



Choice Consolidation: Assessing VA's Plan to Improve Care in the Community

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STATEMENT OF
THE INDEPENDENT BUDGET

FOR THE RECORD

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Choice Consolidation: Assessing VA's Plan to Improve Care in the Community

WASHINGTON, D.C.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the three co-authors of The Independent Budget, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and the Veterans of Foreign Wars (VFW), thank you for the opportunity to offer our thoughts regarding the new choice plan released by the Department of Veterans Affairs (VA), as required by Public Law 114-41.

The plan put forward by VA to restructure and integrate VA and non-VA health care programs into high-performing networks for veterans is an important step in the right direction to provide veterans with high-quality, comprehensive, accessible and veteran-centric health care now and in the future.

After months of working closely with VA officials and other stakeholders, we are pleased

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that many of our key recommendations were incorporated into this plan, such as ensuring veterans have access to a nationwide system of urgent care. We are also pleased that VA's plan is closely aligned with the IB's veterans' health care reform framework, which is appended at the end of this statement.

The IB supports VA's concept of developing high-performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community whenever necessary, resulting in new options for veterans to receive care closer to home. The VA plan also starts to move beyond arbitrary federal standards regulating when and where individual veterans can access medical care, keeping those clinical decisions between a veteran and his or her doctor, without bureaucrats, regulations or legislation getting in the way.

However, the plan makes two particular recommendations *The Independent Budget* co-authors do not support. While we support the plan to expand emergency treatment and urgent care in the community, the proposal calls for a \$100 co-payment for emergency care and \$50 for urgent care. These co-payments are meant to serve as a perverse disincentive for veterans to utilize these critical services. Moreover, this proposal seemingly makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments, including Priority Group 4 catastrophically disabled non-service connected veterans. We cannot support a proposal that would charge veterans for service-connected care regardless of the location where that care is provided.

VA has also submitted a proposal to amend title 38, United States Code, by requiring veterans to report information on other health insurance. We support the intent of this proposal, but we oppose the enforcement mechanism used to ensure veterans report their health insurance information. We are concerned that efforts to collect other health insurance information could result in veterans being denied non-emergency care.

Veterans are currently required to inform VA when their insurance information has changed and VA typically asks veterans about any changes to their insurance coverage when they present to a VA medical facility. To preclude veterans from receiving VA health care because they may not have known their insurance status changed or because they did not disclose this information would only harm the veterans VA was created to serve.

The IB's veterans' health care reform framework builds on VA's progress by addressing barriers that were outside of the VA plan's limited scope. The IB co-authors have leveraged historical expertise, extensive conversations with veterans around the country and survey data to develop a veterans' health care reform framework centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system. The IB's four-pronged framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that is best for veterans.

Restructure the Veterans Health Care Delivery System

Our framework would optimize the strengths and capabilities of VA and combine them with other public and private health care providers by establishing local Veterans-Centered Integrated Health Care Networks. VA would be responsible for organizing the networks, coordinating care, and in most cases, would remain the principal provider of care for veterans.

Similar to VA's consolidation plan, the IB framework would consider network providers an extension of VA care, which would enable veterans to work with their health care providers to determine the best way to receive care. For rural and remote veterans who live outside network catchment areas, the IB framework would establish a Veterans Managed Community Care program that would ensure all veterans have an option to receive veteran-centric and coordinated care wherever they live.

Redesign the Systems and Procedures that Facilitate Access to Health Care

We recommend that VA move away from single, arbitrary federally regulated access standards. Under the IB's framework access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

We also recommend establishing a nationwide system of urgent care at existing VA clinics and affording veterans the opportunity to receive urgent care from smaller urgent care clinics around the country to alleviate much of the pressure on outpatient clinics.

Realign the Provision and Allocation of VA's Resources to Reflect its Mission

The IB calls for significant change to VA's Strategic Capital Investment Planning (SCIP) process by including public-private partnership options and blending existing replacement options to better leverage federal and local resources. VA must be required to engage community leaders to develop broader sharing agreements so it could plan infrastructure in a way that allows communities to share resources, so VA can invest in services the community lacks. Further, there should be a dedicated appropriations fund so VA is only

developing plans for projects it knows will be funded.

Our framework also calls for reforming the congressional appropriations process to ensure VA has the resources it needs and the flexibility to allocate them to provide the health care and services veterans demand, instead of limiting the amount of care VA is able to provide.

We also call for the establishment of a Quadrennial Veterans Review process, similar to the Quadrennial Defense Review, to align VA's strategic mission with its budgets and operational plans, and help provide continuity of planning across all administrations.

Reform VA's Culture with Workforce Innovations and Real Accountability

The IB framework would establish a biennial independent audit of VA's budgetary accounts to identify accounts and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations.

In addition, we call for strengthening the VA's Veterans Experience Office by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code, a veteran's right to seek redress through clinical appeals, claims under title 38 USC §1151 and the Federal Tort Claims Act, and the right to free representation by accredited veteran service organizations are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, including both private and public health care entities.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2015

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** — Grant to support rehabilitation sports activities — \$425,000.

Fiscal Year 2014

No federal grants or contracts received.

Fiscal Year 2013

National Council on Disability — Contract for Services — \$35,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

DAV and the VFW have not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

A Framework for Veterans Health Care Reform

In April 2014, whistleblowers from around the country brought to light instances of fraud and manipulation within the Department of Veterans Affairs (VA) that have since led to changes in executive leadership and a wide array of proposals to overhaul the VA health care system. To *The Independent Budget* (IB), the fact that veterans were waiting too long for the care they have earned and deserve was no surprise.

The IB co-authors—Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—have been ringing the alarm on VA health care access problems for more than a decade. In 2002, the IB included an article on waiting times for outpatient appointments, in which the IB veterans service organizations (IBVSOs) urged the Veterans Health Administration (VHA) to “identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide.”

The transformative effort underway at VA, known as MyVA, and recent actions taken by congressional leaders, such as enactment of P.L. 113-146, the “Veterans Access, Choice, and Accountability Act of 2014,” have made progress in addressing the access issues that have plagued VA. While such progress is commendable, access remains the principle problem

facing the VA health care system, and this problem will continue to negatively impact the health care veterans receive until the VA health care system is significantly reformed. Organizations, politicians, members of Congress, VA officials and other stakeholders are advocating for specific reforms. What has been missing from these discussions is a plan that truly represents what veterans want, expect, and need their health care system to be and a comprehensive set of reforms to accomplish that vision.

In order to develop a framework that puts veterans' needs and preferences first and understand the extent of the health care access problem from a veterans' perspective, the IBVSOs have sought direct feedback from our members and the veterans' community as a whole. Their responses have validated what we have long known:

- Veterans prefer to receive their care from VA.
- They turn to VA because they like the quality of care they receive.
- They believe VA health care is an earned benefit and VA is best suited to provide veteran-specific health care.

When asked how they would improve the VA health care system, veterans suggest that VA hire more doctors and extend clinic hours to expand internal capacity, improve customer service, and expand overall access by providing convenient health care options in their local communities.

The IBVSOs have leveraged historical expertise, extensive conversations with veterans around the country and survey data to develop a veterans' health care reform framework centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system. The IB's framework includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high-quality and veteran-centered health care system. The framework would provide high-quality health care closer to home by seamlessly combining the capabilities of the VA health care system with public and private health care providers in the community when and where necessary.

In order to accomplish our long-term vision, veterans' health care reform must address four fundamental ideas:

- Restructure the Veterans Health Care Delivery System
- Redesign the Systems and Procedures that Facilitate Access to Health Care
- Realign the Provision and Allocation of VA's Resources to Reflect the Mission

- Reform VA's Culture with Workforce Innovations and Real Accountability

We hope that Congress, VA, veterans, and other key stakeholders will consider these ideas as the ongoing efforts to reform veterans health care move forward.

Restructure the Veterans Health Care Delivery System

In the 1990s, under the leadership of Dr. Kenneth W. Kizer, the VA health care system underwent a dramatic transformation from a hospital-based system to an integrated ambulatory care system. While the shift to a holistic approach of providing a full continuum of care has made VA one of the premier health care providers in the world, it has largely ignored one of Dr. Kizer's objectives: "Seek opportunities for sharing activities with private sector entities when doing so would be cost effective and improve service to VA patients." In its plan to consolidate community care programs and authorities entitled "*Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*," (mandated by P.L. 114-41, the "Surface Transportation and Veterans Health Care Choice Improvement Act") VA reports having existing agreements or contracts with more than 200 federal health care facilities, 700 academic teaching affiliates, 700 federally-qualified health centers, and 76,000 locally contracted providers. Such contracts and agreements are generally used as safety valves to augment health care veterans receive from VA medical facilities, rather than integrating them into the the health care delivery model.

Traditionally, the relationship between VA and non-academically affiliated private sector providers has been unnecessarily adversarial. Many VA medical center directors have wanted their facilities to be everything for every veteran and have viewed the use of private sector providers as a threat to their ability to provide high-quality care to the veterans they serve. In addition, the overall inadequate levels of funding provided to meet veterans needs resulted in a tension between fully funding direct services and fully funding non-VA care needs. As a result, VA medical facilities rarely benefited from leveraging the capacity of private sector medicine to improve its health care delivery model. Far too often, community care was uncoordinated, failed to guarantee sufficient access or quality, and was highly susceptible to improper billing of veteran patients and improper payments by VA. Additionally, with inadequate funding levels for medical services, as the IBVSOs have pointed out regularly, VA has been unable to expand capacity fast enough to keep up with demand for services, continues to rely upon outdated software and processes, and has suffered from inconsistent administration of community care throughout the system. As a result, veterans who have faced barriers accessing VA care are forced to wait longer for community care, placed on waiting lists when they should be given the opportunity to receive community care, or forced to forgo needed health care altogether.

With the implementation of coordinated community care programs like Project Healthcare Effectiveness through Resource Optimization (HERO), Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program supported by reform efforts like Secretary McDonald's MyVA initiative, VA has made significant improvements to the way it purchases health care. Through this work, VA has expanded partnerships with private sector providers, identified and addressed a number of the issues highlighted above, and dramatically increased the use of community care. However, VA's consolidated plan acknowledged that VA's community care programs continue to lack system wide consistency and integration with the larger VA health care system.

Several ideas for reforming the way VA purchases care have gained national attention in the past year. Many of them fail to put veterans' needs and preferences first and some do not properly account for second or third order effects that would lead to unintended consequences for the health and wellbeing of our Nation's veterans. For example, proposals that would require VA to compete with private sector providers for veterans' health care dollars perpetuates the adversarial relationship between VA health care and community providers. Rather than force veterans to choose between an overburdened and underfunded system (VA) and one that does not guarantee access and lacks the required specialized care services and cultural competencies uniquely defined by veterans' needs (private sector), veterans deserve a system that integrates the two so that VA's veterans' health care expertise can be complimented with the convenience of private sector providers.

The IBVSOs acknowledge that an exclusively federal solution is not feasible due to the changing nature of the veterans' population. Moreover, simply making VA a payer of veterans' health care erodes the benefits of VA's patient centered medical home model. That is why the IB's framework takes a logic-based approach that optimizes the strengths and capabilities of VA and combines them with other public and private health care providers. Simply put, we recommend establishing local Veterans-Centered Integrated Health Care Networks. These networks would leverage the capabilities and strengths of existing local health care resources, to include VA, other public health care systems and private providers, to meet the needs of veterans in each uniquely different health care market. This includes increasing capacity to deliver urgent care at existing VA medical facilities and developing new capacity through private sector urgent care clinics around the country to create new options between emergency care and primary care.

VA must be responsible for organizing these integrated health care networks, coordinating care, and in most cases, it would remain the principal provider of care for veterans. Similar to VA's proposed consolidation plan, the IB framework would consider network providers an extension of VA care, which would enable veterans to work with their health care providers to determine the best way to receive care. For rural and remote veterans who live outside network catchment areas, the IB framework recommends creation of a Veterans

Managed Community Care program that would ensure all veterans have an option to receive veteran-centric and coordinated care when they need it and where it is most appropriate

Redesign the Systems and Procedures that Facilitate Access to Health Care

Over the years, the VA health care system has relied on a number of methods and standards to measure access and timeliness of health care delivery. Prior to the scandal that enveloped the VA health care system in the spring of 2014, the Department's wait-time goal was 14 days from a veteran's preferred date for existing patients or 14 days from the date an appointment request was created for new patients. After the health care access crisis exposed that the 14-day goal was unattainable, VA reevaluated its standard and moved to 30 days from a veteran's preferred date. Less than a year later, VA changed its wait-time standard again to facilitate the implementation of the Veterans Choice Program. In an attempt to align its standards with industry best practices, VA elected to base its wait-time goal on clinical need first and rely on a veteran's preference when a clinically indicated date was not identified.

VA has also relied upon a number of geographic-based access standards over the years to determine accessibility. Through the Strategic Capital Investment Planning (SCIP) process, dating back to its fiscal year 2008 budget request, VA has used a 60 minute drive-time distance for veterans who live in urban areas and 90 minutes for veterans who live in rural areas as a standard for specialty care. In 2013, VA's long range SCIP process began to include a corporate target of 70 percent of veterans having access to VA primary care within a 30 minute drive-time in urban areas and 60 minutes in rural areas.

Additional geographic based standards have accompanied statutory programs, to include 40 miles from a primary care provider (as well as 30 days) for the Veterans Choice Program, or 60 minute drive-time from primary care, 120 minutes from acute care, and 240 minutes from tertiary care under Project ARCH. VA has also established geographic based network standards for contracted programs. Under Project HERO, VA required Humana to provide access to required services within 50 miles of a veteran's home. Under PC3, HealthNet and TriWest are required to provide health care options within a 60 minute drive for veterans who live in urban areas, 120 minutes for veterans who live in rural areas, and 240 minutes for veterans who live in highly rural areas, when seeking general care. For veterans who need a higher level of care, the PC3 network must provide them options within 120 minutes for urban areas, 240 minutes for rural areas, and an acceptable community standard for highly rural veterans.

The independent assessment on access standards conducted by the Institute of Medicine (IOM) determined that industry benchmarks for health care access vary widely throughout the private sector. IOM was unable to find national standards for access and wait-times

similar to the Veterans Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days-based calculations, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. The IBVSOs strongly agree with IOM's recommendation that "decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families."

The IBVSOs have reported for years that VA's access standards are not aligned with veterans' perceptions. Moreover, the IB firmly believes that federally-regulated, arbitrary access standards, such as living 40 miles from a VA clinic or waiting up to 30 days for an appointment, should not inhibit a veteran's access to care. That is why the IBVSOs propose to move away from federally-regulated access standards. Under the IB's framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

Realign the Provision and Allocation of VA's Resources to Reflect its Mission

Since it was not required by P.L. 114-41, the VA did not address the issue of capital infrastructure in its plan to consolidate its community care programs. However, without proper planning of its current infrastructure responsibilities and needs, VA will face significant challenges in order to effectively deliver quality, timely health care to our veterans.

For more than 100 years, the government's solution to providing facilities to provide health care for our military veterans has been to build, manage and maintain a network of veterans' hospitals themselves. While building these facilities was a necessity, maintaining them and replacing them has saddled the Department with a \$60 billion bill that will need to be paid over the next 10 years in order to properly address the existing access, utilization, and condition and safety gaps to provide veterans with access to the care they have earned and need in safe and timely manner. Moving forward, VA will need to streamline its procurement and project delivery processes, leverage community resources, realign its footprint to provide appropriately-sized facilities in more locations, and provide dedicated construction appropriations to efficiently deliver a full continuum of care as close to home as possible.

Currently, VA takes too long and makes too many changes to construction plans leading up to and during the building phase. We only have to examine the problems experienced in the construction of the new VA medical center in Aurora (Denver), Colorado, to affirm this

point. Changes proposed to reform construction management through the inclusion of the Army Corps of Engineers are a necessary reform that must be monitored and assessed going forward.

In addition, VA's infrastructure problems will never be met if they do not find a better way to estimate and request resources through the budget development and appropriations process. Currently, VA's budget requests for construction are unrelated to the actual cost of maintaining their capital infrastructure, as evidenced by the funding gap between SCIP projections and budget requests, a fact verified by the Independent Assessment. In order to resolve this structural problem, VA must base its resource requests for infrastructure on demand capacity assessments and through the development of an actuarial estimate and schedule for maintaining that infrastructure. VA should be required to publicly update and report these actuarial estimates each year concurrent with the budget submission so that the real need for infrastructure resources is known to Congress, veterans and the public.

To better align medical care and services with where veterans need that care, the IB's framework would require VA to reassess all currently proposed and future major construction projects and find ways to leverage community resources to identify private capital for public-private partnerships (P3) as an alternative and more efficient manner to build and maintain VA health care facilities. This would enable VA to invest in services the community lacks, while ensuring it continues to provide specialty care, such as mental health and spinal cord injury/disease care, in state-of-the-art facilities. Future capital infrastructure expansion would be based on need and demand capacity assessments, which would incorporate the availability of local resources.

The IB framework would also change VA's SCIP process to include P3 options that would blend existing replacement options to better leverage federal and local resources. It would also require VA to engage community leaders to develop broader sharing agreements so it can plan infrastructure in a way that allows communities to share resources, while allowing VA to invest in services the community lacks.

The access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system that impact VA's ability to provide direct care. Evaluating VA's capacity to care for veterans requires a comprehensive analysis of veterans' health care demand and utilization measured against VA's staffing, funding, and infrastructure. However, VA's capacity metrics are based on deflated utilization numbers that fail to properly account for the true demand on its system.

For example, a shortage of nurses within the Spinal Cord Injury and Disease (SCI/D) system of care has precluded SCI/D centers from fully utilizing available bed space and has forced SCI/D centers to reduce the amount of veterans they admit. This has caused a decrease in the daily average census at some SCI/D centers and implies that there is a lack of demand on the system when in reality veterans who want to access SCI/D care are turned away

because those centers lack the staff to man available beds.

Recognizing that VA's Veterans Equitable Resource Allocation (VERA) model is based on utilization, VA's inadequate staffing ratios cause a downstream impact on funding for capital infrastructure projects and the resources local VA facility leaders are given to meet demand. For this reason, the IB's framework recommends establishing staffing models based on population density thresholds, actual medical need, functional level and other critical factors. This model would also need to account for changes in the veteran population and surges in demand as VA health care improves and military downsizing continues. Doing so would ensure VA is able to measure the true capacity of its medical facilities.

Regardless of how well VA reforms staffing and capital infrastructure processes, it will not be able to close access gaps if it does not receive the resources it needs to meet demand. In fact, the CMS Alliance to Modernize Healthcare emphasized in its report *"Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs"* (released on September 1, 2015) that VA's ability to meet its promise to veterans is limited by the resources it receives from Congress, and that VA would need increases over the next five years to meet expected demand. The IBVSOs annually conduct a thorough analysis of VA health care utilization and submit detailed recommendations for full and sufficient funding to address current and future utilization and access gaps. Unfortunately, for fiscal year 2015, Congress enacted appropriations that was nearly \$2.0 billion short of the IB's fiscal year 2015 recommendations for VA's Medical Services accounts. Less than six months after passage of that bill, the VA reported a \$2.6 billion budget shortfall in its Medical Services accounts that could have forced the Department to limit health care to veterans if Congress was unable to provide additional funds. Fortunately, the VA was authorized to use the Veterans Choice Fund to address the short fall. The IBVSOs believe that it is likely VA will face another budget shortfall could in fiscal year 2016, and this pattern could continue without additional structural changes.

The IB agrees with the Independent Assessment's finding that the congressional appropriations process does not provide VA the flexibility it requires to meet the demands on its health care system. With this in mind, the IBVSOs believe that the congressional appropriations process must be reformed to ensure VA has the resources it needs to provide the timely, high quality health care services veterans demand instead of limiting the amount of care VA is able to provide. While the IB was at the forefront of efforts to enact advance appropriations to relieve the pressures of a broken appropriations process on the VA health care system, we believe that consideration should be given to new proposals that might optimize the funding process. There have been a number of proposals over the years to address this issue ranging from adopting methods that have worked for other departments (a VA health care fund similar to the Department of Defense's overseas contingency operations fund) to and technical changes to the existing appropriations process (authority

to transfer advance appropriations to current year budget). The IB's framework calls on Congress to evaluate the merits and feasibility of these and other proposals to strengthen the appropriations process to ensure VA has the ability to provide the health care veterans need.

To ensure VA's budget requests are accurate and properly aligned with the health care needs of the veterans population, the IBVSOs would also call for reforming VA's current planning methodology, budget forecasting and resource allocation systems to align them with the changing demographic and health care needs of the veterans population. The IB framework recommends the establishment of a Quadrennial Veterans Review (QVR) process, similar to the Quadrennial Defense Review. The QVR would serve as the benchmark for the Future-Year Veterans Program (FYVP) that can take a long view of the prospective resource needs based on demand for health care services within the entire integrated health care network. This would better align VA's strategic mission with its budgets and operational plans, and help provide continuity of planning across all administrations.

While ensuring VA has the resources it needs to meet demand is vitally important, it is also critical that VA continue to serve as a good steward of federal resources used to provide timely, quality care to veterans. To support this point, the IB's framework calls for a biennial independent audit of VA's budgetary accounts to identify line items and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations.

Reform VA's Culture with Workforce Innovations and Real Accountability

Secretary McDonald has made improving veterans experience a main pillar of the MyVA transformation. To ensure VA leaders are aware of the issues veterans face when they obtain their earned benefits and health care, the MyVA taskforce has established the Veterans Experience Office, with a Chief Veterans Experience Officer who reports directly to the Office of the Secretary. VA plans to have veterans experience officers throughout the country who collect and disseminate best practices for improving customer service, coordinate community outreach efforts, and serve as subject matter experts on the benefits and services VA provides to veterans.

The IBVSOs have consistently heard from veterans that their patient advocates are ineffective or seek to protect the medical facility's leadership instead of addressing their concerns. The IB believes that patient advocates cannot effectively meet their obligations to veterans if their chain of command includes VA medical facility staff that is responsible for the actions and policies they are required to address.

The IB framework would strengthen the Veterans Experience Office by combining its capabilities with the patient advocate program. Veteran experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under Title 38, United States Code, a veteran's right to seek redress through clinical appeals, claims under Title 38 USC §1151 and the Federal Tort Claims Act, and the right to free representation by accredited veteran service organizations are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, both in the public and private sector.

Finally, any plan to reform the culture of VA must also take into consideration the need to modernize VA's workforce and ensure VA employees serve the interest of the veterans' community. While Congress has focused on firing underperforming employees, the IB partners believe that the situation is more complicated and demands a holistic approach to workforce development that allows VA to recruit, train, and retain quality professionals capable of caring for our veterans, while simultaneously ensuring that VA has the authority to properly discipline employees whenever appropriate.

The IB partners applaud the MyVA taskforce for acknowledging that employee experience is vital to its transformation efforts. The MyVA taskforce has developed a number of programs and initiatives to engage and empower VA employees. However, federal hiring still reflects a mismatch between the skills desired and the compensation provided for many of the professionals VA recruits. If Congress is focused on bolstering VA's ability to fire poor-performing employees, Congress must also give VA the leverage to hire employees quickly and offer compensation commensurate with their skill level.

By focusing solely on disciplinary proceedings and failing to properly cultivate a motivated and compassionate workforce, we make VA an unattractive employer to potential recruits. The IBVSOs believe that we must build a framework that makes VA an attractive employment option for the best and brightest who want to care for our veterans.

Conclusion

Congress, the Administration, the IBVSOs, and other key stakeholders in the veterans community have an obligation to ensure that the veterans' health care system is properly aligned to meet the unique needs of the veterans it serves. Meanwhile, the VA is at a crossroads that will determine how it will carry out its mission to America's veterans. The IBVSOs will continue working to ensure that our nation's veterans receive high-quality, accessible, comprehensive, and veteran-centric health care designed around their needs and preferences.

The IB's four-pronged health care reform framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that is best for veterans. Moving forward, the IBVSOs will use this framework to inform legislative proposals and ensure reforms of the VA health care system focus on the service delivery, management, accountability, budget and planning processes, and system-wide patient advocacy system that are needed to meet the unique and complex health care demands of the men and women who have served and sacrificed. Only through meaningful reforms can we live up to President Lincoln's promise "...to care for him who shall have borne the battle, and his widow and his orphan."

IOM (Institute of Medicine). 2015. Transforming Health Care Scheduling and Access: Getting to Now. Washington, DC: The National Academies Press