STATEMENT OF

NANCY M. SCHLICHTING

CHAIRPERSON, COMMISSION ON CARE

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES SENATE

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Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

I am pleased to appear this afternoon to discuss the workings, deliberations, findings, and recommendations of the Commission on Care, which I was privileged to chair. And I am delighted to be accompanied by my colleague, Dr. Delos (Toby) Cosgrove, the Commission Vice Chairperson, and the Chief Executive Officer (CEO) of the Cleveland Clinic. I also want to take this opportunity to thank you for your support of the Commission, and your assistance in providing us an extension of time to complete our work.

For the last 13 years, I have served as the CEO of the Henry Ford Health System (Henry Ford), a Detroit-based $5 billion, 27,000-employee organization, which I joined after many years of senior-level executive positions in health care administration. I believe my experience in leading Henry Ford through a dramatic turnaround of its finances and culture and in winning a Malcolm Baldridge National Quality Award and national awards for customer service, patient safety, and diversity initiatives played a role in the President's selecting me to chair this important body. I accepted this position not only because I was honored to be selected, but because I hoped that this commission could make a difference. I believe our report offers that promise.

As you well know, Mr. Chairman, just a little more than two years ago, Congress and the Administration faced a real crisis of confidence in a health system some had once seen as providing the best care anywhere. In 2014, alarming delays in providing needed care, and the scandal surrounding deceptive reporting on patient-scheduling, led to the enactment of a far-reaching omnibus law that established the Commission on Care.

Congress is to be commended for including in that law provisions that commissioned an independent assessment of VA health delivery and that charged our commission to assess access to care and critical strategic issues. I was privileged to work with a group of commissioners who brought a diverse, rich breadth of experiences and perspectives while sharing a strong commitment to our veterans.

The Commission's Veteran-Centered Approach

The Independent Assessment, released in September 2015, was invaluable in providing the Commission a comprehensive, carefully-researched, system-focused analysis that both informed our work and provided an invaluable integrated framework for our examination and deliberations.

As we explained in our interim report, early on the Commission adopted a set of principles to guide our work; that identified both how we would proceed and the core values we would honor. Our adherence to those principles proved critical, in my view, to the development of a final report that is value-based and centered on our veterans.

While each of those principles was meaningful and important to our work, let me highlight just a few I think are particularly relevant to our dialogue this morning:

- The deliberations and recommendations of the Commission will be data-driven and decided by consensus.
- The Commission will focus on ensuring eligible veterans receive health care that offers optimal quality, access, and choice.
- Recommendations will be actionable and sustainable, focusing on creating clarity of purpose for VA health care, building a strong leadership/governance structure, investing in infrastructure, and ensuring transparency of performance.

I believe you will find that these core principles profoundly influenced and are deeply embedded in the content of our final report.

Our work over a ten-month period -- including 12 deliberative and educational meetings over the course of 26 days -- was not easy. Our public hearings were wide-ranging; our discussions were frank. Through testimony and dialogue, the Commission considered the broadest span of perspectives we could assemble: these included senior VA leaders and VA program and subject-matter experts; stakeholders, including representatives of national veterans service organizations, union and association leaders representing Veterans Health Administration (VHA) employees, individual veterans, Choice Program contractors, representatives of medical school affiliates and associations of behavioral health care professionals; former VHA Under Secretaries of Health and VHA network and medical center administrators; experts in health care and health care economics; and members of this Committee. Our Commission, with its diverse membership, had spirited discussions, debates, and sometimes difficult deliberations – perhaps not unlike the process that leads to good legislation. Importantly, too, those deliberations were conducted in public sessions, in a process which was stronger for its transparency. Like your own work on this Committee, we were focused on and bound together by the unifying question, "What's best for the veteran?" I believe we have been true to that challenge, and that our report provides actionable, sustainable recommendations – many of which invite congressional action.

Importantly, we discussed at length the challenge of determining what veterans themselves want. To what, we asked, could we look to find the "voice of the veteran?" Time constraints and regulatory requirements ruled out conducting a Commission survey of veterans. But we pursued multiple other avenues and sources to tap and ascertain veterans' views, certainly including your advice, Mr. Chairman, that we engage the veterans' service organizations, who participated fully in our work.

Status of VA Health Care Delivery System and Management Processes

In its sweeping report, the Independent Assessment identified troubling weaknesses and limitations in key VA systems needed to support its health care delivery. Reaching very similar findings, the Commission concluded that -- if left unaddressed -- problems with staffing, facilities, capital needs, information systems, procurement and health disparities threaten the long-term viability of VA care. Importantly, though, neither the Independent Assessment nor our review called into question the clinical quality of VA care. Quite the contrary. The evidence shows that care delivered by VA is in many ways comparable to or better in clinical quality than that generally available in the private sector.[1] This is a testament to the high quality of its clinical workforce.

Yet we found a system that faces many grave problems: high among them, an ongoing leadership crisis, confusion about strategic direction, significant variation in performance across the VA health system, and a culture of risk aversion and distrust. Despite the various deep problems facing VHA, our report does not propose shuttering the system or placing its future at risk.

With our focus on what is best for the veteran, the commissioners recognized that the VA health care system has invaluable strengths. It is an integrated health care system with a compelling mission that combines care-delivery, educating health professionals, conducting research, and carrying out a contingency national-emergency mission. VHA has developed and operates unique, exceptional clinical programs and services tailored to the needs of millions of veterans who turn to it for care. For example, its behavioral health programs, particularly their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered the effects of battle or military sexual trauma, or for whom VHA is a safety net. VHA's "wraparound" case-management services meet the most vulnerable veterans where they are to prevent them from falling through the cracks. As the largest national health care system, VHA continues to have the capacity to bring about reforms in the larger health care industry. By way of example, it pioneered bar-coding of pharmaceutical drugs, and championed improvements to patient-safety through systematic identification and review to identify root causes of medical mistakes and "near misses." In working to close access gaps, VA

[1] VA care has often been cited to be as good as or better than that of private sector. The following paper, identifying about 60 studies by disease type, supports that statement.
http://avapl.org/advocacy/pubs/FACT%20sheet%20literature%20review%20of%20VA%20vs%20Community%20Heath%20Care%2003%2023-16.pdf

has developed one of the largest telehealth and connected-care operations in the world. While VHA can learn from private sector care, we also benefit from its successes.

Transformation

We are clear, however, in our view that VHA must change, and change profoundly, because veterans deserve a better organized, high-performing health care system. Certainly, some elements of such a high-performing system are already in place. VA has high-quality clinical staff, and this integrated health care system is marked by good care-coordination. VHA today, however, relies significantly on community providers to augment the care it provides directly, although those community partners are not part of a cohesive system. VA and VHA are already undergoing substantial change under the leadership of Secretary Robert McDonald, Deputy Secretary Sloan Gibson, and Under Secretary for Health David Shulkin, and it is important to recognize and encourage this change process.

All of our commissioners agreed on the need to transform VA health care. At the heart of that transformation, we call for VA to establish high-performing health care networks that include and that integrate the care provided by credentialed community-based clinicians along with VHA and other federal providers, and that afford veterans primary care provider-choice, without regard to criteria like distance or wait times. The establishment of integrated care networks – what we refer to in the report as a new VHA Care System – is nothing less than a fundamental change in the model of VA care-delivery. It is a model that will much more closely integrate VHA with its community partners, with an emphasis on coordination of care that is so important to the population VHA serves, one with more chronic illness and behavioral health conditions than the general medical population. High quality care is a critical element, so we propose that VA control network design; set high standards for community-provider participation, to include a credentialing, quality and utilization performance, and military/cultural competence; and tightly manage the networks. Our vision for this transformed system is one that would offer major improvements: improved access to care, care-quality, and choice, with resultant improvement in patient well-being.

Such a system, which Dr. Cosgrove and I would be happy to discuss in more detail, would provide our veterans with the high quality health care they richly deserve. But successful implementation of that recommendation is not only contingent on legislative action but, as importantly, on adoption of other major inter-dependent initiatives proposed in our report. In short, our report – as well as the Independent Assessment – makes very clear that providing veterans access to needed care cannot be achieved by "tweaking" existing programs or mounting a complex new delivery framework on a weak infrastructure platform. Rather, it requires an integrated systems approach that not only redesigns VA's health care delivery system, but re-engineers fundamental internal systems. Transformation will require streamlining key functions such as IT, HR, procurement, facilities-management; investing in IT and facilities; building a strong leadership system; strengthening VHA governance; and reorganizing the relationship

between VHA leadership and the field. Clearly, it will take time and will require relentless commitment by all stakeholders.

Let me add that in recommending a transformation of VA health care delivery and the systems that underlie it, we used the term "transformation" advisedly to mean fundamental, dramatic change – change that requires new direction, new investment, and profound re-engineering. Virtually all the commissioners agreed our recommendations are bold, though you have, no doubt, heard isolated voices of disagreement. One view disputes our belief that our report's recommendations would be truly transformative, and says instead that the report proposes only limited reforms and will do little to redirect veterans' health care. At the same time, our work has also been characterized as a "horrendous, anti-veteran proposal." Both critiques widely miss the mark, in my view. Our focus, however, was not on how our recommendations would be characterized, but with developing a report that would result in meaningful improvement in veterans' care. I believe we have laid that foundation.

"Privatization"

It is no secret that the Commission debated the merits of so-called "privatization" or of veterans being offered unfettered choice from among all Medicare-qualified providers. It is also no secret that some among the membership are deeply skeptical of government-run health care, and some believe current trends will ultimately lead VA to a payer only role. Regarding the 20-year horizon to which the Commission was to look, though, we can foresee continued dynamic change in health care. Already, there has been a dramatic increase in outpatient care. We can also speak with some confidence about the potential for explosive growth of telemedicine, increasing emphasis on preventive care, the introduction of precision medicine and the likely proliferation of technologies that permit routine home-based health monitoring of patients with chronic illnesses. But we're also in agreement that the rapid changes overtaking health care make it impossible to accurately forecast further than five years out.

While we cannot fully foresee the medical breakthroughs of the next decades, the Commission did acknowledge important realities:

- Despite profound challenges it must overcome, the VA health system is important to millions of veterans and has great value in providing clinical care, educating health professionals, conducting research, and carrying out a contingency national-emergency mission.
- Millions of veterans will continue to need care in the future that VA provides through critical programs and special competencies that are either unique or of higher quality or greater scope than is available in the private sector.
- Many veterans have complex medical and well-being needs, often greater than are commonly present in the general population.

- As a result, in considering the option of VHA becoming solely a payer, one must acknowledge that health care systems and facilities across this country are generally not equipped to meet many of the unique and complex health needs among the roughly six million veterans whom VA treats annually, particularly those with the highest priority in law: the service-connected disabled and those with limited financial means.
- The difficulties veterans have experienced in accessing timely care in the VA health care system are also relatively common experiences among health care consumers outside VA where national shortages of primary care physicians, psychiatrists, and certain specialists are everyday problems.
- Finally, many private health care systems have not established programs to fully coordinate care – an important attribute of VA-provided care.

This last point has particular relevance to the idea that veterans would be better served if they were simply provided a card or care-voucher that entitle them to get care virtually anywhere at VA expense. That strategy would surely lead to more fragmented care. As described by one highly acclaimed former Under Secretary for Health—

> "Fragmentation of care is of concern because it diminishes continuity and coordination of care resulting in more emergency department use, hospitalizations, diagnostic interventions, and adverse events. The VA serves an especially large number of persons with chronic medical conditions or behavioral health diagnoses – populations especially vulnerable to untoward consequences resulting from fragmented care."[2]

Needed Congressional Action

Importantly, our recommendations highlight the critical role we see for Congress. The Commission certainly recognizes that veterans' access to care has long been a high congressional priority. Congress has strengthened the foundation of care-delivery through legislation, provided needed medical-care funding, and conducted important oversight. In creating our Commission, you asked the important question, how can the nation best deliver veterans' care in the years ahead? Let me highlight some of the critical steps we recommend Congress take:

- Provide VA needed authority to establish integrated care networks through which enrolled veterans could elect to receive needed care from among credentialed providers without regard to geographic distance or wait time criteria;

[2] Kenneth W. Kizer, MD, MPH, "Veterans and the Affordable Care Act," JAMA, vol. 307, no. 8 (Feb. 22/29, 2012) accessed at https://commissiononcare.sites.usa.gov/files/2016/01/20151116-02-Veterans_and_the_Affordable_Care_Act_JAMA_Feb2012_Vol307-No8.pdf

- Address fundamental weaknesses in VHA governance;
- Provide VA more flexibility in meeting its capital asset and other needs, including –
  (1) Establishing a capital asset realignment process modeled on the DoD BRAC process;
  (2) Waiving or suspending the authorization and scorekeeping requirements governing major VA medical facility leases;
  (3) Lifting the statutory threshold of what constitutes a VA major medical facility project;
  (4) Reinstating broad authority for VHA to enter into enhanced-use leases; and
  (5) Easing, for a time-limited period, otherwise applicable constraints on divestiture of unused VHA buildings.
  (6) Establishing a line item for VHA IT funding and authorize advanced appropriations for that account.
- Create a single personnel system for all VHA employees to meet the unique staffing needs of a health care system; and
- Invest in needed VHA IT funding and facilities.

I'd be happy to discuss any of these in more detail, but let me amplify one point, which our commissioners viewed as foundational. The Commission saw VHA's governance structure as ill-equipped to carry out successfully the kind of transformation required to re-invigorate this health system, which all agreed would be a multi-year process. Continuity of leadership and long-term strategic vision -- critical both to implementing a transformation and to sustaining it – cannot be assured under a governance framework marked by relatively frequent turnover of senior leadership and near-constant focus on immediate operational issues. The Commission believed that two fundamental governance changes were needed: establishment of a board of directors with authority to direct the transformation process and set long-term strategy, and change in the process for the appointment for and tenure of the official currently designated as the Under Secretary for Health. Of course, I'd be happy to discuss these and other recommendations in more detail.

Cost

Let me emphasize that the Commission's aim was to develop recommendations that are actionable, sustainable, and would realize the vision of improving veterans' access, quality of care, choice, and well-being. We did not set out with the preconceived notion that bold transformational change was needed. Rather we stayed true to our guiding principles and to where our findings led us. Also, we were not constrained by cost considerations, though we did recognize early that the U.S. taxpayer is one of the Commission's stakeholders and we worked with health economists to model different options. Our report includes an appendix chapter that presents estimates of the cost of alternative policy proposals.

We recognized that our recommended option for expanding community care through the establishment of integrated care networks would result in higher utilization of VA-covered health care and, accordingly, in additional costs, in the view of our economists. But we believe adoption of other Commission recommendations and options discussed in our report can help mitigate the increased costs. Projecting costs, as you know, includes elements of uncertainty. Our economists could not estimate savings or costs that might result from reducing infrastructure, for example. Similarly, they could not assign costs to needed investment in IT and facilities.

Implicit in our discussions, though, has been the question – should the nation invest further in the VA health care system? Our report answers that question in the affirmative, even as it underscores the need for sweeping change in that system. We do not suggest that Congress has not already made very substantial investments in the system. Rather we call for strategic investments in a much more streamlined system that aligns VA care with the community.

In my judgment, our report points the way to meeting the central challenge Congress identified in 2014: improved access to care, while offering a vision that would expand choice, improve care-quality, and contribute to improved patient well-being. It is a vision that puts veterans first, not an approach crafted to win buy-in from system administrators or other interests. My long experience tells me that that veteran-centered focus will ultimately improve the service veterans receive while strengthening the system and providing increased transparency and accountability. In my view, this is a vision that merits your support.

I would be pleased to be a resource to this Committee as you continue to work on these issues. I would also be happy to respond to your questions.