Testimony of
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to the
U.S. House of Representatives Committee on Veterans Affairs,
Hearing on
"Opportunities for Veterans Health Administration Restructuring"
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Thank you, Chairman Bost, Ranking Member Takano, and members of the Committee for asking me to provide testimony to be considered in your deliberations about the proposed reorganization of the Veterans Health Administration (VHA) and the Veterans Affairs (VA) Healthcare System.

In offering these comments, please know that I am not representing any government agency, private organization, or other entity. I have been advised by Committee staff that you have sought my input because I am the person who originally conceptualized and then operationalized the VHA's current Veterans Integrated Service Network (VISN) structure in the 1990s during my five-year tenure as VA's then Under Secretary for Health. My input was also solicited because I have extensive experience with organizational change, both within and outside of the government.

I am currently a Distinguished Professor Emeritus at the University of California, Davis, School of Medicine, and a Senior Scholar with the Clinical Excellence Research Center at Stanford University, as well as a senior advisor to several private sector entities. I am a veteran, a physician with board certification in several specialties, and a health system executive with some 50 years of combined professional experience that spans state and federal government, the military, the private sector, academia, and philanthropy. I am a member of the National Academy of Medicine and a Fellow of the National Academy of Public Administration. Over the years, my views on health system performance and management, among other things, have been sought by organizations throughout the United States and by foreign countries on five continents. I am pleased to offer my views to you on the proposed VHA reorganization.

Key Observations About Organizational Change Efforts

As a frame of reference and context for my later comments about the proposed reorganization of the Veterans Health Administration, let me first summarize several important research findings and experiential observations about organizational change. These provide a useful context that should be kept in mind when contemplating any substantive organizational restructuring, whether such an

initiative is called a reorganization, transformation, or something else. It is especially important to be mindful of these real-world experiential findings when considering a change that will affect the functioning of an organization, such as the VHA, that directly impacts the lives of millions of vulnerable people, as well as how billions of dollars of taxpayer funds are spent.

I particularly call out seven key findings.

1. **A large majority of organizational change efforts fail.** Studies have repeatedly shown that organizational change efforts have a high failure rate; that is, most reorganizations fail to achieve their desired outcomes. The data in this regard have been quite consistent since John Kotter published his landmark study about organizational change in 1995.[1] He found that 70 percent of organizational change efforts fail. More recently, McKinsey found that only 23 percent of re-organizations were considered successful.[2] Earlier this year, Bain & Company reported similar findings. Importantly, Bain & Company noted that organizational redesigns often "fall short because leaders focus on structure while underinvesting in how work actually gets done."[3]

2. **Organizational change efforts are disruptive of operations and consume large amounts of resources.** Major organizational change efforts, even those that are most carefully developed and genuinely necessary, are essentially always disruptive of normal operations and require substantial resources. Re-organizations invariably cause confusion and uncertainty, disrupt the usual processes for getting work done, break established relationships, cause stress and anxiety among employees (often more than layoffs), and impede productivity. Re-organizations are well known to increase inefficiency, at least temporarily, and are often very demoralizing for employees.

   Experienced leaders generally agree that solutions tailored to the root causes of problems should be sought whenever possible. Such "surgical" solutions are usually preferable to structural re-organizations unless there are compelling organizational design problems that must be fixed. For these and other reasons, re-organizations also consume a lot of resources and almost always end up costing more and taking longer than planned.

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[1] Kotter JP. *Leading Change: Why Transformation Efforts Fail*. *Harvard Business Review*. 1995. Kotter JP. *Leading Change*. Harvard Business Review Press. Boston, MA. 2012.
[2] McKinsey & Company. *The secrets of successful organizational redesigns: McKinsey Global Survey results*. July 1, 2014.
[3] Bain & Company. January 29, 2026.

3. **Most organizational performance deficiencies are not due to structural problems.** Most organizational performance problems stem from unclear strategy or aims, ambiguous or unclear policy, capability gaps, misaligned incentives, dysfunctional procedures, cultural conflicts, insufficient or insufficiently trained personnel, inadequate resources, or any number of other functional or "physiologic" problems, rather than faulty organizational anatomy. The failure to understand the difference between functional deficiencies (and their root causes) and structural problems is one of the reasons why so many attempted re-organizations fail. Put differently, re-organizations so often fail because the cause of the symptoms or problems is incorrectly diagnosed.

4. **Use of change management key practices increases the likelihood of success.** It is well established that the use of change management key practices enhances the likelihood of successfully achieving the desired outcome(s) of any organizational change effort. Conversely, failure to utilize these practices minimizes the chances of success. Table 1 lists the key organizational change practices cited by GAO in 2002 and which they have repeatedly used over the years in assessing numerous government agency reorganizations. Kotter and others have identified other key practices that increase the likelihood of successfully re-organizing or transforming an organization.[4]

5. **New leaders have a propensity to undertake reorganizations because it is a quick and visible way to create an impression that problems are being addressed.** It has been repeatedly observed over the years that new leaders often embark on re-organizations because restructuring is highly visible and creates an illusion of progress, even though such structural solutions may not address the root causes of performance problems.

   Politically appointed leaders in government agencies often exhibit this behavior. That may be because major re-organizations typically take 2-3 years to fully implement, which is often longer than the tenure of the government leaders who launch the organizational change. Government leaders have often moved on before the re-organization they initiated gets implemented and, thereby, avoid accountability for any failures in their plans.

6. **The timing of re-organizations is important.** In view of the operational disruption typically caused -- and the resources consumed -- by organizational restructuring, it is critically important to consider other

[4] Ibid. Kotter JP. 1995 and 2012.

challenges or demands facing an organization when deciding whether to launch a re-organization. As already noted, large re-organizations usually take 2-3 years, or longer, to complete. Leaders need to carefully consider the overall environment in which the organization is functioning and whether there are other priorities that should take precedence over restructuring. Questions like the following should be carefully addressed: Is it the right time to initiate a major restructuring of the organization? Would less disruptive solutions address the functional problems? Will the restructuring impede or interfere with progress achieving other critically important priorities? What happens if the other priorities are not achieved?

7. **A clearly articulated transformation plan is critically important.** A consistent observation about organizational change is the importance of having a clear and focused transformation or re-organization plan that includes a vision for the organization, a clear delineation of the new organizational structure and functions, and a new accountability system.[5] The need and value of broad employee and other stakeholder input to the plan is also a major success factor in successful organizational transformations.

[5] Ibid. Young G. 2000.

Table 1. ***GAO's key practices for successful mergers, acquisitions, and transformations**** *

1. ***Ensure top leadership drives the transformation.*** *Leadership must set the direction, pace, and tone and provide a clear, consistent rationale that brings everyone together behind a single mission.*

2. ***Establish a coherent mission and integrated strategic goals to guide the transformation.*** *Together the mission and goals define the culture and serve as a vehicle for employees to unite and rally around.*

3. ***Focus on a key set of principles and priorities at the outset of the transformation.*** *A clear set of principles and priorities serve as a framework to help the organization create a new culture and drive employee behaviors.*

4. ***Set implementation goals and a timeline to build momentum and show progress from day one.*** *Goals and a timeline are essential because the transformation could take years to complete.*

5. ***Dedicate an implementation team to manage the transformation process.*** *A strong and stable team is important to ensure that the transformation receives the needed attention to be sustained and successful.*

6. ***Use the performance management system to define responsibility and assure accountability for change.*** *A "line of sight" shows how team, unit, and individual performance can contribute to overall organizational results.*

7. ***Establish a communication strategy to create shared expectations and report related progress.*** *The strategy must reach out to employees, customers, and stakeholders and engage them in a two-way exchange.*

8. ***Involve employees to obtain their ideas and gain their ownership for the transformation.*** *Employee involvement strengthens the process and allows them to share their experiences and shape policies.*

9. ***Build a world-class organization.*** *Building on a vision of improved performance, the organization adopts the most efficient, effective, and economical personnel, system, and process changes and continually seeks to implement best practices.*

*General Accounting Office. *Mergers and Transformation: Lessons Learned for a Department of Homeland Security and Other Federal Agencies*, GAO-03-293SP. Washington, DC. November 2002.

Historical Context and the 1990s Reorganization of VHA

Since its founding as a dedicated safety net health system for veterans in 1924,[6] the Veterans Healthcare System has been restructured several times to address changing needs and circumstances. Three large system-wide reorganizations are especially notable: (1) in 1930, when all veteran benefits programs were consolidated to create the Veterans Administration; (2) in the late 1940s to meet the needs of the 12 million World War II veterans; and (3) in the late 1990s to address structural and widespread operational problems. Several less extensive reorganizations have also taken place over the years to address other situational circumstances.

In 1994, I was recruited into VA as the first Under Secretary for Health to come from outside the organization in more the 30 years. My charge from both the Congress and the Administration was to re-engineer the system to address a dysfunctional and cumbersome organizational structure and numerous system-wide operational problems, including among other things, fragmented, disjointed and overall poor-quality care. Working closely with the Congress and the Administration, the VHA organizational transformation that I engineered sought especially to make superior quality of care predictable and consistent throughout the system, to improve access to care, to make VA health care value equal or superior to care provided in the private sector, and to make VHA a high reliability organization. Multiple documents of various kinds discuss the strategies and tactics pursued to accomplish these goals.[7]

Establishment of the Veterans Integrated Service Network (VISN) organizational structure was one key component of the 5-pronged re-engineering strategy that included: (1) reorganizing care delivery assets for the primary purposes of increasing accountability, creating a reasonable management span of control, and improving efficiency of operations and utilization of resources; (2) implementing structures, policies and procedures aimed at better integrating and coordinating services; (3) improving the quality of care; (4) modernizing VHA's information management infrastructure, including implementation of a systemwide electronic health record; and (5) aligning system finances with desired outcomes, which included establishing a new resource allocation methodology (the Veterans Equitable Resource Allocation or VERA) to take account of geographic shifts in the location of the veteran population. Subsidiary or corollary strategic aims and objectives included, among other things, catalyzing innovation in care delivery,

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[6] Public Law 68-242, World War Veterans Act of 1924

[7] *Vision for Change*. Department of Veterans Affairs 1995. *Prescription for Change*. Department of Veterans Affairs.1996. Kizer KW, Dudley A. Extreme Makeover: Transformation of the Veterans Health Care System. *Annual Review of Public Health*. 2009;30:313-330. Young GY. *Transforming Government: The Revitalization of the Veterans Health Administration*. Washington, DC. PricewaterhouseCoopers Endowment for the Business of Government. 2000.

encouraging health promotion and disease prevention, and encouraging public-private partnerships. The VISN structure was modeled after an organizational design of integrated service delivery that was beginning to be adopted by leading health systems in the private sector, albeit not on the magnitude or scale of the VA health system. The VISNs became the scaffolding around which a new way of doing business and a new culture were constructed.

The performance improvements this re-engineering produced were both rapid and dramatic and were tangibly demonstrated in many and diverse ways, including by systemwide enrollment more than doubling within 4 years – that is, Veterans very quickly voted with their feet. Ironically, because of the rapid growth of VA's enrolled population due to the operational improvements in VA healthcare, the Bush Administration cut off new enrollments for category 7 and 8 veterans in 2003,[8] although this decision was reversed some years later.

The VHA's transformation of the late 1990s has been described and discussed in multiple books and hundreds of peer-reviewed professional journal articles, as well as in myriad reports by the Government Accountability Office, Congressional Budget Office, VA Office of Inspector General, and various consulting organizations. Literally hundreds of research studies have documented VHA's improved quality of care, operational efficiency, and access. It also has been the subject of multiple doctoral dissertations and similar academic reports.

In these myriad reports, the VA Healthcare System's transformation has been characterized as the largest and most successful healthcare turnaround in U.S. history, or by similar verbiage. And it has been regularly used as a case study in healthcare executive training programs. (See, for example, the Harvard Business Review case study published in 2006.[9])

Perhaps one of the best validations of the strategies used to accomplish VHA's transformation is that over the past 30 years much of American healthcare, despite different financing mechanisms and missions, has pursued substantially similar change strategies and tactics as were pioneered by VHA 30 years ago. Integrated delivery networks (IDNs) analogous to the VISNs are now the preferred operating model of private health systems throughout the U.S.

When I left the VA in 1999, I viewed VHA's transformation as a work in progress, notwithstanding its already demonstrable success. In the quarter century since I left VA, the original principles and goals of that re-engineering effort have been variously and inconsistently pursued or re-affirmed. To cite just one example,

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[8] Per the enrollment system created by the Eligibility Reform Act of 1996.

[9] Edmondson AC, Golden BR, Young GJ. 2006. *Transformation at the Veterans Health Administration. N9-607-035*. Boston, MA. Harvard Business School.

efforts to evolve VHA into a high reliability organization were continued for some time after I left VA but were later abandoned, only to be relaunched anew in 2019 by Dr. Richard A. Stone, the then Acting Under Secretary for Health.

While the overall improvements in quality of care, efficiency, and access resulting from VHA's re-engineering in the late 1990s are very well documented, it has to be acknowledged that the continued evolution of the system that was then envisioned only partially occurred. And, regrettably, there have been significant managerial missteps over the years, some of which I have written about in articles published in respected professional journals.[10]

VHA's overall superior quality of care has been and continues to be well documented by academic studies and reports in professional journals. Nonetheless, there continue to be robust opportunities for improving overall systemwide performance, especially with regard to the consistency of high quality care being provided, ease of access to care, and assuring demonstrable accountability at all levels of the organization. Importantly, the Covid-19 pandemic, new policies and priorities associated with the expansion of Community Care, and new patient populations (e.g., PACT Act) have also created novel challenges for the VHA. Implementing a responsive, high quality, and cost-effective Community Care program in which providers have demonstrable expertise in Veterans' specific healthcare problems is one area that should be a top priority for VA leadership.

As I have written about elsewhere, VHA "is now challenged with both operating a national direct care system while also being a large and rapidly growing health insurance plan for an enrolled population mostly having health insurance coverage from one or more payors additional to VA." and "The skills, functionalities and support systems needed to be an effective and efficient provider of health care are different from those required of a prudent purchaser of care, and VA has not yet developed the requisite benefits coordination and data infrastructures necessary to effectively support care management of its multiply insured enrollees, or to ensure prudent care purchasing."[11]

Implementing the necessary infrastructure to support Community Care should be among VA leadership's highest priorities.

Likewise, addressing the duplicative spending associated with VA-Medicare Advantage enrolled veterans is another problem that should be a high priority, if for no other reason than the large amount of public funds that currently are going to

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[10] Kizer KW, Jha A. Restoring Trust in VA Health Care. *New England Journal of Medicine*. 2014; 371(4):295-297. Kizer KW, Kirsh SR. The Double Edged Sword of Performance Measurement. *Journal of General Internal Medicine*. 2012;27(4):395-397.

[11] Kizer KW, Curbing the Growing Fragmentation of Veterans' Health Care. *JAMA Health Forum*. 2025;6(12):e254148.

subsidize private Medicare Advantage plans through such dual enrollees. In 2023, VA spent $22.7 billion on MA-enrolled veterans for services that were also paid for by the Centers for Medicare and Medicaid Services (CMS).[12] In recent years, such duplicative federal spending has grown to well over $100 billion in the aggregate.

Without question, the VA Healthcare System is one of the most complex and difficult to manage healthcare organizations in the world. The system's large size and national scope, in and of itself, presents enormous management challenges. In addition, no other healthcare system treats patients with as many highly sensitive conditions, many of them exacerbated by or acquired through military service and, thus, largely unknown outside of the VHA. Further, and this point cannot be over estimated, no other healthcare system in the U.S. is statutorily mandated to fulfill so many different core missions, which include providing medical care for eligible Veterans, educating and training more than 40 types of healthcare professionals, conducting research to improve Veterans care, preparing for public health emergencies and providing contingency support for the military and private healthcare sectors, and combatting homelessness. These disparate missions can complement each other but also create a management setting requiring the best of both clinical, public health, and administrative management and leadership.

Having good leadership is critical to the success of any organization, big or small, and leadership problems are a recurring challenge in all enterprises. Indeed, if exercising effective leadership were easy, then our libraries and bookstores would not be filled with so many volumes extolling the secrets of effective leaders and promising to produce better leaders.

Because the VA Healthcare System is the most managerially complex healthcare organization in the nation, having highly skilled and expert leadership is especially critical for its successful management. In this regard, I do not believe that VA has done enough in the past, nor does enough now, to develop, nurture, and grow the leadership and teach the managerial skills needed in its workforce to address the system's challenges and to fulfill the sacred trust and promise the nation has made to its military veterans. Teaching and consistently improving organizational management and leadership skills should be a top priority for VA's leadership.

Rather than spending scarce resources on an unclear and unnecessary organizational restructuring plan, energy and time should be devoted to creating and implementing a much more robust, healthcare-specific leadership

[12] Trivedi A, Jiang L, Meyers D, Schwartz A, Kizer KW, Yoon J. Spending by Veterans Affairs for Medicare Advantage enrollees, 2019-2023. *JAMA Health Forum*. 2025;6(12):e255653. Kizer KW, Ibrahim S. Medicare to Veterans Affairs Cost Shifting – A Challenging Conundrum. *JAMA Health Forum*. 2024;5(12):e244319.

development program than VHA now has – and especially since so many experienced VHA leaders have left VA in the past year. This leadership program needs to be tailored specifically to the issues, challenges, and circumstances that VHA leaders confront in managing a national, government funded and administered healthcare system with multiple missions and a very special patient population. These are not the same skills that may be learned in typical private sector healthcare executive training programs.

Finally in this regard, I should note that having been a medical practitioner, state regulator of healthcare, health system leader, healthcare payor, and consultant in, or for, the private healthcare sector for much longer than I was with VA, I am mindful that no healthcare system always "gets it right." There are no perfect healthcare systems. Leadership failures and errors of care occur in all health systems. And all health systems grapple with the vexing question of how some of the best policy initiatives and practices fail to be adopted at the frontlines of care.

As the spouse of a now deceased patient who had several serious chronic health conditions, as well as being a patient myself, I have had the opportunity to observe these failures and problems at the front lines of care in some of the most renowned healthcare institutions in the nation. Sadly, I have witnessed first-hand egregious lapses in the care provided by these vaunted organizations. I mention this merely to underscore the reality that healthcare broadly is very much a work in progress and has myriad opportunities for improvement in every setting.

Committee Staff Questions

In conversations with Committee staff, several questions were posed to me to consider in my testimony. My interpretation of those questions and my responses are noted in the paragraphs that follow,

1. **Does the VISN structure continue to be the preferred organizational structure for the VA Healthcare System?**

In a word, "yes".

The original selection of 22 VISNs in 1995 was based on experiential information available at that time indicating that an integrated delivery system needed between 200,000 and 400,000 users and a broad mix of care delivery assets rooted upon robust primary care to achieve truly integrated, coordinated, and continuous care in an efficient manner. It was understood that these numbers might vary based on the disease burden of the population, geography, climate, and possibly other factors. With that foundation in mind, the catchment areas of the original VISNs were determined on patient-focused criteria such as the prevailing

patient referral patterns between and among clinicians and facilities, the ability of each VISN to provide a continuum of primary to tertiary care with VHA's then existing care delivery assets, and, to a lesser extent, on state or county jurisdictional boundaries, which often have no significance from the perspective of healthcare. Establishing 22 VISNS was a point-in-time pragmatic judgment based on these criteria. It was expected that the number of VISNs would change over time as circumstances changed and as the system evolved. And this is what has happened.

Because it is often not recognized, I should also note that the VISN structure was intended to provide some redundancy of internal oversight to facilitate accountability for outcomes, quality, and costs, as well as adherence to established policies and procedures. If oversight and accountability were to fail at the local level, then it could be exercised at the regional (i.e., VISN) level. If it fails at both local and regional levels, then it could be exercised at the national level. In something as critical as publicly funded healthcare for Veterans, it is important to have some redundancy of oversight designed into the system. Of course, VHA also has an unparalleled number of entities providing external oversight, with this committee being one of those many entities.

The fact that so much of the rest of American healthcare has established, or is in the process of establishing, integrated delivery networks analogous to the VISNs should reassure the Committee that the conceptual underpinnings of and rationale behind the VISN structure are quite sound.

2. **Are the performance and accountability problems that have been detailed by Secretary Collins as the justification for restructuring the VHA due to the VISN structure?**

In a word, "no".

Structures are not independent of the people who work in them, nor of the leaders and managers whose job is to ensure that staff achieve desired outcomes, whether that be in quality of care, cost management, or other domains. It has been my experience that lapses or failures in leadership, unclear strategies and aims, ambiguous policies or poor execution of established policies and procedures, and/or insufficient delineation of roles and responsibilities, among other reasons, are much more likely explanations for performance or accountability problems than organizational structure. The organizational management research literature supports this view. So do many of the reports that are cited to support the proposed reorganization plan.

It is important to remember that all too often performance problems are incorrectly attributed to organization structural issues when, after careful analysis, lapses in leadership and poor execution of policies and procedures are instead the

actual root causes of various problems. It is critical not to confuse problems in leadership or adherence to policies with issues of structure.

3. **Does VHA's current VISN structure present insurmountable barriers to addressing the problems called out by the GAO and others?**

In brief, "no".

Instead of launching a disruptive and resource intense re-organization, it would make more sense to embark upon more "surgical" or tailored solutions to the problems called out by GAO and others.

4. **How can the right balance be achieved between having national, systemwide standardization while assuring the kind of regional or local flexibility that facilitates local leaders and care providers address what are often unique situational circumstances and to innovate?**

Finding the right balance between systemwide standardization and local or regional flexibility is one of the most difficult challenges confronting the leadership of any large health system - or any large service provider, for that matter. While some organization-wide standardization is needed in large organizations, local and regional flexibility that allows managers and service providers to address unique or unusual local circumstances is also needed. This is an especially difficult challenge for VHA because the system is national – indeed, the only national healthcare system in the U.S. It must provide care in many very different settings and circumstances which often present quite different challenges.

Having said this, however, I would note that it is imperative that VHA have significant standardization of its policies and procedures and processes of care so that both caregivers and patients, as well as health system leaders, know what they can reasonably expect regardless of where they are in the system.

Perhaps the most prominent example of VA's failure to standardize over the past 30 years, in my judgment, is what occurred with VistA, VHA's once highly acclaimed electronic health record. An electronic health record is in many ways the glue that holds a health system together, and VA leadership should not have allowed so much facility-based "customization" of VistA to occur over the years, causing an originally standardized systemwide EHR to essentially morph into 170 versions of VistA that ended up creating digital chaos.

As a now outside observer of the VA Healthcare System, albeit one who has and continues to see it through multiple different lenses, it appears to me that the system might benefit from increased standardization in some areas. Conversely, it

would benefit from continued flexibility in areas where there is no demonstrable benefit or value achieved by standardization.

5. **Has VHA optimally leveraged its diverse and wide-ranging assets and its advantages as a national healthcare delivery system to optimize care delivery?**

Notwithstanding some gaps and vulnerabilities, the VA Healthcare System has enormous human, technological, intellectual, educational and training, investigational, and policy assets that few, if any, other health systems have. Regrettably, too often, VA has not capitalized on its many assets and fully used them to its advantage in caring for Veterans.

Let me offer just one possible example of how these various resources could be used to address a Veterans' care problem.

VHA continues to face significant shortages of mental health caregivers, as does the rest of American healthcare. To address this ongoing problem, VHA could use its various caregiving and educational tools to launch a multi-pronged mental health care enhancement initiative that aligns these resources and tools around a goal of increasing the system's mental health care capacity. In so doing, it needs to be understood that: (1) no one strategy can fill the need for mental health care providers; (2) the private sector can be of only limited help since it is generally in a far worse state than VHA; and (3) there are no quick fixes. This mental health enhancement initiative would have both short- and long-term goals aimed at better utilizing existing mental health care assets and developing new assets. Tactics that might be utilized in this strategy – all of which are within VHA's control to do - include:

- Reassign existing GME and other training slots to increase mental health care trainees/providers. A similar strategy was pursued in the late 1990s to increase the number of primary care providers in VHA, increasing the number of funded GME positions for primary care specialties from 34% of the total (>9,000 positions) in 1994 to 49% in 2000.

- As a national system of care, rethink how assets in better resourced areas might be utilized or deployed in ways to aid shortage areas, taking advantage of time zone differences, telehealth and other technologies, VHA's lack of state licensure restrictions, and other things.

- Extensively leverage technology to support, extend and augment providers (e.g., telehealth, mobile device apps, and virtual reality/immersive technologies).

- Develop in-house training programs that would empower non-mental health care providers to expand their competence in taking care of mental health patients.

- Establish new types of mental health care providers to fill gaps in services. (Remember that the specialty of clinical psychology was born in the VHA.)

- Develop and fully utilize partnerships with community care organizations and providers. This means much more than just sending Veterans to Community Care providers; some examples of innovative community partnerships are mentioned in the 2023 National Academies of Sciences, Engineering, and Medicine workshop report that was prepared for VHA.

Among the many other potential opportunities in this vein, I would especially call out expanding use of telehealth and immersive technology, pioneering application or uses of machine learning and augmented/artificial intelligence, and systemization of expanded function clinical call centers

6. Given other events and circumstances, is now the right time to undertake a major restructuring of the VHA?

In a word, "no".

I do not believe this is the right time to undertake a major re-organization of VHA, nor, for that matter, that such is even needed. The problems called out by GAO and others should not be ignored or left unaddressed, but – as already stated – these problems are related more to shortcomings in policy and procedures and strategy and aims, than structure. Several other problems – such as successfully implementing a new electronic health record, implementing a new third-party administrator community care contract, fixing wasteful and duplicative VA-Medicare Advantage spending, implementing a much-needed community care infrastructure, and growing leadership skills – should take precedence over re-structuring the VHA.

Addressing the variability in administrative procedures and clinical outcomes across the VISNs should be a priority. As a broad statement, and understanding that some variability in performance is to be expected across the VISNs and VAMCs, I believe there probably should be more systemwide consistency and uniformity in the processes of care and administrative procedures so that both patients and caregivers know they are in the same healthcare system regardless of where in the country they receive care or how they otherwise interface with the VA.

Achieving greater administrative consistency should begin with clearly defining managerial and leadership roles and responsibilities and clarifying when

and for which matters consistency or standardization is necessary or advantageous, and why. Importantly, this is not to say that all administrative variability is bad. In some things, it may not matter whether there is consistency or not. The key is knowing when and where it does matter, and why, and then developing standard operating procedures and policies for those matters.

Of course, even with managerial and leadership roles clarified, it is necessary to have appropriately skilled and experienced people in leadership and management positions to effectively carry out those roles and responsibilities. This is why attention needs to be directed towards growing leadership skills, especially given the exodus of so many experienced VHA leaders and managers during the past year.

Similarly, ensuring consistent high-quality care across the VISNs, which includes convenient and easy access, should be VACO's immutable top priority, and continuous quality improvement should be built into and inherent to the fabric of the organization. Quality improvement should be integral to everything that is done. Of course, improvement begins with having accurate measurement of performance and ensuring that what truly matters is being measured. There are numerous specific tactics that can be utilized to drive improved and consistent quality of care, and VACO should have a robust menu of these tactics that can be applied or utilized in different situations or circumstances, as needed and appropriate to the circumstances.

Perhaps a good example of the kind of desirable consistency that the VHA has achieved is found in its pharmaceutical management program.

When I started my tenure as Under Secretary for Health in 1994, the most frequently voiced problem and source of frustration that Veterans complained about was the different pharmaceuticals available at different VAMCs. No two VAMCs had the same formulary of drugs. Having so many local drug formularies not only frustrated patients but also jeopardized quality of care and did not make managerial or fiscal sense. To address this variability, over the course of two years we created and implemented a national formulary. Subsequently, as a result, Veteran complaints dropped dramatically, and it facilitated increased efficiency of dispensing and mail order distribution, as well as improving quality of care in multiple ways. The National Formulary also allowed VA to negotiate better prices for drugs from the pharmaceutical companies. It is worth noting that VHA's consolidated mail out pharmacy program was the first healthcare service anywhere to consistently operate at a six-sigma level of excellence.

7. **Access to care remains a critical issue for veterans. What strategies are most effective for improving access to care within the VISN**

system? How can VISNs ensure that veterans in both urban and rural areas receive timely and high-quality healthcare services?

Convenient and easy access is an essential component of high-quality care. Ensuring access to high-quality healthcare services begins with having adequate numbers of appropriately trained and skilled staff. Without sufficient staff, the VHA cannot provide timely access, nor high-quality care, notwithstanding the potential for technology to support and augment staff. The Community Care program, which was intended to supplement, not supplant VA's in-house care, is an essential adjunct to VHA's direct care system. As discussed elsewhere, however, it needs substantive improvements.[13]

As far as technology is concerned, I am optimistic that various established and emerging technologies can be used to facilitate convenient access, especially expanded use of telehealth and use of individual mobile device apps, as well as regionalized multi-purpose clinical contact centers (i.e., VA Health Connect).

I am also enthusiastic about how some private health plans are harnessing machine learning and artificial intelligence (AI) technologies to identify high risk or especially vulnerable patients that, once identified, can then be enrolled into intensive case management programs to ensure they have continuous easy access to needed services. It has been asserted that AI may even be more astute at identifying these vulnerable patients than traditional primary care teams.

Based on what I hear from Veterans and VA caregivers alike, perhaps the biggest leap forward in improving access to VA care would be to have a reliable and easy to use patient scheduling system, along with state-of-the-art telephone systems. Given how foundational these technologies are to access, it is very concerning that they continue to be prominent sources of frustration for both Veteran users of VHA and caregivers. Ideally, any improved scheduling system would include mechanisms and means for Veterans to self-schedule their appointments.

Conclusion

In conclusion, it is unclear how and why a major structural re-organization of VHA is likely to fix various functional problems that have been called out by GAO and others, including myself, especially when the proposed re-organization has so few details about what exactly will change and how it may affect day-to-day clinical processes, Veterans' care, and other functions of the organization. It would be much

[13] Kizer KW, Perlin JB, Guice K, Granger E, Friesen D, Safran DG. *The Urgent Need to Address VHA Community Care Spending and Access Strategies. A "Red Team" Executive Roundtable Report*. 2025.

more prudent to consider whether a re-organization is needed after other solutions to identified problems have been tried. It is also critical that the construction of any detailed plan for broad transformation of the system be informed by widespread employee and other stakeholder input and is available for wide review before being considered for implementation.

That concludes my testimony. Thank you for the opportunity to provide comments to you. I hope that my comments are helpful as you continue to provide oversight of the Veterans Healthcare System.