Statement of
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before the
Committee on Veterans' Affairs
U.S Senate

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Chairman Sanders, Ranking Member Burr, Distinguished Members of the Senate Committee on Veterans Affairs, thank you for the opportunity to appear before you and offer my comments on S. 543, "VISN Reorganization Act of 2013". I believe the proposed legislation is both timely and necessary to ensure that the Department of Veterans Affairs with predictable regularity, reviews, reorganizes or right sizes, as appropriate, its VISN organizational structure and operation to more efficiently and effectively oversee and manage the budgetary and planning responsibilities for veteran healthcare in the respective networks.

By way of personal background, I retired from the Marine Corps in September 1999 after 30 years having served as both an infantry officer and Judge Advocate; my last assignment as the Senior Military Assistant to the Under Secretary of Defense for Personnel and Readiness. Upon retirement, I joined the Committee on Government Reform and Oversight, U.S. House of Representatives as a Senior Counsel and served there until February 2002 when I joined the Department of Veterans Affairs. I served in various positions at VA headquarters which included Acting Assistant Secretary for Public and Intergovernmental Affairs, Deputy Chief of Staff and Chief of Staff. I departed VA Central Office in January 2009 and assumed the position of Senior Advisor to the Director of the VA Sunshine Healthcare Network (VISN 8) in St. Petersburg, Florida. I retired from the VA in June 2012.

In 1995, Dr. Kenneth Kizer, then the Under Secretary for Health for VA implemented a plan for the reorganization of both the field operations and its central office management. It was called *Vision for Change: A Plan to Restructure the Veterans Health Administration, March 17, 1995*. Under the plan the basic budgetary and planning unit of healthcare delivery in the field was moved from

individual medical centers into integrated service networks providing care for veteran beneficiaries in pre-determined geographic areas. Dr. Kizer stated:

"These network service areas and their veteran populations are defined on the basis of VHA's natural referral patterns; aggregate numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and to a lesser extent, political jurisdictional boundaries such as states."

VISN GEOGRAPHIC BOUNDARIES

Although 22 VISN's were part of the original implementation plan, two of the smallest VISN's were combined to better justify and accommodate staffing, funding and patient population leaving 21 VISN's to initiate Dr. Kizer's plan. The VISN staffing level was to be 10 FTE. There has been no serious review and right sizing of the VISN geographic boundaries in approximately 18 years until prompted by the proposed legislation.

The proposed legislation reduces the number of VISN's from 21 to 12 by combining existing geographic boundaries and eliminating excess VISN headquarters, and assisting the transfer or reassignment of affected personnel to nearby VA medical centers, or other VA facilities. Many could fill existing vacancies at these facilities based upon their exceptional skillsets. With the closure of 9 VISN headquarters under the reorganization, the funding saved could be provided to other VA Medical centers to support clinical needs and other capital asset upgrade and maintenance, as needed. Attached is a map reflecting the proposed realigned boundaries identifying affected VISN's. The map also reflects the current location of existing VA medical centers, community based outpatient clinics (CBOC) and VISN headquarters locations.

The geographic combinations result, across the VA, in a re-balancing and closer standardization of the aggregate number of today's veteran beneficiaries under the budgetary and planning management of one VISN director instead of spread across two or, in one case, three separate VISN headquarters with its associated staff. In essence, the combining of the selected VISN's is analogous to what Dr. Kizer found appropriate to do for roughly similar reasons in the very beginning when he combined two VISNs.

By way of an example below, I am using approximate 2011 VA data for VHA unique patient/veteran enrollee numbers. Combining VISN 1 (232,490/353,911), VISN 2 (129,815/140,415) and VISN 3 (167,172/183,382) would result in approximately 529,477/677,708 total unique patients/veteran enrollees would result in one VISN director and associated staff managing them, instead of the VISN headquarters budget and FTE overhead of three VISN. Those numbers compare more favorably to what one VISN, VISN 8, had as numbers for the same categories at the same time – 505,133/714,755. Another example is combining VISN 17 (261,560/394,110) and VISN 18 (240,044/363,209) would result in one VISN director managing 501,604/757,319. A further example is combining VISN's 19 and 20. VISN 19 (170,608/261,736) combined with VISN 20 (243,872/375,968) results in 414,480/637,704 total unique patients/veteran enrollees; numbers still smaller than those of VISN 8.

Some might argue that despite smaller unique and enrollee patient numbers, you need separate VISN's because of the challenge presented by the number of VA Medical Centers or the expansion of geographic areas that the combinations would entail. VA Medical Centers are not all the same complexity level or size. The same management process and procedures for budgeting and planning can be applied whether the number of medical centers is 8, 14, or in the largest proposed VISN (combining VISN's 1, 2 and 3) would be 20. The management tools, reports, IT and tele and video communications venues available to a VISN director and staff are significant and effective, if utilized appropriately. Much of the intended mission of the VISN operation is accomplished through data analysis and "dashboards" All too often in recent years the immediate response to any additional tasking or expansion of responsibility at the VISN headquarters level has is a request for more FTE instead of working with what staff already exist. Doing so underestimates the fact that current VISN staff are individually and collectively more capable of assuming more responsibilities if asked, especially in the restricted budget environment that VA will be challenged with in future years.

It is important to note that the realignment of the VISN geographic boundaries would not adversely impact individual veteran patient referral patterns. They would continue as before. Patients would still be cared for by their VA Medical Center staff, or wherever they may be referred for care. The VISN headquarters does not currently, nor under the proposed restructuring, provide direct patient healthcare. What would change is that VA Medical Center directors in realigned

VISN's would have a new VISN director to which they will be accountable….a new boss.

VISN STAFFING

The current review by VHA into the VISN headquarters FTE staffing numbers seems to be consistent in its results (55-65 FTE) with VISN staffing levels recommended by the proposed legislation – not more than 65 FTE. However, the current VHA review was done assuming 21 VISN's. I believe the review started with approximately 1720 adjusted VISN FTE staff, and VHA is in the process of reducing VISN staffing to a total of 1230 FTE, a reduction of approximately 490 FTE. With the proposed realignment, VISN staffing could be further reduced by approximately 520 FTE. The budgetary savings and FTE benefit could be moved to support operations at the VA medical centers

In conjunction with the reorganization of the number of VISN's, I would strongly urge that the position of VISN Deputy Director be upgraded to SES level at all VISN headquarters. VA Medical Centers are healthcare systems and each health system has a director that is an SES. They are accountable to the VISN director (an SES) in the chain of command. As the term Deputy Director is currently applied, it is a misnomer. If a VISN director retires; is replaced for cause; or, absent for a significant period of time, VA has to identify an SES level individual to replace him or her for the duration of the absence or vacancy. Usually that replacement is through detailing a current sitting medical center director within the VISN, or seeking someone from another VISN to assume the director responsibilities until a replacement is appointed. At the present time, that recruitment and appointment process can be rather time consuming.

An SES Deputy Director can immediately assume the Acting Director role with current understanding of the VISN issues; no "learning curve" would be necessary. Medical center directors will be more inclined to see the SES Deputy Director as more of a "peer" and interact with that person more completely and confidentially on business and other related issues that they usually reserve for conversations with the VISN director. Additionally, upgrading the position can be an excellent succession planning venue for potential medical center director candidates allowing them to gain significant experience and insight into executive planning and decision making. SES allocations for these positions can possibly

come from SES positions that become available through the VISN consolidations if retirements occur or from those currently available within VA Central Office.

LOCATION OF VISN HEADQUARTERS

The proposed legislation states, in essence, that a VISN headquarters is to be located on the grounds of a VA medical center. At the same time, however, it provides that the Secretary can justify keeping the VISN headquarters in a leased location off campus by justifying his decision in a report to appropriate Congressional oversight committees. The preference for colocation upon a VA medical center campus is in keeping with what Dr. Kizer recommended. Colocation on a VA medical center campus provides for veteran and medical center situational awareness for the VISN staff by witnessing their budget policy and planning being implemented at the operational level. If the Secretary ultimately directs the movement on campus, there would possibly be some associated costs, but that would be the decision of the Secretary.

VISN BALANCED BUDGET

In the absence of an unanticipated exigent circumstance (natural disaster, or other unforeseen emergencies), there is very little justification for not being able to balance at the end of the fiscal year. VISN's begin to plan for the closure of their books, and VA Central office is generally well aware of any deficiencies in advance of the end of the fiscal year. VA Central Office has the ability to transfer reserved funds held at their level to cover the deficiencies in VISN accounts in advance of the end of the fiscal year where and when they want to do so. In addition, the Under Secretary for Health has a number of manner, means and methods of holding VISN directors accountable for year-end budget deficiencies.

TRIENNIAL REVIEW OF VISN STRUCTURE

A review and report to Congress every three years will provide appropriate "checks and balances" for VA leadership as it plans and programs for VISN field operations; preclude unnecessary FTE increases; and, facilitate and enhance appropriate Congressional oversight of VISN operations.

Mr. Chairman, this concludes my statement. I am pleased to answer any questions that you or other Members may have.

Map showing VISN Offices, VAMCs, and CBOCs