

## **COMMISSION ON CARE**

*ving is a proposed strawman document developed by Commissioner David Blom with the input of Commissioners Cosgrove, Hickey, Johnson, Selnick, Steele and Webster.*

*erve as the basis of discussion by the full Commission on Care at the March 21 – 23 meeting.*

## Considerations and Recommendations Table of Contents

Preface	Page 2
Synopsis	Page 2
America’s Veterans	Page 3
Background on Veteran Health Administration Facilities	Page 4
Background on Veterans and their Utilization of VHA Health Care	Page 5
Urgent Challenges	Page 5
Staffing, Leadership and Governance	Page 6
Facilities and Capital Needs	Page 8
Information Systems, Data and Tools	Page 9
Operations and Processes	Page 10
Vision for the Future: Bold Transformational Change	Page 11
The Transformation – in Brief	Page 12
Path to the “End State”	Page 14
Other Transition Issues	Page 17
Training	Page 17
Research	Page 17
Emergency Management	Page 18
Summary	Page 19
Appendix A. Veterans Health Administration	Page 21
Appendix B. Primary Care and Mental Health; and Other Innovative Initiatives	Page 23
Appendix C. Governance Board	Page 26
Appendix D. Eligibility	Page 29
Appendix E. Facility Prioritization	Page 33
Appendix F. Cost Concerns	Page 34

## Considerations and Recommendations

### Preface

Recognizing the current challenges enrolled veterans have in gaining access to health care services, Congress passed The Veterans Access, Choice and Accountability Act of 2014 which established the Commission on Care. Section 202 identifies the function of the Commission “to examine the access of veterans to health care from the Department of Veteran Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of enactment of this Act.” The Commission shall “undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.” Further, the Commission will submit a report “to the President, through the Secretary of Veterans Affairs.” The report is to include recommendations, and will be assessed at various levels, and then will be submitted to Congress.

### Synopsis

The Veterans Health Administration (VHA), and all aspects of VA health care should focus on the needs of the veteran. Unfortunately, these needs are not currently being met. The goal is to meet these needs – for each and every enrolled veteran. The Commission believes this will require a bold transformation.

From their first public meeting in September 2015 until the present, the members of the Commission on Care have discussed the Independent Assessment; listened to numerous speakers at Commission meetings; listened to veteran service organizations (VSOs); made site visits to VA facilities; exchanged ideas with individual veterans, providers, members of Congress, and others; and have reviewed numerous other materials and information sources. The Commissioners, in general, agree with the majority of findings in the Independent Assessment, which are, in large part, consistent with the other materials presented.

The Commission concludes that the Veterans Health Administration (VHA), at present, has significant challenges including governance, leadership and staffing; facilities and capital needs; data and information systems; operations and processes; and others. In order to provide the health care our nation’s veterans have earned, deserve and need, VHA is in immediate need of bold transformation.

Further, the Commission is committed to recommending a transformation that will lead to a sustainable veteran-centric health care system that focuses on veteran needs and preferences.

Considering the “current state” of the VHA, both its strengths and liabilities, the Commission recommends that VHA move forward, in a transformational way, to develop an integrated health care system. This will involve networking and coordinating with community providers for care, while, over time, reducing the VHA provider footprint. There is urgency, much improvement is

needed immediately in the care for veterans, and facilities that are no longer meeting the needs of the VA and veterans should be transitioned. Yet, it must be recognized that any transformation of this magnitude requires deliberate concurrent and sequential actions; and any “steady state” will always be “evolving”. Thus, this transformational plan requires immediate drastic change (perhaps over the next five years) to resolve the most urgent issues, though the overall transformation will continue throughout the next two decades as facilities become obsolete, veteran demographics and geography change so that more care is needed in some areas and less in others; and new technology changes the nature of health care delivery. This will lead to the closure of numerous VA health care facilities, with funding following the patients to community providers. No matter how well-planned and effectively implemented the current transformation is, even by the year 2035, the process of continual improvement should become an integrated reality and a permanent sustainable component of the system, so that the system is ever-adapting and ever-leading health care delivery. Though assuring our veterans receive the health care they have earned, deserve and need is the first priority, the VHA transformation should be managed so that the overall veteran community and community at large continue to have the benefits of VA’s research, training and emergency management.

### America’s Veterans

The mission of the VHA is to “honor America’s Veterans by providing exceptional health care that improves their health and well-being.” This implies a robust comprehensive quality health care system that veterans can readily access to meet their needs. Unfortunately, recent events have revealed that many veterans are not receiving “health care that improves their health and well-being.” Newspaper reports, legal investigations, and formal studies have identified gaps in the system. The deliberations of the Commission on Care have focused on ways to address the health care access problems.

Precise demographic data are not available on many aspects of the veteran population. However, there are about 22 million veterans in the United States, of which about 9 million are enrolled in the VHA. In 2014, about 6 million veterans received at least one service from the VHA (from VA employee and contractor health care providers.) About half of enrolled veterans are eligible for Medicare; about 1.3 million enrolled veterans have no other health insurance. The “average” enrolled veteran who uses the VA gets about one third of care there.

The number of veterans using care varies over time. Current predictions are the population of Veterans is expected to decline by 19 percent over the next decade, though the demand for health care services is expected to rise before it levels off in five years. (Page xiii. Independent Assessment Vol 1: Integrated Report.)

### Background on Veteran Health Administration Facilities

The Veterans Health Administration is the United States' largest integrated health care system consisting of 150 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers and domiciliaries. The U.S. is divided into 21 Veterans Integrated Service Networks, or VISNs.

The VHA Medical Centers (VAMC) provide a wide range of services including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology and physical therapy. In addition, most of the medical centers offer additional medical and surgical specialty services including audiology & speech pathology, dermatology, dental, geriatrics, neurology, oncology, podiatry, prosthetics, urology, and vision care. Some medical centers also offer advanced services such as organ transplants and plastic surgery.

VHA includes more than 800 Community-Based Outpatient Clinics (CBOCs) to increase access to health care and to provide the most common outpatient services, including health and wellness visits. Some CBOCs are staffed by VHA employees, while others are contracted out to private providers. About one fourth of the CBOCs are fully contracted clinics with private (non-VA employee) health care providers.

The Vet Centers provide readjustment counseling and outreach services to all Veterans who served in any combat zone. Services are also available for family members dealing with military related issues. VHA operates 278 community based Vet Centers in all fifty states, the District of Columbia, Guam, Puerto Rico, and the US Virgin Islands.

The VHA has four disease specific Centers of Excellence for epilepsy, multiple-sclerosis (MS), Parkinson's Disease, and war related illness and injury. The VHA system also funds 19 Centers of Innovation (COINs)

The VHA also has three additional congressionally mandated missions - education, research and service in National emergencies.

Currently, the VHA health care system provides care through its own facilities with employee and contract providers and in totally contracted out facilities (such as about one fourth of the CBOCs). Though numerous and geographically diverse, these VHA facilities and regional centers do not and cannot provide all of the care needed for the veterans enrolled for their health care services. Thus, the VHA also contracts with community providers to meet the demand.

(See Appendix A, Veterans Health Administration for more information on the VHA facilities and services.)

### **Background on Veterans and their Utilization of VHA Health Care**

Though the VHA is our nation's largest health care system, it provides only a fraction of the care used by enrolled veterans. Only about two thirds of enrolled veterans use the VA, and relatively fewer still receive all of their care from VHA employee providers in VHA facilities. Further, for a variety of reasons, most of the veterans who use VHA services, only use them for part of their care. Some of these reasons relate to the geographic distribution of veterans and VHA care and the services provided, as well as some of the negative perceptions about the nature of care provided in VHA facilities.

In 2014, 30 percent of the urban Veteran population lived further than 40 miles from the nearest VAMC. For the rural Veterans population, over 80 percent lived further than 40 miles from the nearest VAMC. (Source, Independent Assessment, Volume A, p. 54) Traveling to these centers can be difficult for veterans; thus many choose providers closer to home, even when that means using Medicare, private health insurance, or paying for care themselves.

In some geographic areas, only primary care or certain selected services are available, so veterans utilize community providers for more specialized services.

Certain benefits – such as hearing aids and eye glasses – are available at no charge at VHA facilities but not through most health insurance plans, so some veterans use VHA only for these services. Other veterans lack a prescription benefit in their health plans, so go to the VHA for prescriptions and refills.

Overall, though the VHA facilities and the care provided in them varies widely, many veterans choose not to receive care in VHA facilities because of appointment timing, quality of care, courtesy of staff, or in general, find the environment lacks a veteran focus.

VHA also funds care from providers in the community. Some VHA-funded care is provided by community providers since VHA facility services and overall capacity requires these referrals. Further, when the choice of community care is available (such as through some of the VA-funded community care programs), veterans may prefer to choose community providers. In other cases, veterans who are eligible for VHA funded care, elect to use non-VA funding sources and select their own community providers independent of any VHA benefit. These veterans may fund their care with private health insurance, Medicare, Medicaid, their personal funds or other sources. Alternatively, some veterans who are not eligible for “free” VA care, still choose the VA and provide cost-shares for the VHA care. These cost-shares include private insurance and self-pay; however, an enrolled veteran cannot use his or her Medicare or Medicaid benefit at a VHA facility. Medicare and Medicaid cannot be part of the “bundling” of payment funds for VHA care, whether at VHA facilities or VA contracted providers in the community.

### **Urgent Challenges**

Numerous gaps in VHA health care have been identified in the “Independent Assessment,” congressional hearings, and even the popular press. It has become well recognized that the VHA

is in a state of crisis, and as a result, our deserving veterans are not receiving the medical care and related services they need. This crisis is exemplified in a number of urgent challenges. The Commission finds significant gaps in staffing, leadership and governance; facilities and capital needs; data and information systems; operations and processes. These and other factors contribute to the resulting significant inefficiencies and inadequacies.

### Staffing, Leadership and Governance

The Commission believes that “people” are the most important asset of any health care system and thus staffing, leadership and governance are of critical importance.

The Commission finds that:

- For a true veteran focus, a full complement of qualified staff – clinical and administrative – are necessary. The VHA lacks these.
- Human Resources. VHA has significant vacancies. In 2014, nationally, one in six positions — nearly 41,000 — for critical intake workers, doctors, nurses and assistants were unfilled throughout the system; 24% of total VHA vacancies were for providers. (Source: [http://www.usatoday.com/story/news/2015/08/20/half-critical-positions-open-some-vas/32003103/.](http://www.usatoday.com/story/news/2015/08/20/half-critical-positions-open-some-vas/32003103/))
- Positions at all levels are difficult to fill. A few of the many reasons include potential stigma in working in “today’s VA”, bureaucratic hiring practices, poor morale, a “culture of fear,” and non-competitive financial compensation in some job categories and geographic areas, etc. The staffing situation appears to be growing progressively worse and the trajectory is for this negative trend to continue.
- Leadership. Senior leadership is key to effective operations. Unfortunately, many of the VHA senior leadership positions are vacant, and have not been filled for some time. When vacancies occur, they are often filled with “acting” persons rather than effectively filling the positions with permanent leaders.

As of March 2015, 16 percent of VAMC Quadrad and VISN Network Director positions were vacant or had acting leaders. Twenty-three VA Medical Centers (16 percent) did not have a permanent Director. Nine VISN Network Directors (43 percent) were Acting (Sources: VHA Office of Workforce Services, 2014; Independent Assessment L page 8.)

Recently, over half of the senior leadership positions were not filled with incumbents (source: Independent Assessment G, p. 34) and approximately 25% of the medical centers and regional networks reported executive openings (source: <http://www.modernhealthcare.com/article/20160102/MAGAZINE/301029974>)

- Governance Structure. As a federal agency, the VA is subject to numerous federal statutes and other processes related to almost all aspects of its operations including the budget

process and contracting. Further, the “board of directors” is functionally Congress- setting the budget, providing oversight (often through hearings), and passing numerous statutes. These activities, in an effort to provide positive oversight, can limit flexibility and contribute to bureaucracy. This is only compounded in times of stress, such as the present, when even more hearings and oversight attempts are made to resolve the various operational inefficiencies and other difficulties. Further, this large “board of directors” with vested interests in every state and congressional district, may not provide an unbalanced national view. The system can cater to power, and at times foster local priorities at the expense of national objectivity.

The VA bureaucracy is only complicated by the executive branch processes represented by the VA regulatory response to congressional statutes – developing regulations to implement the statutes. These regulations often contribute even more to the bureaucracy and complexity, and further slow the operational processes. Rather than facilitating efficient implementation of the statutes, the VAs own processes often add complication and additional burdens. VA leadership often does not utilize the flexibility provided in its own regulatory processes to assure a “can do” approach; rather the regulatory process is often used as an excuse to delay change.

- Managing a complex health system. The VHA health care system is the largest integrated health care system in the country, and has even more complexities than its community colleagues. As mentioned above, the VHA health care system must be responsive to the general federal statutes (such as the FAR for government contracting and federal personnel systems), as well as various special VA statutes (such as those regarding facilities). In addition, as a health care system, VHA and its facilities are also expected to be responsive to many of the same federal health care statutes and national standards (such as accreditation of its facilities) that apply to its community colleagues. As a result of these and other factors, managing a hospital or clinic in the VA system is markedly more complex and inefficient than in the private sector.
- Need for Transformational Change. Considering the urgency to provide appropriate care for veterans, findings of the Independent Assessment, and tone of recent Congressional Hearings, incremental change will not adequately address the urgency and seriousness of the current situation. Individual veterans, many members of Congress, and others, are seeking a bold transformational approach.
- In summary, the Commission has found that the staff, leadership and governance to resolve the shortcomings of the current health care provider system are not readily identifiable or available.

### Facilities and Capital Needs

Recent studies concur that the capital needs exceed any realistic capital budget expectations. The Commission finds that:

- The capital budget required to address facility obsolescence is not obtainable. VA has identified more than \$51 billion in total capital needs over the next 10 years through its capital planning methodology. These requests cover current ten-year projections; however, new projects may be added as needs change and could change the total capital requirement. Provided that average funding levels remain consistent over the next 10 years, the \$51 billion capital requirement would significantly exceed the anticipated funding level of \$16-26 billion. (Source: Independent Assessment, Volume K)
- Multiple factors drive the scale of the capital need. VHA facilities are older buildings, with significant repair needs, and some are poorly suited to emerging models of care (such as multiple exam rooms per primary care provider.) The average VHA building is 50 years old, five times older than the average building age for not-for-profit hospital systems in the United States. While many facilities have been extensively renovated, the renovations themselves have aged, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities through the VHA Facilities Condition Assessment (FCA) found that VHA facilities average a “C minus” score, meaning that much of the total facilities portfolio is nearing the end of its useful life. More than 70 percent of VHA facilities correction costs result from infrastructure and facilities that are D rated, meaning that they are at the end of their useful life.
- The Veterans Health Administration (VHA) operates approximately 5,559 buildings on 15,968 acres of land, and over 1,604 leases, encompassing over 15 million square feet of space in its portfolio.
- Current facilities, whether they have been maintained adequately or not, often do not match current models of care. The overwhelming majority of VHA hospitals were designed when care was focused more heavily around inpatient hospital treatments. Over the past eight years, Veteran inpatient bed days of care have declined nearly ten percent while outpatient clinic workload has increased more than 40 percent. Space for outpatient care is typically housed in converted inpatient spaces or VHA’s growing number of clinics. As a result, VHA’s capital needs fall into a broad range of categories, including ensuring adequate facility condition, providing sufficient and appropriate space for Veteran care, and upgrading infrastructure. As facilities age further and care continues to shift to the outpatient setting, the size of the capital need could continue to grow.
- These facilities are rapidly deteriorating, and this trend will continue without excessive and unrealistic capital investments. The scope of facility gaps precludes incremental change as a remedy.

- Need for Transformational Change. The capital needs of the current VHA health care system exceed any realistic expectations of funding. Recent experiences with hospital construction (such as Aurora, Colorado) cause further question about the VA's capacity to lead additional capital campaigns and construction projects. A bold transformational approach is needed to address these infrastructure challenges.
- In summary, the Commission has found that the current facility and overall infrastructure of the VHA health care system is in need of immediate overhaul and modernization, and that the costs of this exceed any reasonable expectation of available funds, both now and throughout the next two decades.

(Source: Independent Assessment, Volume K)

#### Information Systems, Data and Tools

The Information Systems, overall, are obsolete and do not meet today's needs. Appropriate data – clinical, financial, operational, etc. – are not available and the systems utilized are not able to communicate with each other.

The Commission finds that:

- VA information systems do not work effectively in support of operations
- Developing effective information systems would be a long, expensive and cumbersome process.
- For example, in August of 2005 the VA awarded \$624 million contract to overhaul its medical appointing system. In March 2016, VA announced awards of up to \$22 billion for information technology upgrades, for health and other systems. Even with these expenditures, much remains to address the immediate and varied clinical and operational health care IT needs.
- Unfortunately, the time required to develop the needed comprehensive IT infrastructure is not consistent with the current emergent situation.
- Developing effective information systems requires coordination and communication both internally and externally. For example, at one time, VA had a "home grown" state of the art electronic medical records system, Veterans Health Information Systems and Technology Architecture (VISTA), that met its needs internally. Unfortunately, VISTA has not kept pace with commercial electronic medical records systems, and has become outdated; some say "obsolete". It doesn't effectively communicate with the major systems used by community providers or the Department of Defense. The initial and on-going costs to make it world class again would exceed expected funding.

- However, today, with the growing use of electronic medical records in the community, and the VAs augmentation of its own care with community care, effective, near real-time electronic communication of patient care, laboratory, pharmacy, coding, billing, appointing and other information is needed.
- Further, as electronic medical records and other electronic record-keeping and tracking systems have evolved in the community, it has become obvious the essential role these electronic systems have in contributing to an efficient healthcare network. Unfortunately, the VAs systems have not kept pace with community standards. Information transmission of all sorts – clinical data, billing, appointing – should be efficient and electronic. Unfortunately, the VA systems do not permit this – even within the VA system itself.

Further, when communication with the community becomes necessary – which is now routine – the gaps in the VA systems become even more apparent. Proof of these inefficiencies are the truckloads and truckloads of paper copies made from electronic data, which are transported across town, scanned and discarded.

- VA's information system does not effectively connect with Cerner, EPIC, Meditech or the other commercially available systems commonly used in community care. More veterans' care is and will be delivered in the community, so connectivity with these systems is imperative. The path for the current VA systems to reach an efficient level of connectivity is long and treacherous; some say unrealistic.
- Need for Transformational Change. Incrementally modifying the current IT system with the hope of developing a modern and effective IT infrastructure is not realistic or practical, both in terms of time and cost. The system needs something urgently, and the complexity of designing and implementing a new system is far beyond the needed timeline. Further, the costs of such a system would exceed a realistic budget.
- Summary. Effective electronic systems are needed for all aspects of patient care and record keeping (such as appointing, clinical charting, pharmacy, lab, coding, billing, etc.), recording and tracking quality measures, and general operations such as budgeting. The now inadequate VA electronic systems (many of which have been internally constructed) are unable to effectively manage these functions and have not developed at the same rate as the commercial sector. Unfortunately, they have, in large part, become obsolete.

### Operations and Processes

An efficient and effective operating system requires many components, working in close harmony, for the system's mission to be met. Tragically, the current VHA lacks the components for effective operations. The VHA is not effective, and cannot become effective without significant change – a bold transformation is needed.

The Commission finds that:

Multiple processes that have become standard for a health care system are lacking for VHA. Some have already been identified – IT systems for bills and collections; an efficient HR system for hiring; and infrastructure that accommodates today’s medical practice. Many reasons can be given for these gaps. Frequently, the reason given is the “rules of the federal environment.” Few will argue that functioning in a federal system is different than in a private corporation. However, many of the perceived restrictions on a federal system are just that – perceived. For example, though there are federal HR statutes which provide direction, many of the detailed guidelines, rules and regulations affecting VHA operations and processes could be changed by the VA through the processes available to it. With effective leadership, many of the obstacles currently facing VHA could be removed. Further, Congress has expressed a willingness to make statutory changes to facilitate more effective operations. Some of these “obstacles” appear to be “excuses”.

Tragically, the impact of the current situation can be seen in the daily lives of many veterans. For example,

#### ANECDOTES FROM VETERANS TO BE INSERTED

- Need for transformational change. The VHA operations and processes do not support effective or efficient health care delivery. The tragic stories relayed by our nation’s veterans provide specific examples of this. The current VHA health care system is not adequately meeting the needs of its enrolled veterans.
- Summary. The operations and processes currently in use by VHA detract from its ability to provide care to the enrolled veteran population. This is coupled with the other gaps in the overall health care system (described in earlier sections). The overall condition of the VHA as a provider is in drastic need of bold transformation.

#### **Vision for the Future – Bold Transformational Change**

The Commission finds that the current VHA health system lacks the essential components to effectively and efficiently provide health care in the 21<sup>st</sup> century. These include a range of concerns around staffing leadership and governance; facilities and capital needs; information system and data; and general operations and processes. These have resulted in significant gaps in the access to health care provided to our veterans, who deserve the health care they have earned.

The Commission is committed to assuring that each and every enrolled veteran receives coordinated quality care consistent with the benefit package. Further, based on the current status of the VHA health care provider system, as briefly noted above, the Commission questions the reality of expecting this health care system to become a 21<sup>st</sup> century provider delivery system

due to many factors including the timeline required to meet the critical and urgent needs of our deserving veterans. Therefore, the Commission finds that, in the best service of our veterans, a bold transformation is needed within the VHA.

The transformation is complex, and will require carefully planned and executed steps. A timeline and milestones should be developed, monitored and tracked. It should begin immediately, with the recognition that it will take about two decades to complete, with adjustments being made along the way.

### The Transformation – in Brief

The basic element of the transformation is service to our veterans – assuring that veterans receive the care they need in the environment they choose. The goal is to be of service to veterans; not for veterans to be of service to the “system”.

The basic element of this transformation is integration with community providers. Integration means a close working relationship – a reliability – on the community. The essence of the vision is that enrolled veterans would have “choice of care” and would be able to choose between VHA provided care and providers in the community. The current “Choice Act” tried to meet this need but various challenges prevented this.

Since its inception Choice Act has not been veteran centric; the basic rules veterans must follow to get care are extremely cumbersome. The VA’s process to authorize care is a lengthy, complicated process that makes it practically impossible to use. There are provider challenges as well - VA has not adequately reimbursed community providers, along with cumbersome processes and lengthy payment delays, so that some providers who initially participated are leaving the program, further reducing the “choice”.

Veterans should have a system that gives them the choice about where they want to receive care and from whom. It should be easy to access, and have limited bureaucratic “hassle”. Veterans should be given at least the same choice offered those on Medicare to determine where they receive care. They have earned this care from their service to our nation.

As veterans choose their providers of care, the demand on VHA care may change. If the utilization of VHA care changes, the expectation is, that, over time, VHA would realign its provider base to be consistent with veteran demand. As VA facilities become obsolete and are underused, they would be closed when availability and accessibility of care in the community is assured. Throughout the process, the dollars would follow the veteran (the patient).

Some hypothesize the migration to community care may evolve for several reasons. Many enrolled veterans currently have long commutes for care, and with the increased availability of providers closer to home they will likely transfer from VHA to community care. As the veteran population demographic changes, some care will move to the community as veterans move to areas remote from VHA care. Many younger veterans tend to choose community care over VHA

care, when the option is available. Some enrolled veterans may choose community care so that their entire family can be seen by the same set of providers. Others may prefer the community providers for a host of other reasons.

Overall, the end-stage vision for the transformation includes the following:

- Choice: VHA will develop a veteran centric process for veterans who prefer community care to access it. This will likely increase the amount of community care, and consequently reduce the amount of direct-VA provided care.
- Operations: VHA will need to develop expertise in managing the clinical and administrative components of community care, using some of Medicare's and others' "best practices" as the model. To be successful, implementation will need impeccable business practices, using outside expertise and modeled after the best in the commercial world.
- Two VHA offices should be established - one office to manage community care (including the related transition, administrative and payer issues); and the other office to focus on the internally provided VA clinical care, especially to develop national policy to be implemented at the local level. Expertise in both areas will be essential for a successful transformation.
- Navigator: VHA would provide case management and other services to assure that veterans receive the comprehensive range of services they need, and that none "fall through the cracks" when receiving community care.
- Social Programs: are essential to veteran care, and should be funded. These include housing, homeless programs, etc. They should be funded both on a "fee for service" basis as well as a "program" basis, with the VA funding new programs offered by community providers in areas where the veteran need exceeds community resources.
- Services. Where gaps exist, special incentives may be necessary to develop community provider services. For example, the integration of mental health services with ambulatory care may require some augmentation in the community (see APPENDIX B.) No veteran should receive less care than being offered now.
- Centers of Excellence. VHA may continue to provide care through its own Centers of Excellence, or these Centers may be transitioned to university partners and other major institutions, with VHA funding. These decisions will be made in consideration of national policy as well as of local resources and expertise.

### Path to the "End State"

Effective implementation of this transformation will require several steps – some concurrent and some sequential.

The basic components include the following:

- The delivery of health care to veterans – whether by VHA or community providers - should be veteran centric. It should not be “bureaucracy centric.”
- The transformation should begin immediately, and proceed with all deliberate speed; however, due to its scope, the transformation should not be abrupt, and will likely take two decades to complete.
- Governance and oversight of the transformation will be through a board model. A board to oversee the transformation, and to provide operational oversight and governance, should be appointed. Appointments to serve could follow the same general structure as the Commission on Care. See APPENDIX C for more detail.
- “Day to day” management of the transformation will require significant reorganization within VHA. The VHA organizational structure should staff to the skills and expertise needed for the transformation, as well as managing the current clinical program. As the balance of VA and community care changes, the resources should be reallocated accordingly. Adequate expertise, funding, and attention focused on the transformation will be critical to its success. A separate office for transformation management will be needed.
- Expand community networks so veterans can choose between VHA and community providers, and develop a simple system for veterans to access community care.
- Assess the “Vet Centers” approach, with the expectation this service will continue more or less “as is”. This decision can be revisited at five-year increments.
- Over time, simplify the eligibility criteria. However, immediately address the care of veterans with “less than honorable discharges”. See APPENDIX D for more detail.
- Develop simple systems to incorporate community providers into the plan for community care - privileging, credentialing, billing, payment, etc. The Medicare processes may be used as a model.
- The transition to community care should be deliberate. The Commission was repeatedly told there are a number of facilities VA leadership would like to close because of underutilization, obsolete infrastructure, and other reasons. These facilities should be identified, and these should be the first transitioned.

- A formal process to prioritize and identify other facilities for transition should be instituted. See APPENDIX E.
- Payment rates will be set to incentivize network providers to see enrolled veterans. Rates may be Medicare plus 5 or 10%.
- Some services, such as the integration of primary care and mental health, may require further incentives.
- Appointing – making patient appointments – is critical to access and an efficient health care system. Appointments should be made in the most “veteran friendly” ways – using the “web,” phone, and other approaches. Whatever the system, it will need an electronic base to make and track appointments. The appointment system should be in harmony with the coding, billing, and payment systems.
- The VHA has long been recognized for cost-effective purchasing of pharmaceuticals. Arrangements for pharmacy will be developed. Even in some catchment areas where VHA facilities are closed, VHA pharmacy services may be maintained, whereas in other areas contracting with local retail pharmacies may be more appropriate. The same applies to hearing aids and eye glasses. Provision of these services should be part of the master plan for each transition.
- Efficient electronic coding, billing and payment systems will be needed to retain providers in the network; commercial off-the-shelf systems are available. These services require specific expertise, and are not current “core competencies” of VHA. At least in the short-term, contracting these services to experts would facilitate the transition.
- Though the thrust is to develop comprehensive networks in the catchment areas of facilities to be closed, networks would be developed throughout the United States with the goal to provide comprehensive coverage for all enrolled veterans so they can have “choice”. As veterans migrate to community care, VA facilities would be downsized and closed. Funding would follow the patient.
- To maximize choice, especially in rural areas with relatively few patients, enrollment for the provider should be simple, while assuring the provider is appropriately credentialed. For example, Medicare participation could be the credential required to become a VHA network provider.
- Enrolled veterans should have the option to choose between VHA care and community care - a simple system to facilitate their access to community care is essential. For example, enrolled veterans could be provided a “veteran card” to provide access to community providers throughout the country.
- As each facility is identified to become part of the transition, a localized service-area-wide plan (with timeline and milestones) will be developed to phase-out the services offered by

the facility, and transition all patients to community care, or in some instances, to other VA facilities. It is critical that each and every patient is provided necessary services throughout and after the transition.

- The impact of facility transition should impact VHA staff and employees as little as possible. Some VHA employees may choose to transfer to other VHA facilities, and since the overall VHA vacancy rates are high, this should be possible for many who choose that route. These VHA employees will be given preference in hiring at other VHA facilities. Additionally, since the "total amount of care" provided within the community should be relatively constant with the transition (e.g. care is being transferred from VHA to community facilities, though the total amount of care provided should remain relatively stable), the community providers should have a need to expand their staff and hire additional employees. The community providers accepting the additional enrolled veterans should be incentivized to hire these VHA employees. Further, the benefits (such as VA retirement) should be protected. Appropriate national policies and procedures to assure fairness, as well as localized implementation, will be essential. Management of personnel issues will require expertise and continual monitoring to assure every employee is treated fairly.
- Transitioning facilities will also require transitioning health manpower training dollars. Funding should follow the patients.
- Plans to dispose of the property no longer in use will need to be made and implemented. Since real estate management is not a "core competency" of either VA or VHA, another entity such as the General Services Administration would be responsible for property involved in the transition – sale to community providers, "government reuse," or disposal. Thus, property management would not become a distraction to the VHA transition.
- (It should be noted that it was repeatedly reported to the Commission on Care that the Office of the Secretary has identified numerous buildings/facilities that should be closed in the short term. Movement on these facilities should begin immediately.)
- Though the primary criteria should be service to veterans, transformation and the end-stage costs are also important. Unfortunately, the VHA data and systems are not robust enough to provide detailed cost information. This complicates cost projections on future options. (See Appendix F.)
- The transition will take about two decades, with the vision being the closure of VA facilities over time. Key to the transformation will be community networks to meet veteran needs.
- If veteran choice dictates it over time, the long term goal of the transformation is the total transition to community care.
- The entire system should revolve around veteran needs; veteran needs should not be directed by the system.

### Other Transition Issues: Training, Research and Emergency Management

The VA provides a significant community service in the areas of education and training, research, and emergency preparedness. The VA should remain a leader in these areas while moving forward with transformational change.

#### Training

The VA's current training programs are led by community providers, including universities. Trainees complete most of their rotations at community facilities, and are assigned to the VA for separate rotations, generally of several months. The VA funds these rotations, and reimburses the "host" institution for the trainees' time. The VA doesn't have its own "slots" for training - it "rents" trainees. Even if the VA provides very little (or no) clinical care, the VA can still have a leadership role in training, though the specific activities may change. For example, VHA could coordinate primary care training around veteran needs in the community, fund specific initiatives, and make certain that trainees are sensitized to veteran needs.

Within the current regulatory framework, the VA should maintain its leadership roles in supporting training for a range of health care disciplines. The focus may be adjusted to address key gaps and to focus on veteran's specific manpower needs. For example, one area of emphasis may be the specific medical problems that most affect veterans - and this may change over time. At present, there are well-defined manpower gaps in mental health, TBI, and PTSD manpower. Other areas lacking, for both veterans and non-veterans, are primary care, services in underserved areas (both rural and urban), and care for diverse populations, to include the homeless. Through targeted training funding, to both VA and community programs, the VA can have a leadership role and tremendous impact on filling gaps in today's health manpower. The health of veterans can be improved, and the current statutory requirements can be met through this transformational change.

In summary, the training dollars should follow the patients.

#### Research

The VA supported research has resulted in improved health outcomes for our nation's veterans. The VA is committed, both by culture and statute, to continue this progress. The transformation process will support and foster research, both now and in the future, consistent with the VA's current statutory requirements.

The VA's research budget should be focused on the needs of veterans, and should be managed to maximize the positive impacts it can have. At this time, both health services and clinical research are needed. As transformation continues, it would be advantageous for the VA to increase partnership with its fellow federal research offices. For example, it may be more effective for the VA to work closely with the National Institutes of Health (NIH) on its research agenda, and perhaps to even involve the NIH in the administration of VA research funds. The key element of any future approach is to maintain the strategic focus on veteran health. Through

various programmatic and organizational structures, the VA can retain its leadership role in veteran health research, and maximize the impact of this research. Much flexibility is possible within the current statutory structure, and by further developing its approach to research, the VA can improve veteran health while meeting its current regulatory requirements.

#### Emergency Management

The primary foci of the emergency management programs are the VHA health care services in time of emergency, though they also have some responsibility to augment community resources. As patient care moves to the community, these emergency management activities can also be transitioned. Though some policy will be federal, the specific details will vary for each community, based on the local strengths and gaps. The current emergency preparedness budget for general community support can be transferred to these community activities.

## Summary

In summary, the Commission concurs in general with the findings of the Independent Assessment; a bold transformation is needed. The Commission finds the current VA health care system is seriously broken, and because of the breadth and depth of the shortfalls, there is no efficient path to repair it. Thus, the Commission recommends a transformation with a focus to integrated care. Immediately, the most obsolete and underutilized facilities should be closed and those patients transferred to local providers. All enrolled veterans should now be given the option of community care. A deliberate plan should be developed to transition the others to community care over the next two decades, with the details based on veteran preference, geography, infrastructure condition, and other variables.

Further, the Commission recommends the following:

- The essence of the transformation is a veteran-centric system with integration of VA and community providers.
- Operations: VHA will need to develop expertise in managing the clinical and administrative components of community care, using some of Medicare's and others' "best practices" as the model. To be successful, implementation will need impeccable business processes, using outside expertise and modeled after the best in the commercial world.
- Two VHA offices should be established - one office to manage community care (including the related transition, administrative and payer issues); and the other office to focus on the internally provided VA clinical care, especially to develop national policy to be implemented at the local level. Expertise in both areas will be essential for a successful transformation.
- Within an established timeline, enrolled veterans will be given the choice between VA and community providers.
  - Choosing community providers will be the decision of the veteran, and the process for doing so will be simple (such as it is for Medicare beneficiaries to choose a Medicare provider.)
  - The community providers will be those providers who accept Medicare.
  - The entire scope of VA and Medicare providers becomes the network of providers from which veterans can choose.
- To assure an adequate provider-base, providers will be incentivized to see enrolled VA patients:
  - Reimbursement will be the Medicare rate-plus (about 5-10%)

- Provider enrollment will be essentially Medicare enrollment.
- Billing and payment systems will be efficient – at least as efficient as Medicare.
- IT systems will be developed such that:
  - Continuing of care will be assured with the communication of health information among VA and community providers, as well as the patient
  - A coordinated IT infrastructure will be developed for coding, billing, payment and the other business processes.
- As the transition to community care continues, VA facilities that are under-utilized will be dispensed with. No new facility construction or major renovations will occur. A BRAC-like process will begin to close the other facilities. Over time, the VA will become primarily a payor, though it will continue to pay for the veteran care provided by the community system.
- Establishment of a Board (with staff) that has the authority to “decide and direct” the transformation. This Board will be independent of the legacy VA structure.

## **APPENDIX A. Veterans Health Administration**

The Veterans Health Administration is the United States' largest integrated health care system consisting of 150 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers and domiciliaries. The U.S. is divided into 21 Veterans Integrated Service Networks, or VISNs — regional systems of care to better meet local health care needs.

**VHA Medical Centers:** Provide a wide range of services including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology and physical therapy. In addition, most of the medical centers offer additional medical and surgical specialty services including audiology & speech pathology, dermatology, dental, geriatrics, neurology, oncology, podiatry, prosthetics, urology, and vision care. Some medical centers also offer advanced services such as organ transplants and plastic surgery.

**Community-Based Outpatient Clinics:** To make access to health care easier, VHA utilizes more than 800 Community-Based Outpatient Clinics (CBOC) across the country. These clinics provide the most common outpatient services, including health and wellness visits. About one fourth of these are contracted clinics.

**Community Living Centers:** Community Living Centers (CLC) are skilled nursing facilities, often referred to as nursing homes. Veterans with chronic stable conditions such as dementia, those requiring rehabilitation or those who need comfort and care at the end of life are served within one of the 135 Community Living Centers.

**Domiciliaries:** Forty-eight VHA Domiciliaries provide a variety of care to Veterans who suffer from a wide range of medical, psychiatric, vocational, educational, or social problems and illnesses in a safe, secure homelike environment.

**Vet Centers:** Vet Centers provide readjustment counseling and outreach services to all Veterans who served in any combat zone. Services are also available for family members dealing with military related issues. VHA operates 278 community based Vet Centers in all fifty states, the District of Columbia, Guam, Puerto Rico, and the US Virgin Islands.

**VA's Health Services Research and Development Service (HSR&D):** Funds nineteen Centers of Innovation (COINs). The COINs will build on the successes of HSR&D's earlier Centers of Excellence (COEs) and Research Enhancement Award (REAP) programs. The COIN program rewards research innovations and partnerships to ensure that research has the greatest possible impact on VHA policies, healthcare practices, and health outcomes for Veterans. A unique feature of the COINs is that they include one or more focused areas of research that addresses questions of significance to VHA clinical and operational partners, and these partners will be engaged in the research activities of the COINs.

**Centers for Excellence:** These four centers oversee, innovate, and enhance the quality of care, improving health for Veterans across the entire nation.

Epilepsy Center of Excellence (ECoE): 16 sites that are linked to form 4 regional centers. The ECoE seek to provide the best possible epilepsy care to Veterans throughout the United States with state-of-the-art diagnostic and therapeutic services. The goal is to deliver the highest quality of ongoing medical care to Veterans suffering from epilepsy; and to promote outreach and educational efforts for both patients and their physicians, and to further the understanding of this chronic condition.

Multiple-Sclerosis (MS) Center for Excellence: Is dedicated to further the understanding of the disease, its impact on Veterans, and effective treatments to help manage MS symptoms. By partnering with Veterans, caregivers, and health care providers the goal is to minimize disease impairment and increase the quality of life for Veterans with MS. Its mission is to improve the healthcare for Veterans with Multiple Sclerosis (MS.), improve coordination between VA medical centers by developing an informal network within the VA and provide resources to VA providers through a collaborative approach to clinical care, education, research, and informatics.

Parkinsons Disease Research, Education and Clinical Center (PADRECC) Network: This network supports six PD Centers of Excellence located in Portland/Seattle, San Francisco, Los Angeles, Houston, Richmond, and Philadelphia. Each PADRECC is designed to deliver state-of-the art clinical care, innovative research, and outreach and education programs to its surrounding region, also referred to as their "service area".

War Related Illnesses and Injury Support Center (WRIISC): Is dedicated to Veterans' post-deployment health concerns and unique health care needs. Post-deployment health expertise is developed and provided to Veterans and their health care providers through clinical care, research, education, and risk communication. As a tertiary care center, partnering with referring providers and their healthcare teams supports the post-deployment care of Veterans.

The VHA also supports three additional congressionally mandated missions - education, research and service in National emergencies.

(Source: VHA website.)

## **APPENDIX B. Primary Care and Mental Health; and other Innovative Initiatives**

Concerns about primary care and mental health care in the community have been identified. More specifically:

- Availability and accessibility of primary care in the community
  - Especially an integrated approach with mental health services with primary care
- Availability and accessibility of mental health care in the community, for example
  - Inpatient
  - Outpatient
  - Substance abuse (including alcohol, illegal drugs, and prescription drugs)
  - Co-occurring disorders (substance abuse and psychiatric disorders; mental health and physical health)
  - Ability to care for certain disorders common in the VA population such as PTS and TBI
- Availability and accessibility in the community to care for a diverse patient population with cultural competence
- How to maintain the current non-profit programs that are specific to veterans such as many of the homeless initiatives
- Recognition of the need for active case management for those with the most severe afflictions
- Need for integration of medical services with housing and other VA benefits for a select group of veterans
- Overall role of case management

Innovative approaches may be needed to incentivize local providers to meet the primary care and mental health needs of Veterans - beyond fee for service purchasing at Medicare-plus rates from community providers. For example,

- Use of some research funds (perhaps to the Universities) to develop evidence based practices for the enrolled veteran population to meet some of the above gaps related to mental health and primary care integration; this could be done by the VA or through inter-agency agreements with the National Institutes of Health
- Develop demonstration programs to apply the evidence based practices to the "real world"; this could be administered by the VA or through an inter-agency agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA) with the funds to go to community providers that render services to enrolled veterans

- Other incentives for community providers - such as paying for a mental health provider in a community clinic that has a high volume of veteran patients
  - Expanded utilization of Community Mental Health Centers - provide incentives for them to improve their cultural competence as related to veterans; for them to develop specific programs, such as for PTS, where veteran patient demand is adequate
  - Identify community based providers and incentivize them - homeless shelters, "free" clinics, etc. that see veterans and develop innovative ways to support them to further veteran services
  - Determine what the in-patient psychiatry and substance abuse treatment needs are, and how they may be met (VA, community, VA to pay to expand community services, etc.)
  - Effective strategies to address prescription drug abuse
  - Ways to work with DoD on shared research areas - TBI, PTS, trauma, etc.
  - Develop a better understanding of the programs for the blind, and formulate a strategy for the care of this patient population
- Chaplaincy and Faith Community - is there a role for it?

Further, it may be useful to establish an "office" in VHA Headquarters to be focused on development of innovative delivery systems in the community. The appropriate office may be an existing one, or a new one. It may be part of the "Transformation Staff". This office should probably also include the existing community programs that are related - homeless programs, etc. so that new programs can be built on existing successes. With the transformation, it is critical that effective VA-funded community programs continue without interruption.

An alternative to this office being "in house" is that these functions could be assigned to other federal agencies, with the corresponding transfer of funding - Health Resources Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHA), etc.

Whatever direction the transformation takes, it won't be seamless. However, there are few "alerts" that seem to warrant further thought and discussion.

These are just a few possibilities - there are many more. The message is that creativity and innovation are needed to develop effective funding streams and payment mechanisms to facilitate the increase in community care, and to assure the transition doesn't result in overall less service.

The specific example here relates to primary care and mental health. However, a similar approach may be needed in other areas as well.

## APPENDIX C. Governance Board

	<b>Governance Board</b>
<b>Charge</b>	<p>The Board is responsible for the overall governance of the VHA – much like a fiduciary board is responsible for a corporation. The Board has the authority to “decide and direct.” The Board’s focus should be the long term perspective, recognizing that “day to day” operations determine the long term outcome. Thus, the Board has the authority to “decide and direct” critical tactical decisions, or can delegate them within VA. The Board will be involved in development of the long term strategy, and will approve that strategy.</p> <p>The Federal Advisory Committee Act (5 U.S.C. App.) will not apply to the Board or to any advisory committee established or utilized by the Board.</p>
<b>Membership/ Appointment</b>	<p>The Board will have eleven voting members. The President, Speaker of the House of Representative, Minority Leader of the House of Representatives, Majority Leader of the Senate, and Minority Leader of the Senate will each directly appoint two members. In addition, the SECVA (or acting SeCVA) will serve on the Board during the duration of his/her term as SECVA. This structure is modeled after the Commission on Care.</p> <p>The appointments of members of the Board shall be made not later than 180 days after the date of enactment of this Act; the first meeting of the Board shall be within 180 days of enactment of this Act.</p>
<b>Member Terms</b>	<p>Members will be appointed for seven-year terms. The initial appointees will have staggered terms. One appointee from each of the above will be appointed for a four-year term and the other appointee for a seven-year term. Appointments to fill any interim terms will be for the duration of the term being filled.</p> <p>The Board elects its own Chairman and Vice-Chairman for three year terms from among its membership.</p> <p>Board members must be senior recognized leaders and experts in their fields. Each member of the Board who is not an officer or employee of the Federal Government shall be compensated. To recruit these, compensation similar to private sector boards will be necessary. Members of the Board may serve full-or-part time; the time commitment of the Chairperson will be significant.</p>
<b>Member Expertise</b>	<p>Members should be selected for their technical and professional expertise, and leadership skills. Ideally, each of those appointing, will appoint at least one veteran. Appointees shall have expertise in one or more of the following - experience as senior management for a private integrated health care system with an annual gross revenue of</p>

	<p>more than \$1 billion; familiarity with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B)); familiarity with the Veterans Health Administration, but except for the SECVA, shall not be employed by the Veterans Health Administration; familiarity with medical facility construction and leasing and/or the government contracting processes; knowledge of finance, especially as related to private health care and/or federal budgeting. Efforts should be made to appoint Board members, who collectively, have broad technical and professional expertise.</p>
<b>Board Staff and Operations</b>	<p>The Chair will determine the number of permanent staff needed, and will have the authority to adjust the number of permanent staff accordingly.</p> <p>The chief of staff, will have oversight of the board and the transformation activities, and will report to the Chairperson of the Board.</p> <p>The executive director, will have primary responsibility for Board operations including government relations. The executive director will report to the Chairperson of the Board.</p> <p>The transformation director, with primary responsibility for implementation of the transformation, including coordination with the SECVA and his/her staff. The transformation director will report to the Chairperson of the Board through the Undersecretary for Health.</p> <p>When any of these senior positions are vacant, the Chairperson of the Board will fill the position, in consultation with the other board members.</p> <p>The Chairperson of the board may fix the compensation of the chief of staff, executive director, transformation director, and other senior personnel as she/he determines necessary. These persons, at the discretion of the Chair, can be compensated at rates equivalent to senior leadership positions in the private sector.</p>
<b>Powers</b>	The Board will report to the President and Congress.
	The Board will “decide and direct” the transformation process, as described in the enabling legislation.
	The Board, working with the Department, will establish priorities, milestones, and timelines for the transition; and will use “decide and direct” authority when necessary.

	The Board will review and approve the budget request to the Department; the budget request to the Department will reflect the Board's priorities, milestones and timelines for the transition. The Board may release an independent assessment/comment on the President's request.
	The Board will review and approve any acquisitions, including specific ID/IQ work orders, over \$20,000,000. The Board will have the authority to decide whether related work orders and other acquisition elements under this amount should be "bundled" for review and approval (such as 10 CBOC contracts for \$5,000,000 each.)
	The Board will review and approve VHA major operational and organizational plans; these may include, but are not limited to, modernizing technology, training, outsourcing, reorganization, facility alignment. It is expected these plans will reflect the Boards priorities, milestones, and timelines; and will use "decide and direct" authority when necessary.
	The Board will review and approve budget requests for veteran-specific activities in other Federal Departments (such as the homeless programs in the Department of Housing and Urban Development; the substance abuse and mental health programs in the Department of Health and Human Services, etc.) to assure coordination across the federal government.
	The Board will review annual financial audits.
	The Board will review and approve: strategic and business plans; goals and measures (metrics); relative to the priorities, milestones and timelines. These will reflect the Board's priorities, milestones and timelines.
	The Board may secure directly from any Federal agency (including but not limited to VA and VHA) such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.
	Authority in legislation to receive employee reports of concerns on quality, safety, and ethics. Have access (without individual patient or employee identifiers if required by other statutes) to information reported to the department "ombudsman" and through the fraud and other "hotline" phone numbers. Authority to assign and track follow-up responsibility and reporting on these to appropriate VHA offices and to receive periodic updates on follow-up, or as requested.
	Provide an annual report for the first five years, and bi-annually thereafter, to the President and Congress on the transformation.

## APPENDIX D: Eligibility

### Simplifying Eligibility

Currently, veteran eligibility for health care is complex, and includes eight priority groups. This system has often been confusing for veterans, VHA providers, and community providers. The Commission anticipates that, over time, this approach will be simplified. However, this is beyond the current scope.

### "Less than Honorable" Discharge (NOTE: Footnotes to be inserted later)

One group of veterans who deserve immediate attention – the veterans with "less than honorable discharge."

Background: "Access to care" is at the core of the charge Congress set for this Commission.

Veterans – even those with service-incurred health problems – face a range of barriers to care, from geographic barriers to facility-specific problems such as long wait times for an appointment or lack of evening or weekend hours. These problems can be overcome. But some former service members have encountered a more fundamental barrier when applying for care. They've learned that, because of the character of their discharge they aren't considered veterans, and thus aren't eligible for VA care.

Who is a Veteran?: Veteran status is the basis for eligibility for all VA benefits, and, under law, a veteran is a person who has met three criteria: active duty military service; (subject to specified exceptions) two years of continuous service; and discharge or separation from the military under conditions other than dishonorable. (The military characterization of discharge falls into one of five categories: honorable, general (under honorable conditions), other than honorable (OTH), bad-conduct (adjudicated by a general court or special court martial), and dishonorable.) Conditions that create a legal bar to VA benefits: Congress has established specific bars to VA benefits. (Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.) In addition to those statutory bars, VA has promulgated regulations that interpret the phrase "discharged or released...under conditions other than dishonorable" (in the definition of the term "veteran"). Under those regulations, benefits may be barred to service members who receive an OTH discharge as a result of any of the following conditions: (1) acceptance of an OTH discharge to escape trial by general court martial; (2) mutiny or spying; (3) an offense involving moral turpitude; (4) willful and persistent misconduct; and (5) certain homosexual acts involving aggravating circumstances.

Limited exceptions to those statutory and regulatory bars permit the awarding of benefits: a claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to the discharge. And benefits may be granted based on a prior period of other than dishonorable service for individuals with two or more periods of service.

Importantly, a former service member with an other than honorable discharge as a result of a regulatory bar is eligible for VA care for a service-incurred condition, but only if that discharge was due to a regulatory (rather than a statutory) bars-to-benefits.

The Problem: Former service members with "other than honorable" discharges are not recognized as veterans unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. When an individual with "other than honorable" (OTH) discharge seeks medical care, that OTH status signals that the individual is not a veteran. He or she is, accordingly, routinely denied treatment. Nothing in that encounter by itself triggers an adjudication that might result in a determination that the discharge is not dishonorable. Yet in many instances, the character of that individual's discharge was NOT dishonorable; instead, behaviors that led to the individual's discharge have resulted from, or are linked to, behavioral health conditions that had their origin in service. However, VA regulations are a bar to their receiving earned benefits.

#### Findings:

Veterans' benefits are understood to be earned, and the idea underlying the concept that "bad paper" should bar one from those benefits has been expressed as follows:

"...in harsh environments where lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise remove eligibility for the special military benefits and entitlements reserved for honorable and meritorious service...The thesis is...honoring those who loyally served by preserving the distinction from those who did not."

Another view, however, says that one must take account of the offender's mental state at the time of the misconduct. Many have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline. VA regulations not only fail to take account of the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service.

To illustrate, commentators have identified two of the regulatory bars as particularly problematic: those based on "moral turpitude," and "willful and persistent misconduct." Neither of those two regulatory terms, which originated in 1944 is defined; neither provides criteria or examples of what is or is not covered. Both are ambiguous and susceptible of subjective judgment, with great potential for different VA regional offices reaching different outcomes on the same facts. VA officials have acknowledged that these terms are broad and imprecise, and advocates have documented the resultant disparities in VA adjudicative decisions.

The only specific mental-health exception to the bar-to-benefits rules – that the person was insane at the time of the commission of offense -- is very limited. VA regulations define the term "insane," as follows:

An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the

accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.

The VA's Office of General Counsel in a (now almost twenty-year old) precedential opinion has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters of the types of behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that "[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing" or, in a more general sense, as a mental disorder in which "mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life."

"Insanity," as understood at the time by the VA Office of General Counsel, and as reflected in practice, is – with its emphasis on "gross" impairment – a very severe, limiting standard. That narrow standard is also limiting with respect to the range of symptomatology that could be considered under the "insanity" exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range of symptomatology effectively excludes behaviors associated with a widely prevalent service-related condition, post-traumatic stress. Those behaviors include aggressive behavior, substance-use, impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior). These behaviors that often lead to disciplinary actions. Indeed, research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes. Yet other than its "insanity" rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, the disciplinary issues leading to an individual's discharge.

Advocacy has highlighted how these regulations have worked in practice, citing illustrative examples (names have been changed for confidentiality reasons):

Tom: Marine with multiple deployments to Iraq and Afghanistan; seven years of service. Received OTH discharge after self-medicating with marijuana. Denied VA treatment for PTSD.

Dick: Marine rifleman with two purple hearts and four campaign ribbons for service in Vietnam. He was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. Denied service connection for PTSD because of his discharge.

Harry: Combat infantryman in first Gulf War. On his return, he started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family, but left anyway. After 60 day absence he returned and was given an OTH discharge. He was denied services for 20 years.

In short, the VA regulation that governs determinations as to whether the character of a veteran's other-than-honorable discharge is disqualifying does not take account of the behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

The implications of this barrier to treatment are alarming. Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse, depression, homelessness, premature mortality, and suicide. And commentators have noted that access to VA health care is vital to the successful reintegration of combat-traumatized veterans because it provides "the only reservoir of combat PTSD expertise."

#### "By Exception" - Patients from the Community

In a few selected situations, it may be advantageous to allow community patients access to VA care. For example, some of the specialized services offered at some VHA facilities are "state of the art" and are not replicated in the community. Some programs may have capacity in excess of that utilized by the enrolled veterans. In these rare situations, a simple process should be developed so that a very limited number of community patients, not otherwise eligible for VHA care, can receive these services. Since these situations would involve very few patients on an isolated basis, one approach would be to give the medical center director authority to approve this care on an individual patient basis, and to determine the reimbursement (likely based on Medicare rates when available), and then to proceed. The facility should be allowed to accept (and retain) third party payment for these services. Basic data on these patients would be reported to VHA headquarters, and national data maintained on the number of community patients, services provided, cost reimbursed, etc.

## APPENDIX E. Facility Prioritization

VHA officials and others have repeatedly said there are various facilities which should be closed. Progress on this should begin immediately, and these facilities should be the first to transition.

Over time, as more facilities become obsolete, as veterans migrate to other parts of the country, and as veterans utilize more community care, it is anticipated that additional facilities will not be needed. A comprehensive transition plan is needed. The plan should include both the overall national transition, as well as a template for transition of individual facilities and their catchment areas.

The transition should not be abrupt, but at the same time must move forward. Facilities would be prioritized. Based on the Independent Assessment and presentations to the Commission, it seems there are a number of facilities that are ready for immediate transition. A possible general timeline would be to close five medical centers in the first three years, and from these experiences, further refine the transition template. Then, in every 2-year cycle, transition an additional 10 to 15 medical centers, and additional out-patient facilities. The entire transition process will take several years for each facility. The long term objective is the overall transition to community care.

All facilities should be prioritized, based on various criteria such as stability and competence of leadership, condition of infrastructure, utilization rates, quality ranking, clinical strengths and gaps, operational effectiveness, veteran satisfaction (one measure being the VA patient satisfaction surveys), and available community resources. From this prioritized ranking, a transition plan should be developed.

A decision process to formally decide to close a facility will have to be developed. Congress could give the closure authority to a new "commission" managing the transition, in consultation with the Secretary. Alternatively, the process could be modeled after the Department of Defense closure of military bases which gives Congress more authority in the decision process. It is critical that the process begin immediately, and can proceed without obstacle. The Commission repeatedly heard that facilities need to be closed; this transition process needs to begin.

## APPENDIX F. Cost Concerns

Some have assumed that VA-based care costs less than the equivalent amount of care delivered in the private sector. However, a December 2014 report from the Congressional Budget Office found that

“limited evidence and substantial uncertainty make it difficult to reach firm conclusions about those relative costs or about whether it would be cheaper to expand veterans’ access to health care in the future through VHA facilities or the private sector.”

The VA, according to the CBO, “has provided limited data to the Congress and the public about its costs and operational performance,” making direct comparisons to the private sector difficult. In addition, as noted above, even veterans who do use the VA system receive an average of 70 percent of their health care outside of the VA. In 2008, according to CBO, the total was 77 percent. Furthermore, lower per-enrollee costs are only meaningful if the quality of care is equivalent or better.

Determining the costs of VHA-provided health care is challenging – perhaps more accurately described as “impossible”. The Independent Assessment and those who presented to the Commission were in agreement that the VHA lacks clinical and financial systems to calculate the costs of care in parameters that would permit comparison with community practice.

However, several general data points were available. These were used these to calculate, to a “rough order of magnitude,” the cost of VHA health care. There are numerous variables, so it should be recognized this is a very general approximation, with the corresponding level of precision.

The VHA budget in 2015 was approximately \$65 billion.

In 2015 VHA treated approximately 6.5 million different patients.

The “average” patient received about 30% of their care from VHA; 70% of their care was paid for by non-VHA sources.

Therefore, the “average” cost of care for “one full patient of care” was approximately \$30,000.

It should be recognized the VHA benefit includes many services not offered by private health insurance, Medicare, Medicaid, and other payers, so any type of direct comparison is not appropriate.

**MORE ON COSTS CAN BE INCLUDED FROM THE SCENERIOS BEING RUN**

