and a sense of brotherhood and sisterhood combined with dedication, purpose would result in a revolutionary new concept that would be known as the **"Vet Centers"**

An eclectic group for sure, the team leader's were often highly decorated and more than a few had suffered permanent disabilities. People like, **Jack McCloskey, George Gibbs, Lily Adams, Arlan Tihbats, Bob Mertz, Alan Perkal, Mike McCormick, Rose Sandecki, Denver Mills, Mary Sue Planck, Farroll Udoll, Brian Augustine, Billy Nacimeinto, Phillip Moss, Helen Lee, William Jackson, and Judith Rewey.** I would be remiss if I failed to include the names of those V.A. Hospital Staff in whose care I have remained these last 8 months. **Doctor Joan Kotin, Nicol Miller, Ph.D, Andrea Loveday, Tony Alonza, Byron Eggers, Reenie Davidson, Joyce Michelson, R.N.** and my hat is off to the entire staff of residents and interns whose invaluable contributions are so often overlooked. As an afterthought, the V.A. Hospital in Martinez, CA., **should have remained open.** No amount of political doggerel is going to convince this veteran that the closure of this hospital was pure sleaziness. Concocted and authorized by gutless politicians and carried out by bureaucratic sycophants.

It may sound trite, but **Mitch Snyder, activist and samaritan in Washington, D.C., was fond of saying, "that a bureaucracy is just another word for an institution that <u>stops caring</u>."** I should hope that this clamor for reorginization of the Vet Centers will cease and desist. For if it does not, than I fear that those responsible will have to bear the burden of a Veteran's backlash that has not been seen since the days of the debacle of the **Agent Orange Hearings.**

Over these last 25 years, I bear the pain of the walking wounded and the knowledge that my personal contribution to the war in S.E. Asia, wouldn't add up to a cup of spit. But I temper those thoughts with the graditude that for a few brief moments in time, **"I WALKED WITH KINGS."** I had lost that feeling but I got it back when I walked into a Vet Center. I was someone special again. hell, we all are!

The dedicated employee's of the Vet Centers don't need a pat on the back or a tawdry certificate of merit that will only brown with age. They and the Veterans they serve need, **extended funding, a substantial increase in salaries and the support of their superiors. A few of them, who in their never ending climb to the top of the heap may have slightly forgotten, <u>where they came from and who they are mandated to serve</u>.** As long as I'm the subject of funding, why not share the wealth with some of your other V.A. community based programs like. Operation Dignity in Oakland and Swords to Plowshares in San Francisco. Their combined staff and volunteers deserve nothing less than your whole hearted support.

Page 4, (con't)

I would like to close this letter reminding the politicians and the bureaucrats at the Veterans Administration with my final plea for keeping and maintaining the Vet Centers, just the way they are. but with a little more funding.

After all, our first President and Commander in Chief, General George Washington left us with this footnote of history,

"That a Nation
that fails
to honor
and serve
its veterans,
relinquishes the right
to ask
the next generation
to fight its battles."

Respectfully submitted,

Robbie Robinson
Vietnam Veteran
1967-68

cc: San Francisco Chronicle/Examiner
Contra Costa Times
Congressman George Miller
U.S. Senator Barbara Boxer

VIETNAM VETERANS OF AMERICA
TRAYLOR CHAPTER 602
P. O. BOX 2326
ANNISTON, ALABAMA 36202

March 9, 1995

Vietnam Veterans of America
Government Relations Department
1224 M Street, N.W.
Washington, D.C. 20005-5183

ATTN: Vet Center Testimonials

Dear Sir or Madam:

Any change in the Vet Center program would be detrimental to the greater Anniston, Alabama community, especially the Anniston Army Depot.

Currently this VVA chapter is providing facilities for the Birmingham Vet Center staff to conduct individual and group counseling services twice per week at no cost to the Department of Veterans Affairs.

All veterans of conflicts and peace keeping actions from World War II, through Korea, to the Vietnam War and the various military operations including the Persian Gulf War and even the operations in Somolia have affected this community.

The Birmingham Vet Center's willingness to go to problem areas in outreach programs have greatly helped veterans to readjust to civilian life or have provided the needed confidence that veterans lack when they view the Department of Veterans Affairs.

The employees of the Vet Centers are motivated to work together with non government groups such as our Vietnam Veterans of America chapter to improve the quality of life for numerous veterans.

In conclusion, the Vet Center program is not viewed as a veteran's benefit but rather as a resource for readjustment to civilian life after serving in the Armed Services in defense of our national interests.

Sincerely yours,

Ken Rolline
President

March 7, 1985

Lawrence C. Sipe
300 Scary Road
Scott Depot, WV. 25560

Vietnam Veterans of America
Gov't. Relations Dept.
1224 M. Street, NW
Washington, DC 20005-5183

Attn: Vet Center Testimonials.

Gentlemen:

I am a service connected disabled Vietnam Veteran who has been fortunate enough to be able to use our local Vet Center for the past year, for treatment of PTSD. I have also had the opportunity to use the facilities of the Mental Health Clinic at the Regional VAMC in Huntington, WV. The Regional VAMC resources pale by comparison to those available at our local community based Vet Center. I am personally located approximately 40 miles from the VAMC and each time that I have had appointments I have spent far more time waiting to be seen than I had in travel time, to be able to spend maybe 15 minutes with a therapist and in some cases have had to return for another visit because the therapist was not there. In contrast, our local Vet Center is only 12 miles from my home and I have weekly therapy sessions which last at least 2 hours and I can walk in at any time when I am having a problem and there is always someone there who can help me.

I STRONGLY OPPOSE the reorganization and relocation of the local community based Vet Centers.

I also understand that the Senate has passed a Bill and has been waiting on House approval which would effectively allow Readjustment Counseling Services (Vet Centers) to be free standing entities from the Veterans Administration. I would STRONGLY SUPPORT this measure.

I hope that letters like mine from veterans who benefit from the resources available at Community Based Readjustment Counseling Services are taken seriously by those members of Congress who by the way happen to be there only because of our VOTES.

Thank you,

Lawrence C. Sipe

TENNESSEE
STATE COUNCIL, INC.
VIETNAM VETERANS OF AMERICA
1385 Victora Drive SE
Cleveland, Tennessee 37323
(615) 472-4187 (Voice/Fax)

March 9, 1995

Honorable Bob Clement
United States House of Representatives
Room 1230
Longworth House Office Building
Washington, D.C. 20515-4209

Bob

Rep. Clement,

Thank you for your kind letter of January 7, 1995. I am looking forward to a positive relationship between the Tennessee VVA and your office.

I am writing to express the concern of the Tennessee Vietnam Veterans of America about the possible restructure of the Readjustment Counseling Service (RCS)/Vet Center Program.

While it is my understanding that the VHA reorganization maintains the separate authority, structure and budget of the Vet Centers, there is possible opposition from some Congressional leaders who would prefer to have the centers put under the authority of the VAMC and/or have them disappear entirely. Needless to say, our members throughout Tennessee would not like to see this happen.

Not only have the Vet Centers been extremely effective in their dealings with World War II, Korea, Vietnam and Persian Gulf veterans, but are, in many cases, the only available center for counseling for many miles.

We want to ensure that a plan to maintain the autonomous line authority and budgeting of the Vet Center program is adopted. Recent figures show that the veterans mentioned above continue to utilize Vet Centers in even larger numbers than in the past, and many return for additional counseling.

I hope we can count on your support in keeping the Vet Centers open and operating in Tennessee as well as the rest of the country. I will be attending the VVA Congressional recepeion, 6:00 - 8:00 pm at the Washington Vista International Hotel on April 5, 1995. Hopefully we will be able to get together and visit some.

Thank you for your help and support of Tennessee's Vietnam veterans.

Semper Fi

John H. Simmons
President

In Service to America

Vietnam Veterans Of America, Inc.
Oregon State Council — P.O. Box 12606 Portland, Oregon 97212

March 2, 1995

Mr. Jeffrey W. Jepsen
National Director, Government Relations
Vietnam Veterans of America
1224 M Street, NW
Washington, DC 20005-5183

Dear Mr. Jepsen:

Thank you for giving me this opportunity to comment on the effectiveness of the Vet Center program as currently structured. I trust your presentation before various Congressional committees will reflect the views of Oregon's membership -- a view of strong support for a small, highly efficient program amid countless others of dubious performance. There are few programs exhibiting as wise a use of tax dollars.

The basic reason for the outstanding success of the Vet Center Program is the relative autonomy it enjoys. Without this independence from the rest of the U.S. Department of Veterans Affairs (VA), the program would cease to be effective.

Vet Center clients will not continue to access this vital program should this fire wall be breached. Many veterans want no part of the more structured, rigid, bureaucratic VA system. Untreated for their Post Traumatic Stress Disorder (PTSD), these veterans will fall back into the shadows, never to realize the potential in themselves nor to contribute to our society. Any hope of these veterans becoming taxpaying, productive members of society will fade.

The Vet Center Program, and the Salem, Oregon Vet Center in particular, has made an indelible impression on my life. Diagnosed and treated for PTSD, I am now able to make some contributions to those around me. Following treatment, I was able to secure employment, something I had been unable to hold on a permanent basis for many years. Life is not easy, but the Vet Center has given me the hope that life can go on.

Thanks again for the opportunity to share my thoughts with you. The Vet Center program must remain independent of the rest of the VA. Thousands of veterans, from World War II to Somalia, are using the critical services provided. The environment which fosters veterans' participation in this healing must be preserved.

Sincerely,

Robert Fleming

Robert Fleming
Oregon Legislative Coordinator

Carl Alan Rust
P.O. Box 955
Woodland Park, CO 80866
PH: 719-687-9302

February 9, 1995

Dr. Al Batres
Director, R.C.S. (115)
810 Vermont Ave. NW
Washington, D.C. 20420

Dear Dr. Batres:

I am writing to personally encourage the continuation of the Vet Center Program as it now exists. It is my understanding there is some discussion regarding placing the Vet Centers directly under VA Hospital administration. That would be a serious mistake. The fact that the Vet Centers operate independently has been one of the primary reasons for the success of the program. As a Vietnam veteran who has used the program, I can speak with first hand knowledge of how important it is to the health and well being of veterans.

Having served in Vietnam (HHC 1st Signal Brigade, March 1971 - January 1972) and being a "base camp warrior" I had determined that I did not have any issues that needed to be addressed. For too long I had decided not to discuss or relate my feelings and had not realized the extent and depth of the psychological and emotional wear that had taken place. It was only after I had become involved in a veterans organization (VVA) in 1988 that I began to realize that my service had affected me very deeply. Fortunately, because of a close affiliation with our local Vet Center, I was able to seek help in dealing with and validating my grief, guilt, frustration, and anger. It was only through the Vet Center and its staff that I came to an understanding and acceptance of what my tour had meant to me.

During the year that I participated in a group at the Vet Center (1989-1990) I found an acceptance and sense of camaraderie with other veterans, both combat and non-combat, in-country and not, that helped me to realize that my service was important, that my fellow veterans did not place any less importance on what I did or where I was, that the fears and reactions, the animosity, sense of betrayal, and anger, were normal reactions to a situation that had shaped my life.

Since it took some 16 years for me to seek assistance I can well imagine there are still many more veterans, not only from Vietnam, but all of our war time, and in some cases, peace time, that need the assured opportunity and availability of a safe place that the Vet Centers provide. This is especially important now that the special requirements of women veterans have been recognized. There is no doubt in my mind that the minimal costs associated with the Vet Centers is money well spent. They provide the opportunity to be pro-active rather than reactive to problems of readjustment that veterans may have. In these days of military downsizing, this important benefit may become even more critical. In addition, the knowledge gained from the Vet Center Program and its success is now a part of civilian lives in dealing with natural disasters and personal traumas. That knowledge and expertise would not have been gained if it had not been for the Vet Centers.

Sincerely,

Carl Alan Rust

COPY OF LETTER I SENT TO AL BATRES.

CARL

P.S. I AM COLORADO STATE COUNCIL PRESIDENT.

March 3, 1995

Agnes E. Feak
Florida State Legislative Coordinator
Vietnam Veterans of America
936 Andrews Road
West Palm Beach, Florida 33405

To Who it May Concern,

I would like to write this letter in response to the possibility of the Vet Centers being removed from the Veterans Administration's Budget.

I was seventeen years old when I join the Women's Army Corps. I am a Vietnam Era Veteran. Even though the Vietnam War has been over for twenty years, the experiences, nightmares and tragedies of that terrible war will never be over.

I just recently went to the local Vet Center after realizing that I needed help. I came from a war torn Country, Budapest, Hungary and served this country in its time of need. The statement that if your not over the Vietnam War yet, you'll never will be, so why provide treatment is an statement made from ignorance and stupidity. Anyone who has seen the death and destruction of war knows you will never be over it, but with constant help and counseling you can live a full life. Don't veterans deserve that? The Vet Centers provide that needed care. Away from the bureaucrats and pressure of government, the Vet Centers give good care to so many Veterans. All Veterans, even World War II, fifty years later, are being provided needed support.

This Country's record in providing support and care to their Veterans is so POOR!!! We ask eighteen year olds to sacrifice their career, lives, and youth to serve this country, but when it's over and they come home the support is gone. Who cares that over 50,000 Vietnam Veterans have committed suicide? Who cares that 40% of the homeless is Veterans? Who cares that Desert Storm Veterans are dieing from chemical exposure? Who cares that children of Vietnam Veterans are being born with disabilities because of Agent Orange? I ask you why do we have to fight for benefits that we earned from our sweat, and our sacrifices? WE EARNED THEM!!!!

My son, who is sixteen wants to join the military, so like his father and mother he can serve this country.
This country doesn't deserve him or any other young person, not until his government understands my fellow veterans and my pain. I have a suggestion, next time we need to embark on another conflict or war, why don't you send our legislators and senators instead of our children.

Respectfully,

AGNES E. FEAK
US ARMY 72-78
Florida State Council Vietnam Veterans of America
Legislative Coordinator

March 4, 1995

Dear Whom It May Concern,

I am a Vietnam veteran having served there in 1968-1969. My duties were Infantry (11B20) in a Force Recon Unit of the 1ST Division and later as a Communications NCO in the Mobile Riverine Force of the 9TH Division. My total service to my country was four (4) years active duty and one (1) year Active Reserve.

When I came back to the states from Nam it was to a very confusing state of affairs. Not only was I suffering from survival guilt but was met with indifference from a nation that blamed me for the Vietnam War.

I withdrew to escape reality through constant moves and the inability to hold a job. Nightmares and the inability to adjust pushed into the depths of alcoholism and drug addiction.

After a period of homelessness and deep despair I sought help. Through the efforts of a Rehab and VA I have been in recovery since October 1980. My life changed dramatically but there was still something missing.

During my efforts to save a marriage I sought help at the Vet Center in Lake Worth, Fl. in 1989.

One of the greatest attributes of this Center was that it doesn't have the look of bureaucracy and being government issue. It gave me a feeling of being truly home. Being in relaxed surroundings with a group of trained individuals that understood where I was at which I had no earthly idea. They supported and guided me with whatever was necessary.

Through individual counseling I grew to understand why I have difficulty in trusting people, isolation, inability to have close relationships, insomnia, nightmares, memory loss, etc. and was given the life saving tools to cope. They have helped me to deal with the guilt of surviving.

I attend group twice a month with other veterans at the Center now which a tremendous help that I still need. Also since the Vet Center has opened to veterans of all conflicts I've noticed more veterans reaching out for help. These include veterans of World War II and Korea. What I've learned since being diagnosed with PTSD that this is a never ending disorder that must be constantly acknowledged through help and medicine in most cases.

When I went into the service for my country I was promised Health Care for life and as years have gone by the Congress has slowly stripped away those benefits. The only time Congress seems to stand up for veterans is when the country needs them and when all is calm they fade away.

I agree cuts need to be made but why do you take away from those who have served to insure that America would be safe and free. Why do you care more for those who have never served their country than the veterans who sacrificed their lives and careers to insure World Peace? Don't we deserve more? Because of the inability to properly care for veterans we make up 40% of the homeless population, VA Medical Centers have empty beds is because of staff and fund reductions. How many of the over 50,000 suicides among Vietnam Era vets been saved had the government been more supportive?

Why doesn't Congress stand up for those who have stood up for you!!!

Yours truly,

BEN L. FOMBELLES
SSGT U.S. Army
1967-1973
Vietnam Veterans of America
Fl State Council

331 Tequesta Dr #214

Tequesta, Fl. 33469

VIETNAM VETERANS OF AMERICA, INC.
Alabama State Council
Post Office Box 913
Jacksonville, Alabama 36265

Tel: 1-205-447-3044
Fax: 1-205-447-8915

February 28, 1995

Vietnam Veterans of America
Government Relations Department
1224 M Street, N.W.
Washington, D.C. 20005-5183

ATTN: Vet Center Testimonials

The bottom line is if it is not broken, do not fix it. Specifically the Birmingham, Alabama Vet Center will be addressed. I have known this center's director since 1983 on a professional basis while on active duty at Fort McClellan, Alabama. We renewed our professional relationship in 1989 when I was diagnosed with chronic, severe post-traumatic stress disorder. His personal intervention significantly reduced the period of hospitalization and reintegration into the community.

Since 1993 the Birmingham Vet Center was the pivitol point from which the Alabama State Council first internally addressed post-traumatic stress disorder within our veterans service organization and then assisted our state council with bringing the facts or PTSD to the greater Alabama community.

Within the Birmingham area of the Department of Veterans Affairs, the Vet Center is the only resource for information on the Vietnam War for veterans who need to place this definitive life experience into the broader aspects of their lives. Whereas, the Birmingham VAMC's library collection for patients ends with World War II.

The new generation of veterans beginning with the Vietnam-era vets generally do not relate well with the bureaucratic run-arounds of the medical center but will take time to sit in a friendly environment to listen to advise from counselors on health-care issues, to dealing with their wartime experiences, and respect advice on readjustment possibilities. This is not available in the labyrinth of the hospital setting.

Addressing outreach services, the Vet Center's record cannot be approached by any Department of Veterans Affairs element in Alabama. Two examples are addressed. First, in 1989 the Vet Center form Birmingham assisted the Tuscaloosa's Community Service Program Office in establishing the first PTSD group therapy session. I believe this relationship continues through today in Anniston, which is over eighty miles from Birmingham. Second, when it became apparent that veteran-employees at Anniston Army Depot, who were fearful of losing their jobs because of their experiences in

Vietnam, the Birmingham Vet Center contacted the Vietnam Veterans of America's Alabama State Council. VVA Chapter 502 opened its facilities to the Vet Center to provide individual counseling to fearful and reluctant Federal employees and the Anniston area community in general.

The Birmingham Vet Center is also willing to receive input from outside sources if there is the slightest possibility of helping veterans. As recently as February 24 and 25, a respresentative from the Vet Center attended a VVA state council leadership conference that included one seminar and two workshops on Vietnam. Approximately fifty distrusting Vietnam vets listened to the seminar presented by Faild McKinney and Associates of Anniston, Alabama. The end result was that these veterans realized that the war they fought in is long over and Vietnam is quite different today. Many of the vets want to now return to Vietnam to put the ghosts of their youth into proper prospective. The Birmingham Vet Center representative saw and learned first-hand from non-government sources. This conference was held approximately three hours driving time from Birmingham where there is no Department of Veterans Affairs assistance for a three-county area that has approximately 5,000 Vietnam-era veterans.

In conclusion, the Birmingham Vet Center has helped many veterans of all eras and all U.S. Armed Services at a small cost for a high return in services rendered. The Vet Center program will be hindered, if not dismantled, if changes are made. The bottom line is that the Vet Center Program is cost effective and efficient as it is. Changes should not be made.

Sincerely yours,

George Gerdes

George Gerdes
Vice President

VIETNAM VETERANS OF AMERICA
STATE OF MICHIGAN COUNCIL
STATE SERVICE REPRESENTATIVE OFFICE
McNamara Federal Building, 12th Floor, Room 1231, 477 Michigan Avenue, Detroit, Michigan 48226

Detroit Phone
313-961-9568
313-226-4181

Out State Phone
1-800-VVA-MICH
(1-800-882-6424)

02 March 95

To Whom It May Concern,

As an accredited Service Representative, I spend one day per week in an RCS/VET CENTER in Grand Rapids, Michigan. I wholeheartedly encourage DVA Secretary Brown to allow the RCS to maintain its separate authority structure and budget. Many of the Veterans that come to the neighborhood Vet Centers are of an indigenous nature and some are even homeless. I see Veterans of World War II, Korea, Vietnam, Persian Gulf, and it seems as though Veterans from all other eras. The Vet Center serves not only as a counseling center, but as a place for homeless Vets to find shelters, employment, bus fare, assistance in finding medical care, food, clothing, VA benefits counseling, and most of all a friendly smile from someone who they don't see as part of the "BIG" bureaucratic system. By being in the neighborhoods the Vet Centers are more convenient to reach. And in my opinion, many Veterans have had a bad experience dealing with VA Hospitals and refuse to go near them.

Please don't take away a very important service from America's Veterans.

Very Sincerely,

Dan Ashcraft, Field Service Officer

CC: Mr. George Claxton, VVA State Service Program Director
Mr. Jack McManus, VVA State Council President

92-763 0 95 - 6

Viet Nam Veterans of America Inc
1724 M Street NW, Washington DC 2005-518
FAX (202) 625-5880

As an ex-Marine and a Viet Nam vet, I have tried 27 years to get help. I went for private help and they told me I had PTSD years ago. First time I went to VA hospital, I recieved about 7 minutes of doctor's time. Second time I recieved about 3 minutes of doctor's time.

A friend told me about VET Center, West Washington St. Charleston. WVa. First time I recieved 1½ hour and good feeling. I go 2 hrs. a week in group and 1 hr. private therapy and more if needed. I have finally begun to grow, and fit in, and feel good about life.

I am just one of many that feel the same way.

If the VET Center goes back to VA Hospital, there will be no help for NAM VETS. Don't take this time and group away from me and many other VETS.

Richard V [illegible]

NEVADA STATE COUNCIL
VIETNAM VETERANS OF AMERICA
IN SERVICE TO AMERICA

Vietnam Veterans of America
Government Relations Department
1224 M Street, NW
Washinton, D. C. 20005-5183

March 8th, 1995

Attn: Vet Center Testimonials

I am involved with eleven (11) different veterans organizations in Nevada and work closely with both the Reno VAMC & the Reno Vet Center (RCS) on almost a daily basis. I feel they both play an important role in serving the needs of veterans here in Northern Nevada. On a personal level I have been treated at the VAMC & been counseled at the RCS. I can't speak highly enough of the community based Vet Center.

On many occasions I have seen veterans not seek medical assistance at the VAMC because of the threatening bureaucratic environment. When possible, I have personally taken vets to the triage area and explained to the intake personnel that if they pressure this veteran in any way, he will run. I then help them with their forms and usually they will be seen by the triage staff for treatment. The reverse of this scenario is true at the vet center. Most vets that I work with have already been to the vet center before they come to me. This can be attributed; I feel, to the fact that they community based, and low pressure. They are always friendly and their open door policy makes a vet feel welcome. I personally know all of the staff at the Reno Vet Center. I know them to be professional and caring individuals and I would hate to see them tucked away in some obscure area of the Reno VAMC.

In closing, let me further state that I am adamently against the the relocation of any Vet Center staff and would consider the elimination of Vet Centers as unthinkable.

If you have any further questions of me regarding this issue, please feel free to contact me at (702) 688-1240
Fax (702) 688-1247.

Sincerely & Concerned,

Ben Duncan

Ben Duncan, VP
Nevada State Council

Mar 8 1995

Vietnam Veterans of America

This letter I am sending is to address ~~The Vet Center program and the great job they~~ have done for me.

The Vet Center is ran by the most knollegable, unselfish & caring group of people I have found in the Veterans administration.

I have been a Vietnam Veteran for more than 25 years and up until I found the Vet Center, I couldn't understand the system. Nor could I get anything or any of my benefits intideled to me, But with the help of the Vet Center in only 1 year, I have received help with a skin problem, Hearing Aids & help with some PTSD problems, There help is Truly appreciated.

I truly feel it would be a crime to Alter the Vet Center in any way or Connect it with the VAMC, where the True Vietnam Veterans would surly be forgotten

Howard Clemens
PO Box 314
Poca W. Va 25159
755-1272

477 H Street, NW
Washington, DC
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STATEMENT OF

BLINDED VETERANS ASSOCIATION

BY

THOMAS H. MILLER
EXECUTIVE DIRECTOR

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

ON

VETERANS HEALTH ADMINISTRATION'S
REORGANIZATION PROPOSAL

APRIL 6, 1995

VHA REORGANIZATION

Mr. Chairman and members of the subcommittee, The Blinded Veterans Association, (BVA), appreciates the opportunity to present our views, for the hearing record, on the Veterans Health Administration Reorganization, (VHA), Proposal. I regret being unable to appear before the subcommittee at the hearing on April 6, 1995 when you considered this important proposal. We commend you, Mr. Chairman, for holding this hearing so promptly as we believe it is extremely important for the VA to move forward on VHA reorganization as soon as possible.

The Department of Veterans Affairs' Veterans Health Administration (VHA), is proposing the most radical and far reaching reorganization of its field operations and central office structure ever undertaken. The proposed restructuring is in part a response to the administrations efforts to streamline the operations of all federal departments and agencies. And more importantly, in our view, the establishment of a health care delivery system that brings needed medical care services closer to where veterans live. As you know Mr. Chairman, the VA health care system is and always has been a facility based system requiring veterans to come to large facilities to receive the medical care. Often, these facilities are not accessible to veterans because they live long distances from the hospitals or are unable to receive appointments or appropriate care in a timely manner. Additionally, and even more disturbing is the fact that under current eligibility rules, VA cannot provide the most appropriate medical care in the most appropriate setting. VA estimates that 40 per cent of hospital admissions are inappropriate in that the necessary medical service could be provided in an ambulatory care or outpatient environment. Clearly having to treat veterans in a more expensive environment occupying hospital beds is not cost efficient nor is it the most effective method of providing necessary care. Further, it is an inconvenience to the veteran patient and if given any option for receiving care elsewhere it is very likely he or she will exercise that option. I will address the issue of eligibility reform in more detail below. The development of the VHA proposal began over a year ago during the health care reform debate and in an effort for VA to comply with the Presidents health care reform efforts. From the very beginning of that process BVA along with the other major veterans service organizations, were active participants in the process offering advice and raising questions regarding proposed plans.

Although the organizational structure and other details have changed somewhat with the appointment of Dr. Kenneth Kizer as the new Under Secretary for Health, the basic objectives have not changed. Dr. Kizer like his predecessor has involved the VSO at each step of the way and has conducted extensive briefings as each new element has been added to the proposal. BVA concurs wholeheartedly with the focus being placed on customer orientation or satisfaction and bringing medical care to where the veterans are. Without doubt, transition from the facility based system of the past to a managed primary care model of delivery of medical care services is highly desirable and should not only improve the quality of health care but be much more cost efficient as well. However, the most refreshing element of this proposal is that the new model is not driven by the bottom line but on addressing medical needs of veterans where they reside. BVA recognizes that in order for this new method of delivering medical service to the veteran population to be successful, VA must be provided some essential tools to accomplish their objectives. To expand the number of access points to the system, they must receive greater contracting authority in order to establish primary care networks and engage in more sharing arrangements.

Enhanced management flexibility and personnel authority at the local level is essential as well giving local managers the ability to hire and fire as is normally done in the private sector and properly provide incentives and recognition for those doing excellent work. Critical to the entire effort is the absolute necessity for Discretionary appropriation to continue at least at the FY95 level. Additionally, VA should be given the authority to retain all collections from third party players including Medicare.

Generally speaking, BVA is very supportive of the VHA restructuring proposal but we do have some concerns that we want these committees to be aware of. Obviously, we are greatly concerned over the potential impact of this new organizational structure on the special disability programs such as blind rehabilitation and other specialized services currently being provided by VHA for blinded veterans. An essential element of the new structure is the decentralization of as much authority as possible to the local level and altering central offices role to the development of polices and guidance for the field but not to micromanage the local field operations. The desire to decentralize authority is driven in part by the desire of local hospital managers to be able to make decisions quickly that are local in scope and must be made quickly if the facility is to take full advantage of local opportunities and respond to local pressures and needs. While we believe this is necessary and desirable for those programs and services which are indeed local, we do not believe this authority should be granted to local facilities with respect to national programs such as blind rehabilitation. These programs are not local and serve multi-state catchment areas. Under the new organizational structure, the blind rehab centers will likely serve several veterans integrated service networks (VISN) and therefore should not be made vulnerable to local management. There is no question, special disability programs are resource intensive and the existence of a pool of resources at the local level is very tempting to local managers when they are experiencing difficulties in meeting budgetary constraints or FTEE reductions.

We have been advised by Dr. Kizer that under his plan, local managers and VISN Directors will be held responsible and accountable for the protection of these special programs. The accountability will be clearly defined in a contractual relationship between the VISN Directors and the Under Secretary. In theory, this sounds very good but our experience over the years has taught us not to be so trustful of the medical center managers responsible for hosting and supporting the special programs. Recent years have demonstrated just what we are talking about in that many of these facilities have either taken away or frozen FTEE blind rehab specialist positions severely compromising the blind rehab program's ability to operate all their authorized beds and provide blind rehab service in a timely manner. Long waiting lists and waiting times for admission became the focus of an oversight hearing conducted five years ago by the Senate Veterans Affairs Committee. As a result of that hearing, additional resources were provided to be distributed around the system to restore all the blind programs to full staffing levels. Now the erosion is once again beginning as facilities face FTEE reductions and further budgetary constraints. Waiting lists, in time, will undoubtably begin to grow once again to unacceptable levels. Some progress has been achieved in the past few years in reducing the waiting time but these new constraints will certainly undue the progress made.

The other program we believe to be very vulnerable under a decentralized management model is the Visual Impairment Services Team (VIST) Coordinator position. Unquestionably the most important service currently offered to blinded veterans on a day to day basis is the Visual Impairment Services Team (VIST). This is a program that resulted from a cooperative effort on the part of BVA, the American Foundation for the Blind and the VA back in 1967. The VIST is responsible for providing comprehensive services to the eligible blinded veterans. The critical element of the team is the VIST coordinator. This individual serves as the catalyst for delivery of comprehensive services and is the subject matter expert on blindness at that facility. In the early years, the coordinator was assigned part time but the work load required these positions be full time.

Over the years, VA, in response to the urging of these committees provided a number of full time centralized VIST coordinator positions and the program has flourished at those facilities. Without exception, where the full time positions have been established the quantity and quality of service has increased and blinded veterans have benefitted tremendously.

The beauty of the VIST program, Mr. Chairman is that it accomplishes exactly what VHA wants to accomplish in their reorganized health care system. The VIST program is a managed care delivery model that is working extremely well and consequently, we strongly endorse providing service using this model for all veterans. Our experience has been extremely beneficial in this regard.

The program utilizes a truly integrated interdisciplinary approach to delivery service and brings to bear the appropriate service the blind veteran requires with a minimum of red tape and bureaucratic hassal.

We are already aware local managers are now attempting to alter the mission and organizational alignment of these crucial positions without any attempt to discuss proposed changes with the program director in VACO. It seems clear to us that should the new decentralized model of management be implemented with out special consideration to the special programs, monitoring of the performance and commitment of local managers must be very tight. If they are found to be negligent or abusive of the resources provided for these programs, appropriate disciplinary action must be taken. After all, the reason for VA in the first place is to care for disabled veterans and they must be held accountable for the provision of the highest quality care possible. It is important to note here, local hospital managers have already made attempts to subvert the purposes of specialized programs. This is particularly frustrating because it is in direct defiance to Secretary Brown's policy and instructions disseminated to the field by Mr. Sanford Garfunkle, ACMD. Specifically, hospital directors were instructed to protect prosthetics service chief positions and vist coordinator positions from any streamlining or reductions.

Mr. Chairman, we are not trying to be obstructionists but do want a reasonable assurance that the integrity of these extremely important programs will be protected regardless of whatever reorganization is eventually approved. There is every reason to believe that the new structure can indeed work to the advantage of our population and truly enhance the quality and quantity of care required. BVA strongly urges these committees give careful consideration to the VHA reorganization proposal and move quickly on approving the plan. However we caution and request that careful consideration be given to just how the plan proposes to treat special programs and insure that adequate oversight is included in the plan to insure the viability of these important programs.

Again, Mr. Chairman, I want to thank you and the subcommittee for conducting this important hearing and allowing BVA to submit our comments for the record. As always, we are available to respond to any questions you might have regarding our view.

Hearing on April 6, 1995

"Reorganization of the Veterans Health Administration"

Follow-Up Questions for
Dr. Kenneth W. Kizer
Under Secretary for Health, VA

from Honorable Tim Hutchinson
Chairman, House Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs

1. Dr. Kizer, I applaud you for your efforts to promote innovation and creativity within the Veterans Health Administration. Could you describe some of the legislative and regulatory impediments that stand in the way of a successful implementation of this plan?

Answer: The following statutory provisions impede our ability to implement the restructuring of VHA that is proposed:

- Section 7305 of 38 U.S.C. (which requires Medical, Dental, Podiatry, Optometry, and Nursing Services to be in the Office of the Under Secretary).

- Section 7306(a)(5) and (6) of 38 U.S.C. (which requires a Director of Nursing, Pharmacy, Dietetic, Podiatric and Optometric Services).

- Section 7306(b)(2) and (3) of 38 U.S.C. (which requires one ACMD to be a doctor of Dental Surgery or medicine and be directly responsible to the Under Secretary for the operation of the Dental Service, and which requires one ACMD to have expertise or training in geriatrics and be responsible for evaluating all research, educational, and clinical care programs in VHA field operations).

I do not advocate eliminating all of these positions or offices. In fact, I generally support having some type of National Office for each of the professions currently represented in the Office of the Under Secretary. In some instances, however, a National Office could be established at a VA medical center to coordinate relevant professional activities. In other instances it may be necessary to have a centralized National Office. This is likely to change from time to time. Of course, a wide range of health professionals will be required to staff the restructured National Headquarters. Instead of working in discipline specific stovepipe organizational units, however, they will need to be working in coordination with other professionals and administrative personnel in units organized for functional effectiveness. This is consistent with the transdisciplinary nature of health care today.

2. The proposed reorganization states that implementation of the VISN concept should generate an annual savings of approximately $9 million. The reorganization as described in your briefings has been portrayed as budget neutral. Please describe the source of the $9 million savings and how, with increased SES personnel levels and relocation costs, this proposal maintains its budget neutrality.

Answer: The $9 million figure is simply the difference between the projected salary costs for 427 FTE (i.e., the originally budgeted staffing figure for the regions) and those projected for the 270 FTE I see at the VISN and SSC offices. At this time, SES personnel levels are projected to remain about the same as now despite the additional SES slots needed for VISN director

positions. This will be accommodated primarily by the SES slots that are "saved" when health care facilities are consolidated under single management, and by filling some VISN director positions with qualified Title 38 incumbents. Of course, there will be nonrecurring costs associated with implementing the proposed restructuring. These are projected to be between $7 and $11 million, and will primarily involve the costs of relocating employees and equipment to new locations. After the transition period the $9 million is intended to be redirected for patient-care needs, which is why we described the proposal as budget neutral.

3. Understanding that the VISNs were developed on the basis of current VA networks, and that some states may be part of as many as 4 VISNs, do you see this as problematic in the development of major construction budgets or in the development of potential planning or sharing activities on the state level?

Answer: No, because an important corollary aspect of the restructuring plan is its flexibility. After implementation, if it becomes clear that a VISN is not aligned optimally due to budgeting, planning or sharing considerations, or is unwieldy because of its size, complexity or other factors, then that alignment can be changed. Health care is a dynamic field, and for the VISNs to thrive, they must remain agile. Likewise, I am sure that the VISNs as currently conceived will change over time as new access points are sited, as other local circumstances change, as we gain experience with the new organization, and as the ambient health milieu changes.

4. The four region structure has been criticized because the span of control of the regional directors was considered to be too large. The VISN structure, on the other hand, allows 22 individuals to answer directly to your office. Please describe how the current operational focus of central office will be changed. What operational functions will remain in the new headquarters structure?

Answer: The new VHA headquarters' focus will be on enabling and supporting change in the field that improves both the quality and efficiency of care provided to veterans. Operational activities will be decentralized to the field, where possible, and headquarters will remain responsible for providing national leadership and representation for the many clinical, technical and administrative disciplines represented in the VHA workforce. New functions that headquarters should perform that have not been done in the past (due to the press of operational business) will be identified. Among these will be a heightened emphasis on strategic planning, development of clinical benchmarks and practice parameters, quality improvement, and systemwide information management.

Within the Office of the Under Secretary, a Chief Network Officer and a network liaison staff will be responsible for supervision, liaison and communication with the 22 VISNs. I anticipate that this cadre of key staff will provide effective interface between my office and the field organization.

5. The VISN structure has been described as a budgetary and planning unit. Please describe the operational authority that will be vested in the new VISN directors. How will you ensure consistent policy implementation throughout the 22 VISNs? Specifically describe the process you envision for closure of hospital beds and changes in missions of different facilities.

Answer: VISN directors will be granted decision making authority to act within the terms of their performance contracts. Consistent with laws affecting the operation of veterans health facilities, and also consistent with policies promulgated by the Under Secretary, VISN directors will be able to make operational decisions without daily oversight and monitoring by headquarters officials. Specifically, VISN directors will have the authority and responsibility to manage the distribution of the network's resources to maximize the advantages to veterans within the VISN service area. This allocation will be achieved by VISN management working in collaboration with the directors of the component VISN facilities and the input of its Management Assistance Councils and other appropriate entities. In addition, there will be greater systemwide direction in strategic planning, quality improvement, and medical management.

Consistent policy implementation will be one of the expectations of the performance measurement and monitoring system that will be developed for the VISNs. This system will feature the use of performance contracts for VISN directors that are expected to address the following three areas: (1) systemwide needs and tasks that all VISNs will be expected to meet and complete; (2) VISN specific efficiency and service-delivery objectives predicated on past performance of that VISN or its component facilities, as directed by headquarters; and (3) VISN specific objectives as developed by VISN management.

Regarding the closure of hospital beds and the changes in missions of different facilities, the VISN director, consistent with the terms of his/her performance contract, will be delegated authority and autonomy to carry out normal operational activities, including changes in operating beds. Any major mission or programmatic changes will be subject to appropriate internal management review and collaboration with the involved stakeholders. The detailed manner in which the functions of the VISN director will be operationalized will be developed during the VISN activation process.

Hearing on April 6, 1995

"Reorganization of the Veterans Health Administration"

Follow-Up Questions for Dr. Kenneth W. Kizer Under Secretary for Health, VA

from Honorable Chet Edwards Ranking Member, House Subcommittee on Hospitals and Health Care Committee on Veterans' Affairs

1. You have proposed a reorganization aimed at achieving a "transformation" of the VA health system. Apart from the articulated goals of developing a more "customer-focused" philosophy, increasing ambulatory care access, and emphasizing primary care, are there any other specific outcomes you expect this plan's implementation to produce?

Answer: With this restructuring, I hope to be able to align VHA's management structure and processes on providing a true continuum of care for our nation's veterans. I hope to create and support a culture of innovation, creativity, empowerment, productivity and accountability. The result should be consistent high quality, responsive service and convenient access -- all at a reasonable cost. I want to establish a health care system that is focused on providing good health care value. Indeed, achieving good health care value is the central focus of the restructuring effort.

2. There are some who are concerned -- given a relative lack of specificity in your reorganization plan and its apparent intent to decentralize much decision making authority -- that you appear to be asking for a "blank check". They worry that you will give this "blank check" to still unidentified officials with the vague instruction to **"transform"** the VA health care system, and that Central Office staffing cuts and reorganization will deprive you of the means to enforce as yet unwritten "performance contracts". Is this an unfair view?

Answer: The proposal to restructure VHA, as outlined in the Under Secretary's report *Vision for Change*, provides an appropriate level of detail for this stage of the process - and especially prior to the implementation planning teams completing their work. However, great care and effort have already been taken to provide Congress with as much detail as possible, including cost estimates, staffing levels, VISN boundaries, and plans for support services centers. Indeed, to quote the general manager of IBM's Office of Healthcare Solutions, the *Vision for Change* document "...is impressively far-reaching, yet specific. Congratulations on so effectively 'breaking the mold'."

I believe the view expressed in the question is inaccurate. In fact, the new VISN officials, as well as the new headquarters officials, will receive no blank checks or vague instructions to transform the VA health care system. As the *Vision for Change* plan indicates, individual and system performance will be monitored against detailed negotiated plans that will be comprehensive without resorting to micro-management, a management style that tends to engender secrecy and suspicion and that, ultimately, robs the system of its most important assets: managerial initiative and innovation. Neither is the planned reorganization an effort at headquarters staff reduction, although that may be one of the possible outcomes, but it is rather an attempt at making the organization of VHA health care

delivery compatible with its mission at a time when a veritable storm of restructuring is radically altering the national health care scene. Headquarters officials will give up day-to-day operational oversight over activities that are more effectively supervised by local officials who interact with patients on a daily basis.

3. Some critics have suggested that under your plan many veterans will lose "one-stop shopping" for medical care. Is that at all an accurate assessment; if so, at approximately how many medical centers are veterans likely to face that loss? What concrete offsetting gains can veterans who lose a degree of access they now enjoy hope to realize from the restructuring anticipated to occur under the operation of a VISN?

Answer: The reorganization should increase the availability of "one-stop shopping", especially insofar as veterans may be able to access VA care closer to their homes in community-based VHA access points. It is not possible to ensure one-stop shopping for every veteran at every VHA facility even now, nor should it be VA's objective to aim for such a highly resource-intensive goal in an era of limited budgets and a smaller Federal government. VHA's strategic objective is to secure comprehensive, coordinated care for the greatest number of veterans possible within available resources. The restructuring plan described in the report *Vision for Change* is designed to support the stated strategic objective.

4. Your plan states, with respect to "improvements" you project to emerge from VISN actions, that "[s]ome of the savings from improved operations will be reallocated by the Under Secretary to other VISNs or other systemwide priorities." There would appear to be limited incentive for facility or VISN directors to take the kind of actions required to produce savings if those savings will be "spent" outside the VISN. What specific mechanisms or incentives will you establish to address this issue?

Answer: At present, the per capita resource allocation by VISN varies by more than a factor of 2, and this cannot be explained by patient acuity or similar measures. This suggests considerable inefficiency and inequity in the means of resource allocation at present. The newly appointed reorganization Implementation Workgroups within VHA will be addressing the resource allocation management processes for VISNs, which will include consideration of financial incentives and disincentives across and within VISNs.

5. Some have read your plan as intended to foster "managed" or cost-control-driven care in VA, and question whether that approach is consistent with "quality care." Would you please comment?

Answer: I would make three points in response to this question.

At this time, when the American people are demanding more accountability from government, less waste, and less government, knowing your costs and controlling the growth of those costs is extremely important. Most of the health care industry, i.e., Medicare and Medicaid, are growing at the rate of 9 to 12 percent per year, while the VA and the "best" of the "managed care" organizations are growing at the rate of 2 to 3 percent per year. However, for VHA to be competitive we must not only control costs, we must also improve customer satisfaction, access, and organizational quality. Health care organizations who do not offer high quality services will not survive. In addition, I am personally committed to ensuring that the quality of care in the

VA is second to none. I believe quality of care should be the number one concern of the system.

My second point is that what VHA is not planning to implement a "managed care" system, which would tend to focus primarily on cost-control, but more of a primary care driven organization that also encompasses rigorous cost management. While the managed care and primary care systems have much in common, a significant difference is that a primary care system puts health care providers at the forefront of the organization. The benefit here is that while health care providers have some concerns about cost, their overriding concern should be the quality of care provided.

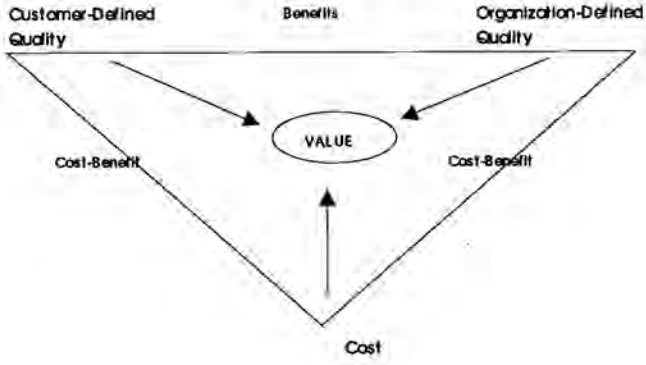
Thirdly, the performance measurement system that VHA will implement, will consistently measure the three areas listed above, customer defined quality (satisfaction), organization-defined quality (results) and costs. Furthermore, we intend to track these measures over time in relation to each other to ensure that no one area is emphasized at the expense of another. We have attached for your information, an excerpt from a VHA publication that outlines our thinking on organizational performance and its measurement. We believe that this information clearly explains why we do not believe that quality of care will suffer even as we focus on cost-restraint.

Attachment

Veterans Health Adminstration
Excerpt from a Handbook titled
An Integrated Performance Process Famework
Currently Being Printed

The triangle in figure two shows one way to assess organizational performance. The points of the triangle represent three core areas where measures must exist in order to determine the quality of a service or product. One must know the level of customers' satisfaction based on the **customers' definitions of quality**, the **organization's definitions of quality,** and the **costs.** The lines connecting the points of the triangle represent relationships. For example, the relationships between the point labeled **"Cost"** and the other two points labeled **"Customer-Defined Quality"** and **"Organization-Defined Quality"** represent types of ***cost-benefit***. Typically, an organization will try to achieve positive results and high customer satisfaction at the lowest possible cost--relationships. That represents value. All three core issues must be in balance to have a high performing organization. For example, if results are good but customers are unhappy, one usually cannot say that customers received quality service. Likewise, a happy customer with a bad outcome does not equal quality service.

Organizational Quality Triangle. **Figure Two**



The relationships of all points of the triangle to each other define the **Value** of a product or service. For many customers, there is only one issue, and that is **Value** as they perceive it; that is, their sense of the reasonableness of the cost versus the results and way they were treated.

Value is what keeps customers coming back. One always wants to reduce costs, but cutting costs too much risks reducing customer satisfaction and worsening results; and, of course, raising costs too much can do the same thing. Therefore, a most important underlying principle of measurement is that an organization must look at all three core issues in relation to each other. And they must do this for the organization as a whole as well as for each major part or function in the organization. Generally, this concept of having a triangle of measures to assess performance can be deployed as far down in an organization as is needed or desired. Having a balance of measures will allow leadership to assess services or functions and how they are performing over time.

The cost benefit relationships illustrated by the triangle are not static, and it is this feature that makes the principle of "Balanced Family of Measures" so important. The relationships are in a constant state of flux because they all contribute to a core set of **Values** that are viewed differently by different people in the organization. In short, the three points of the triangle represent competing interests in many organizations. The inherent and natural tensions between these three points are illustrated in figure three.

Figure three can be used to illustrate the natural, dramatic tensions created by the cost benefit relationships. Take the relationship between cost and customer/organization-defined quality, for example. Professional and front-line staff may tend to value improved quality outcomes even at the risk of increasing costs. ("We're treating patients and saving lives here"). The official in charge of monitoring finances, on the other hand, knows how much money has been set aside for the specific range of services in question and may tend to value reduced costs. ("We've got a budget to maintain here.") A similar tension exists between cost and customer-defined quality where customers would tend to value positive outcomes and how they are treated over cost. Left unchecked or, worse, unmeasured, any of the three core issues on the triangle can skew decision-making in undesirable directions. What the organization is striving for is a win-win, value-driven form of organizational improvement.

Plotting Cost-Benefit Relations Over Time **Figure Three**

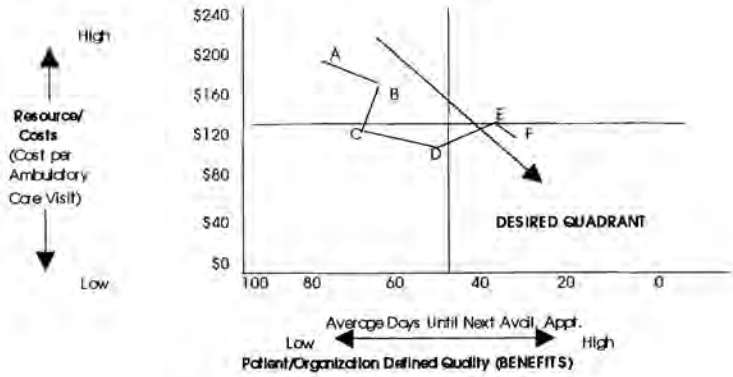


Figure Three is also used to demonstrate how an organization could plot the relationships of **cost** and **benefit** over time.

An example of an Ambulatory Care Service illustrates the relationships. The Service wants to decrease its waiting time for the next available appointment (a measure of organizational quality or **benefit**) and the cost of doing so. It uses cost per Ambulatory Care Visit as its measure of **cost**. The letters A through E sequentially represent different points in time and demonstrate performance in terms of cost-benefit. The Family of Measures concept requires that one also measure the customer's definition of quality along with waiting time, and this could be done by substituting Customer Satisfaction for the "Next Avail. Appt." on the above graph. One could also plot all three measures over time, using a simple X-Y graph. If the organization does not assess how customers feel about the changes in waiting times, one might miss possible changes toward negative satisfaction levels linked to what is being done to decrease waiting time (e.g., patients feeling "rushed").

What does this chart tell us about our Family of Measures? Clearly, if we focus our measures only on cost, we run the risk of poor outcomes or poor customer satisfaction. Likewise, if we measure only organization- and customer-defined quality, we run the risk of bankrupting the business. We must measure our services, functions, and programs along both axes of the chart in order to ensure a balanced view of what is happening in the organization. What we have to achieve, then, is a balanced family of measures that cover the three core issues. By measuring all three, we will be able to see if data become skewed in undesirable directions (such as high cost and low quality), and we will be able to see specific opportunities to improve to more positive directions (such as those yielding higher quality with reduced costs). This concept seems particularly important in a time when we are downsizing the federal government. If we pay too much attention to cost and ignore organization and customer-defined quality, we could easily find ourselves left with programs that indeed cost less, but work less well and which people don't want.

6. With respect to your plan, how can so-called "stakeholders" play a meaningful role in decisionmaking affecting clusters of VA facilities which are potentially many hundreds of miles apart?

Answer: VA stakeholders will have a say on the Management Assistance Councils and, thus, directly influence decision

making. In addition, the Management Assistance Councils' activities will be reported to the Chief Network Officer. The stakeholders will also retain all of the presently available avenues for input into the delivery of veteran health care and into the management of the VHA health care system. The councils are an additional, formal venue for soliciting input from our stakeholders, and as such they should improve communication between VHA and its constituency at the local and network levels where communication is most likely to be needed.

7. Critics assert that most VAMC directors are products of "on the job training" rather than schooling in health care administration. Is that charge accurate; if so, what are its implications for the success of a plan which proposes so dramatic a change for VA and its decisionmaking environment?

Answer: While the level of training and experience of VHA management is much more sophisticated than generally perceived, I do believe that we need to bring more "outside" health care executives into the organization. Of course, we are hindered in this regard by the relatively low level of compensation that we can provide, which is generally much less than what is available in the private sector. Similarly, getting executives to accept a lower paying public service job in today's era of government bashing is a major barrier to attracting outside managers. Likewise, the extraordinary degree of oversight of the VA health care system -- markedly more than the private health care sector -- is a further problem in recruiting administrators.

Regarding VA in-house training, I should note that the Veterans Health Administration (VHA) operates a residential training program, the Associate Director/Health Care Management Training Program (AD/HCMTP), to prepare a select group of individuals for positions as Associate Medical Center Directors and ultimately Medical Center Directors. Participants are competitively selected. The program is widely announced within VHA and to the public and usually receives several hundred applications. Applications are rated and ranked by a panel of Medical Center Directors. The best qualified applicants are further screened by participating in an Assessment Center. Applicants with the highest composite scores from both of these processes are recommended to the Secretary for the program. A range of fourteen to twenty-eight trainees have been selected each year based on the projected turnover in Medical Center Director positions. Applicants must meet basic educational and experiential qualifications. Those ultimately selected for the program tend to be experienced mid-level managers and possess Master's Degrees in a profession, a management field, or specifically in health care administration.

Once in the program, a trainee is assigned to a preceptor who guides the experiential learning process according to defined objectives designed to achieve competency in health care administration. The preceptor is a seasoned Medical Center Director who is chosen based on his or her sustained performance as a hospital administrator and demonstrated interest and ability in education. During the training period of approximately eighteen months, trainees are usually provided with four weeks of classroom training that includes assessment and development of leadership abilities and specific health care administration topics.

Trainees are certified by their preceptor and Regional Director when they have successfully completed training. For a first assignment, a trainee is carefully matched with a medical center commensurate with his or her experience and leadership strengths. Associate Directors progress through several assignments at

increasingly complex facilities before they are considered for Medical Center Director positions.

The Associate Director/Health Care Management Training Program began in the early 1980s. The majority of today's VA Medical Center Directors have participated in this program. In addition, approximately 70 percent have advanced degrees beyond the baccalaureate. Of those, 44 percent have Masters Degrees in Health Care Administration. Many Directors are also members of the American College of Health Care Executives and regularly participate in their continuing education programs. Likewise, many VA physician managers are members of the American College of Physician Executives, and have board certification in medical management, as well as actively participating in ACPE continuing education programs.

8. As I understand it, major decisionmaking authority in VHA would be shifted to 22 network directors, each with a staff of seven to ten people. Given the implications of their decisions on VA patients, will network directors be physicians or have physicians or other clinical advisers on their staffs? If not, why not?

Answer: A critical element in the Veterans Integrated Service Network (VISN) structure is medical management. While no final decisions regarding network directors nor network staffing have yet been made, clinical expertise will be necessary. Our intention is to hire the best qualified individuals for Network Directors. It is anticipated that this will result in a mix of individuals, some of whom likely will be physicians. Also, network directors will include physician expertise on their key staff.

9. Would you agree that physicians should be <u>directly</u> involved in management decisions affecting patient care? How would that occur under your new field reorganization? Is it your position that it is appropriate that the only institutionalized role for such involvement would be through a consultative body like the proposed management assistance council?

Answer: Physicians have to be directly involved in management decisions affecting patient care and the new organizational structure acknowledges and accommodates that need just as does the present structure. VISN management is expected to include expertise in medical management as part of their staffing of seven to ten people. In addition, it is anticipated that each VISN director will work closely with representatives of all the facilities to ensure that the views and concerns of each facility are fully considered as decisions are made. The Management Assistance Council is an additional, new way to obtain input into the operation of and planning for the VISN, but it certainly will not be the only source of input.

10. Some VA facilities under very able leadership have been working cooperatively within existing network arrangements. In such circumstances, one can envision your selecting one of those local facility directors as the director of the new VISN serving that area. In other areas, particularly those without a comparable record of aggressive network planning and coordination, selecting a facility director from among the affected facilities to be director of a new VISN incorporating those same facilities seems to raise real problems in terms of

the appearance of conflict of interest. Would you concur? How will you address this issue?

Answer: The selection of the VISN directors will be a very important aspect of the success of the VISN structure. The selection criteria for VISN directors will need to provide a penetrating assessment of potential incumbents to ensure they are not only highly competent health care administrators, but that conflicts of interest (as you describe) or other problems with the selectees do not occur. The VISN Activation Work Group, one of the special work groups appointed to work on implementing the VISN structure, is working on drafting selection criteria for the VISN director positions. The work group members fully understand that the success of VISNs in large measure will depend on the skill, leadership ability and integrity of those appointed as VISN directors. Once directors are appointed, expectations about objectivity in dealing with medical centers will be clarified, and performance will be monitored.

11. Given the responsibilities associated with the position of a VISN director and the potential conflicts involved in a former medical center director serving as director of a VISN that includes his/her former facility, there would appear to be merit in encouraging the selection of private sector health care administrators to these positions where possible. Would you concur? Will individuals with substantial experience in private sector health care administration have a meaningful opportunity to compete for the VISN director positions?

Answer: VHA will consider all qualified applicants for the VISN director positions. As the VISN structure is based on a private sector model, relevant private sector health care administration experience would be an asset for those seeking VISN director positions under the restructured VHA. I expect that the final selection of VISN directors will include a mix of candidates both from within and outside VHA.

12. What formal criteria will be used in selecting VISN directors? If such criteria have not been formulated, please provide your best estimate of when such criteria will be issued, and, when issued, please furnish them to the Committee for the record.

Answer: One of the special work groups, the VISN Activation Work Group, will make recommendations to me on the selection criteria for the VISN director position. We expect their report by mid-July. We will furnish the subject criteria to the Committee for the record, as requested, as soon as they are available.

13. This hearing prompted one witness to observe that the number of VA physician-directors has declined dramatically over the years. Do you agree that it would be desirable to encourage the development of a cadre of new physician-directors? Is it feasible to institute a training program for that purpose, as proposed?

Answer: The Veterans Health Administration recognizes the value of physician management. During the past year, three physicians have been appointed as Medical Center Directors, increasing the total to six physicians and one doctor of dental surgery. During the 1980s, the Agency operated the Executive Medicine Program to develop physicians interested in pursuing executive careers. The program was modeled on the government-wide Senior Executive Service Candidate Program. Participants were funded for a wide variety of academic courses and experiential assignments that were identified in collaboration with a preceptor. Several of

the graduates became Directors or took executive positions in Central Office. The program was discontinued because of the per capita cost of this approach and the reluctance of some graduates to accept reassignments. Several task forces have recently been convened to review VHA's education and training programs and the process of selecting Medical Center Directors. Their recommendations have not yet been implemented pending Congressional approval of reorganization plans. In that case, both selection and development of executive leadership would be tailored to network needs, guided by systemwide, corporate objectives. Networks would have the capability of identifying needs for physician directors and providing appropriate developmental opportunities.

Likewise, I am pursuing closer working relationships with both the American College of Physician Executives and the American College of Healthcare Executives in this regard.

14. We attach a high priority to successful implementation of the Decision Support System (DSS). Because of its critical link to cost control within VHA, responsibility for the implementation and operation of DSS had been placed under the Chief Financial Officer. I understand you now propose to have the DSS Director report to the Chief Information Officer. Would you explain the reasoning behind this decision?

Answer: The DSS program originated in the Office of the Deputy Under Secretary for Operations and Administration. It was subsequently moved to the CFO office. It is not entirely clear why this reorganization was effected. At this time, VHA has several data systems that do not interface well. Often, the same event is measured and reported upon by two or more data collection systems with variable results. This situation tends to produce a great deal of data and sometimes contradictory information.

In order to correct this problem, I believe that accountability for all VHA information systems should be delegated to one operating official. This individual will be called the Chief Information Officer (CIO). The CIO will be responsible not only for integrating VHA's information technologies but also for providing all users in VHA with comprehensive, timely, valid, and accurate information. The placement of the DSS system will not minimize the importance of its intended functions, nor will it sever its links with current or future VHA cost control efforts. On the contrary, I believe it will become more important for both cost control and other management decision making purposes. As an aside, this organizational structure is also more consistent with what is done in the private sector.

15. Please submit for the record copies of all internal documents (to include memoranda, letters, and white papers) which discuss, offer views, or otherwise comment on your plan's proposed incorporation of the Decision Support System Office into a new Office of the Chief Information Officer.

Answer: The Under Secretary has met and discussed this matter with all of the principals who currently manage and use data systems in VHA. The decision required no written reports or major studies as the discussions between the Under Secretary and the staff were found to produce sufficient evidence to warrant the restructuring of the VHA information systems. The decision was presented to all VHA staff in the draft *Vision for Change* report. In his comments on the plan, one VHA facility director, who had previously served in headquarters and had been responsible for information systems, remarked that "The CIO function in headquarters needs to become a true CIO who manages

information and not just technology systems." It is in this spirit that the DSS system will be transferred to the CIO office. Indeed, once the decision was reached to establish a CIO office, the placement of the DSS program in that office was a logical act of reorganization. Of interest, the GAO has recommended that similar action be taken in the past.

16. Under the proposed reorganization, what will be the relationship between the Chief Information Officer and the Director of MIRMO?

Answer: The Medical Information Resources Management Office (MIRMO) and the Decision Support System (DSS) Office will be incorporated into the CIO office. The CIO will play a critical role in seeing that business and information strategies are carefully coordinated, and it will act as a change agent to implement information systems that will accurately monitor service and productivity objectives. The CIO will ensure that a strong medical informatics support structure is in place to assist the VISNs in delivering high-quality, cost-effective care, and to support VHA's corporate policy, planning, and performance management functions.

17. You have indicated that your new organization will place more emphasis on information systems. Are you prepared to devote more dollars (hardware and software) and staffing to the Decentralized Hospital Computer Program (DHCP)?

Answer: My number one informatics priority is implementing DSS. Having said this, though, I should also note that the success of the proposed reorganization will depend on the development of both financial and clinical information management systems that support integrated networks. Modifications to the current resource allocation model, known as Resource Planning and Management (RPM), will be required in order to refine funding distribution at the VISN level, to accurately measure the financial needs of new programs and access points, and to ensure that the model will meet the requirements of a financial monitoring system.

Implementation teams are now working on determining the information and network support structures which will be needed by the VISNs. DHCP currently plays a vital role in the informatics support structure available to our health care delivery network. We will continue to invest in DHCP where appropriate, and where that investment will accomplish the goals and objectives as stated in the restructuring plan.

18. The Office of the Associate Deputy CMD for Clinical Programs is staffed to include most major medical specialties and subspecialties and allied health services. In proposing instead to establish an Office of Patient Care Service, you would substitute an office that is very differently staffed. Have decisions been made on precisely <u>how</u> this office will be staffed, and which if any of the positions will be decentralized? If so, please provide those plans. If not, please provide the options under consideration.

Answer: The Office of Patient Care Services will be organized according to major functions (e.g., acute care, long term care, etc.) and will include the array of specialties and disciplines now represented in Clinical Programs. However, they will be organized to improve communication cooperation and collaboration so as to improve the quality and efficiency of patient care.

19. We understand outcome measures by which facility and VISN directors will be held accountable for the special disability programs will be developed to insure the provision of quality service. How soon can we expect these measures to be disseminated to the field and directors? In the interim, what will insure against erosion of resources needed to maintain these programs at least at current levels? Please comment, in that connection, on reports indicating that attempts have been made under a new policy decentralizing authority on medical center organizational alignment to realign or otherwise restructure positions under the Visual Impairment Services Team (VIST), compromising the mission they are designed to perform.

Answer: A variety of performance instruments are now in use. Data from these and other sources will be utilized to determine performance measures prior to VISN activation.

Prior to VISN activation, feedback from the program office, budget reports, VSO site visit reports, patient care reports and internal control measures are all being used to assure against erosion of resources needed to maintain the quality of care provided by the special programs.

Regarding the issue of reports about restructuring VIST positions at the local level, there have been several reports of concern from the field. In each case, the program office in central office and the regional consultants have been in contact with the facility to provide assistance and help ensure that services to blinded veterans are not compromised. To help ensure consistency of service access to the system, the Blind Rehabilitation Service in VACO is developing preferred practice patterns, generic performance standards for VIST coordinators, and standardized review criteria to be used during program reviews at individual medical centers.

20. The plan states that a Vet Center "resource coordinator" position will be established at each VISN "to manage vet center programs and facilitate collaborative efforts with other VHA facilities in the VISN. Yet it goes on to say "the incumbents will not necessarily be located at the VISN office site." Why, in a plan which otherwise emphasizes cost reduction, streamlining, and redistribution of resources to improve care-delivery, are you proposing to have such a position at <u>each</u> VISN? Why is it necessary to have a resource coordinator "at each VISN" if it is not necessary to site them at the VISN <u>office</u>?

Answer: The Readjustment Counseling Service (RCS) Vet Centers are a specialized, innovative and responsive Veterans Health Administration Service now in its fifteenth year of providing service to eligible veterans. Vet Center counselors are strategically located in the community and specifically skilled in engaging veterans through outreach activities. As such, the Vet Centers function as a major community access point for veterans into the VA health care system. The Vet Centers together with the specifically designated VA medical center based programs comprise VA's integrated spectrum of care for veterans with war-related, post-traumatic stress disorder (PTSD). The Vet Centers by design are the easiest facilities for the veterans to access, and they deal with the psycho-social aspects of post-war adjustment which are psychologically closest to the veterans' immediate living situation. For many veterans, the Vet Centers are the entry point for VA care and the point of after-care referral for veterans released from more intensive inpatient services at a VA medical center. Case management and coordination of care across the spectrum of needed services are also well developed Vet Center functions.

ATTACHMENT TO QUESTION #19

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

AUG 19 1994

Mr. Thomas H. Miller
Director, Governmental Relations
Blinded Veterans Association
477 H Street, NW
Washington, D.C. 20001

Dear Mr. Miller:

This is in response to your letter regarding Prosthetics and Sensory Aids Service and Visual Impairment Services Team (VIST) coordinator positions. Your similar letter to the Acting Under Secretary for Health was inadvertently misplaced. Please accept this as a response to both letters.

I agree with your comments concerning the success in improving delivery of prosthetic services brought about by the Prosthetics Improvement Implementation Plan. We cannot afford to jeopardize progress made in the last two years, especially with health care reform on the horizon.

Decentralization of classification and recruitment authorities for VIST coordinators should not affect the organizational alignment or the duties of the position. VA will maintain the integrity of the VIST coordinator position to ensure that appropriate comprehensive service is provided to veterans adjusting to the impact of sight loss. VIST coordinators will continue to function solely for the benefit of blinded veterans, and will be aligned under the Chief of Staff or the Associate COS for Ambulatory Care.

Anticipating possible future employment reductions, medical center directors were instructed to review their operations, and to defer filling certain chief and assistant chief positions which might be eliminated in streamlining initiatives. However, they have also been instructed by the Associate Chief Medical Director for Operations, to exempt from review the chief of prosthetics position and the VIST coordinator.

I recognize the importance of these positions to the success of improved service delivery. Please be assured of my continued support for the prosthetics and blind rehabilitation programs.

Sincerely,

Jesse Brown

Jesse Brown

Putting Veterans First

Given the specialized service functions of the Vet Centers and the priority for each Veterans Integrated Service Network (VISN) to develop a coordinated system of health care services responsive to local needs, the siting of a Vet Center resource coordinator at each VISN makes sense. This is particularly true regarding the Vet Center's function as a VHA access point in the community and potentially enhanced role in coordinating the PTSD continuum of care throughout other VISN facilities.

The decision for not requiring the Vet Center coordinator to necessarily co-locate at the VISN office site, reflects the higher priority to grant RCS and each VISN Director maximum flexibility in structuring local management alignments to best meet the service needs of local veterans. In addition, we wish to capitalize on any available cost savings to be realized from any existing VA leases which may be strategically situated for reorganization purposes. This plan adheres to the stated objectives of reconfiguring existing resources to eliminate unnecessary administrative layering and enhance local management accountability and responsiveness to the veteran consumers.

21. Would you please comment on the concern expressed by the National Federation of Federal Employees that the authority vested in a network director may undermine the viability of labor-management partnership agreements being worked out at the facility level?

Answer: The concern is unfounded. Members of Partnership Councils at VA facilities are typically senior managers and top officers of the local union(s) involved. We intend that the Councils will continue to operate as provided by their local partnership agreements and that the management members of the Councils will continue to have full authority to develop partnership agreements and to reach consensus with their union partners on matters of mutual interest. Also, the close proximity of the network director to the Councils involved will enhance the role of the Councils due to the network director's ability to address most of the significant issues affecting the facilities involved.

22. In those instances, such as in West Virginia, where proposed VISN boundaries have the effect of dividing the VAMC's in a single state into different VISNs, what policy will guide VA officials in coordinating with responsible state officials regarding proposals for, or implementation of, health care reform within that State? Will Central Office designate a single office or official to carry out that coordinating role?

Answer: I fully expect that individual facilities and VISNs will coordinate their activities within states and "across VISNs", as necessary for the state in which they are located. Further, I expect that VHA headquarters will continue to monitor state health care reform activities and ensure the appropriate coordination and attention to state issues, regardless of VISN boundaries.

23. Which office will be responsible for reporting to State entities such as licensing boards -- the individual VAMC or each VISN Director even though one State's boundaries include two or more VISNs?

Answer: Current policy places the responsibility for reporting to State Licensing Boards and to the National Practitioner Data Bank with the VAMC Director. It is not anticipated that the implementation of VISNs would necessitate any changes in this process.