

Testimony

of



Presented

by

**Rick Weidman, Executive Director
For Policy and Government Affairs**

Before the

Senate Veterans' Affairs Committee

Regarding

**The Future of the VA:
Examining the Commission on Care Report
And VA's Response**

September 14, 2016

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and other Senators of this distinguished committee. On behalf of VVA National President, as well as the members of Vietnam Veterans of America (VVA) and our families, I thank you for affording VVA the opportunity to testify today regarding the recommendations of the Commission on Care, and what the Department of Veterans Affairs has been doing to improve access for eligible veterans to avail themselves of the generally excellent health care that the VA provides.

Let us begin with some facts:

- The Veterans Health Administration, the VHA, is an integrated managed care network, the largest in the nation. Long before the “scandal” that led Congress to enact the Choice Act, a provision of which established the Commission on Care, the VHA availed veterans of care by community providers, when necessary or appropriate.
- VA Medical Centers provide for the most part “one-stop shopping” for primary and specialty care, something that is not afforded at most private-sector hospitals and healthcare facilities.
- The commission, you should note, acknowledges that the quality of care in VHA facilities is good to excellent and is in many areas superior to care from private hospitals or medical centers.

Certainly, however, VVA does not quibble with the mission of the commission: to enhance and improve a healthcare delivery system that will “provide eligible veterans prompt access to quality health care.”

To the commission’s credit, commissioners rejected the idea of privatizing VA healthcare. They nixed the idea of unfettered “choice,” of giving eligible veterans the option of going to any private-sector healthcare providers of their choosing, with the VA footing the bills and being transformed, in effect, into a source of income. They would scrap the time and distance criteria for access to community care (30 days and 40 miles), one of the provisions of VACAA, the Veterans Access, Choice, and Accountability Act.

The commissioners tripped up, however, in conceptualizing an entirely new governance structure, and in sublimating VA, healthcare facilities into an expansive community context dubbed the “VHA Care System.” Yes, VA clinicians should refer veterans to outside providers when and where appropriate to improve access as well as to provide care that VA clinicians are unable to deliver.

However, no, the VA should not cede, as the commission recommends, the role of primary care clinician to non-VA personnel; this would be a critical misstep, undermining the integrity and managed care the VA offers.

“Foundational among the changes” the commission seeks is “forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.” This concept is mistaken. The governing board that the commission envisions as necessary to achieving a “bold transformation” ignores reality. Their “Board of Directors” would be a paper tiger that, without the power of the purse, can only recommend, not appoint or institute, thus making it a board of *advisors*. And veteran service organizations and veteran leaders in effect already function as an informal board of advisors on both the national and local levels – consider the Independent Budget, for instance. The VA would have far fewer perceptual problems if it acknowledged this and worked in concert with VSOs as a matter of course, seeking and embracing our input at the beginning of a process, not *pro forma* near its conclusion.

Not all of the commission’s recommendations veer away from logic and viability. There is, certainly, a need for strong, sustainable leadership at the top, locally as well as nationally. In fact, it has been the failure of leadership that has gotten the VA into hot water with you in Congress and in the media, with individual veterans and the public, in the first place.

In addition, as you are aware, the commission’s recommendations for transformative change in healthcare delivery are not intended as an immediate palliative; rather, the charge of the commission was to envision what the VA healthcare delivery system should look like in 20 years, and to provide a blueprint on how to get there.

Before I offer VVA’s analysis of each of the commission’s 18 recommendations, I do want to publicly praise the efforts of the commissioners for the sense of purpose they brought to the task. In addition, I want to particularly applaud the strong and steady leadership of commission chair Nancy Schlichting, and the commitment and expertise of the staff who I know labored long and hard to produce the commission’s final report.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System/Recommendation #1

The fundamental problem with the commission's conceptualization for the future of VA healthcare delivery commences in the language of this initial recommendation, which calls for "... community-based health care networks" that will "integrate health care within communities." This would essentially fold VA-provided health care into a wider community-oriented network of providers.

The Veterans Health Administration already is an integrated managed care network that does in fact avail veterans of care by community providers when called for. Individual failures in medical practice as well as access to care, when they occur, have been highlighted in the media which, for the most part, do precious little investigative reporting on systemic problems in VA health care delivery. (Nor do they cover many of the positives in VA health care, e.g., making every veteran patient afflicted with hepatitis C eligible to receive the medication that can now cure this potentially fatal disease.) Now, the illumination of issues revolving around management and medical practice fulfills the oversight and investigations responsibility of Congress. Many times, however, the glare of the spotlight focuses on specific problems, enlarging them, undermining the basic integrity of the VA healthcare system and the clinicians, administrative and housekeeping personnel who are its essence. Problems in other healthcare facilities throughout the nation are not subjected to partisan political punditry, are far less transparent, and do not trigger the same public scrutiny and condemnation as VA health care does.

Perhaps more basic to the relationship between clinician and patient is the assumption that most veterans want to choose their primary and specialty healthcare providers. This precept is fundamentally flawed. If a veteran needs to see a specialist, s/he often has little ability to divine on their own who to go to and must rely on the recommendation of their primary care provider. In the brave new world envisioned by the commission, the veteran can "choose" to see the "credentialed" specialist of his/her choice. Does anybody really think that this will enable a veteran to get same-day service from a busy clinician? Alternatively, provide better care than s/he can receive at a VA medical center or community-based outpatient clinic? On the other hand, save the system money?

In addition, consider the potential for this: If a patient who is covered by private health insurance chooses to be treated by a physician not in the network assembled by her health insurer, she has to pay that doctor out of pocket and fill out a claim form to receive some reimbursement from her insurer. Yet what if that veteran wants to go to a clinician whom the VA has not credentialed? Will he have to shell out his own money, even if he has a disability rated at, say, 70 percent? Will that veteran complain to his Member of Congress, who will then demand from the local VHA Care System why Dr. X has not been “credentialed”? It is not difficult to foresee a bureaucratic headache of major proportions.

Clinical Operations/Recommendation #2

This recommendation negates the acknowledged quality of VA health care. To “enhance clinical operations through more effective use of providers and other health professionals” in effect charges the VA with clinical mismanagement. The core of the problem, which the commission acknowledges, “starts with inadequate numbers of providers.” This, however, is a problem not limited to VA health care. There is something like a 90,000-clinician shortage across the country, a situation that is particularly acute in rural and remote areas as well as inner cities.

The report nitpicks, e.g., “[f]or example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff.” Just who do the commissioners foresee writing prescriptions? Alternatively, ordering consultations? While it is true that if you have seen one VA medical center, you have seen one VA medical center, but . . . doctors escorting patients? Alternatively, cleaning exam rooms? (Attempts to locate these allegations through the report’s footnotes proved well nigh impossible, e.g., there is no page 95 in the cited document.)

The commission does, however, offer some sensible, and well-considered concepts, e.g., that VHA adopt policies to allow health professionals “to make full use of their skills”; and that “VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.”

Recommendation #3

Citing uncertainties among VA patients and clinicians alike as to just what VHA’s policy for resolving clinical disputes is – there appears to be not one but 18

different policies, one in each Veterans Integrated Service Network, or VISN – it is hard to disagree with the commission that VHA ought to “convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.” Achieving this, however, requires neither a whole new system of governance nor a revamped “care system.”

Recommendation #4

Here is another sensible and potentially viable recommendation: consolidating idea and innovation portals, and best practices and continuous improvement efforts, in the currently underutilized Veterans Engineering Resource Center. The commission imagines the VERC as having considerable input in properly aligning “system wide activities [that] require substantial change”– human resource management, contracting, purchasing, information technology.

Recommendation #5

Ever since President Harry Truman issued the Executive Order in 1948 that integrated the military services, the Armed Forces have been, for the most part, a meritocracy that has gradually decreased if not fully eliminated racial, ethnic, and religious disparities in assignments and promotions. As a result, veterans today are perhaps the single most diverse assemblage of Americans in the nation.

There is certain hollowness to this recommendation in that it assumes, with little empirical evidence, that significant healthcare disparities based on race and ethnicity exist in the VA healthcare system. No one will disagree that such disparities are unacceptable and must be eliminated where it might exist. The commissioners’ assumptions appear to be based, for the most part, on a 2007 document, *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*. This work, prepared by investigators with the Portland VA Medical Center for the VHA’s “Health Services Research & Development Service,” is useful, and mirrors other studies that have similar results showing disparities. This recommendation warrants universal endorsement, and points up the need for VHA to regularly monitor clinician behavior to ensure that such systematic bias is eliminated.

The VHA must make health care equity “a strategic priority,” and should “increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with

strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.” A new system of governance need not be put in place to achieve this.

However, there is need to eliminate the foolish bifurcation of the chains of command between operations and policy. This has led to too many people at the VA at the VAMC, VISN, and national level who do not deliver care directly. Those who do not engage directly in patient care need to be re-educated, and out to work directly providing medical care to veterans.

Facility and Capital Assets/Recommendation #6

The commission rightfully cites the need for “transformative changes to the VHA’s capital structure.” It notes that in many areas VA healthcare facilities are housed in aging edifices with outdated or outmoded physical plants. “VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings . . . It is critical that an objective process be established to streamline and modernize VHA facilities . . . to ensure the ideal balance of facilities” within each of the localized networks conceptualized by the commission.

The commission envisions its new governing board as the overseer that will make critical decisions “in alignment with system needs.” Moreover, here the paper tiger effect of the “Board of Directors” comes into sharp focus. Because all of this is dependent on funding, and it is the President who submits a budget based on the recommendations of the Secretary of Veterans Affairs, and it is you in Congress who add funding or cut dollars from the department’s capital budget. It is the local VA medical centers that note their construction needs. Placing a new governing board between local entities and the overall “VHA Care System” will likely have the effect of adding yet another layer of bureaucracy, with Congress remaining as arbiter of how much funding goes into what capital projects. (Think back, if you will, to the VA’s CARES program, which attempted to address this issue. To achieve its goals, \$1 billion was supposed to be requested and allocated each year over an initial period of five years. Alas, this was not to be, as fiscal restraints imposed by both the Executive branch as well as the Congress, even as we spent hundreds upon hundreds of *billions* on the wars in SE Asia, scuttled CARES.)

The commission also offers that the “facility and capital asset realignment process” be modeled after the wildly unpopular but perhaps necessary DoD Base Realignment and Closure Commission (BRAC) process “as soon as practicable.” With Congress not particularly enthusiastic about the BRAC process for eliminating outmoded or unneeded DOD facilities in CONUS and perhaps across the globe, it seems to be unlikely that legislators will embrace this concept to shutter VA facilities.

Information Technology/Recommendation #7

Here is another recommendation the basis of which cannot be challenged: “. . . VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health.” VA senior management have been grappling with IT issues for years, nudged by Congress to devise a system that allows for a “seamless transition” of medical records and information between DoD and VA, and among the trio of administrations within the VA. Achieving this interoperability, as with many other initiatives, demands mutual commitment and adequate funding, and here again this boils down to a matter of funding. Can anyone, including the legislators from both parties in this room today; forecast a scenario in which Congress abrogates its constitutional authority by ceding the power of the purse to a “board of directors”?

Supply Chain/Recommendation #8

The commission savages the ability of VHA to “modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.” The problems in this realm, the commission has concluded, are “systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization.” Because of the inadequacy of VA IT systems, the commission charges, “VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.”

The commission’s solution to this morass? Establish the position of VHA chief supply chain officer, to be compensated “relative to market factors,” the first step

in achieving “a vertically integrated business unit extending from the front line to central office.” Again, if this recommendation is embraced by Congress and VA/VHA leadership, there is no reason why it cannot be implemented under VHA’s current configuration. However, VVA is extremely skeptical of the current occupants of key positions in the VA doing anything to really “fix” problems with procurement. Their idea is to push more and more procurement onto the delegated (by the General Services Administration (GSA) authority VA federal supply schedules, claiming that this saves money. However, there is absolutely no empirical evidence for this claim. The fact that VA continues push “strategic sourcing” as an answer to most of their problems is akin to putting lipstick on the ugliest pig in the pig pen and proclaiming this “marvelous” pig is answer to all of VA’s procurement woes. In fact, the pig is still a pig, and procurement decisions at VA are still messed up.

Governance, Leadership, and Workforce

Board of Directors/Recommendation #9

Here is the crux of the commission’s report. It is based on nuggets of reality, e.g., the “short tenure of senior political appointees [and] each administration’s expectations for short-term results.” The solution proffered by the commission: “Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.”

It is not that the VA currently is so consumed by short-term considerations that it cannot look past the next election. Every few years, the VA puts out another five-year strategic plan, although these plans are little more than a waste of paper as well as hundreds of staff hours engaged in meetings and thinking through and writing up real issues and perceived goals.

The commission cites a 2015 Booz Allen Hamilton report that indicted weak governance as one of the “indirect causes” of the Phoenix VAMC wait-time “scandal.” The “gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed significantly to wait-time problems. The recommendation of the commission: the creation of an 11-member board of directors accountable to the President, “with decision-making authority to . . . set long-term strategy.” Among its responsibilities, and its powers, the board would “recommend a [C]hief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment . . . [and] be empowered to reappoint

this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions.” The recommendation goes on to note: “If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.”

Yet it is the role of the President to nominate, and the authority of the Senate to approve, the appointment of the Under Secretary for Health, the current iteration of the Commission on Care’s “chief of VHA Care System.” Would you seriously consider abrogating your responsibilities and hand over this authority to a board of directors?

Nowhere does the commission come to grips with the costs of operating such a board. Will the directors be full-time, quasi-governmental employees? On the other hand, would they have other jobs and meet on a monthly, bi-monthly, or even quarterly basis? What staff, with what capabilities, will be required to do the work of the board? What might be the costs of operating the board? Just what authority, and how much power, would the board have in hiring and firing, in disciplining workers, in setting policies and allocating funds?

In essence, Congress, and specifically the Veterans’ Affairs Committees in the House and Senate, *is* the *de facto* directors of the Department of Veterans Affairs. Creating a board of directors, even one with a limited power of the purse, is not something that the Congress or the veterans organizations or military organizations are likely to embrace. VVA, for one, rejects this idea.

Leadership/Recommendation #10

Here, the commission sees VHA healthcare leaders being “aligned at all levels of the organization in support of the cultural transformation strategy and [held] accountable for this change.” It asserts that “VHA has among the lowest scores in organizational health in government. For the past decade, VHA’s executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.” (There is no footnote citation for the source of this allegation. Nor is there an explanation of just what “cultural health” is supposed to be.) Next to the creation of a board of directors, the need for strong, sustained leadership is integral not only to the rest of the commission’s 20-year plan, but is a necessity in the current construct of the VHA as well.

Recommendation #11

No argument with the premise here, that “VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders.” The commission asserts that “VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion.”

Among its recommendations is that Congress must authorize “new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.”

Another is the establishment of “two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs.”

What the commission advocates here, and what was a key discussion point during its public meetings, is the need to attract, and to train, the best and the brightest, who would serve for a set term or the long term, and who would be recompensed according to the market in a particular catchment area. To achieve this, Congress must empower the VHA to offer competitive salaries and benefits to attract the most qualified candidates, both from within and from out of the VHA hierarchy.

Again, Congress needs to rethink compensation for medical professionals so that the VA can be competitive in hiring in specific regions of the country. Yet this can be done without introducing a whole new governance structure to VA health care, and it might actually have a salutary effect on attracting, and retaining, the clinicians needed to enable the VA to handle a growing, aging, and medically complex cohort of veterans.

Recommendation #12

Here, the commission targets the confusing model of organization that afflicts the smooth functioning of the VHA. “VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization.” The commission charges that the “responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.”

This situation, to the extent that it is an impediment to the effective functioning of the VHA on a national level as well as the operation of individual VA medical facilities, can be corrected by competent, creative, inspired leadership. It does not require the institution of a whole new system of governance, although the operations/policy split must be eliminated in order to be able to hold those in leadership positions accountable. It needs to attract, and retain, more leaders in the mold of Dr. David Shulkin, the current Under Secretary for Health; in fact, it needs to retain Dr. Shulkin himself, no matter who is elected less than 50 days from now.

The commission, however, does not recommend the scuttling of the VISNs, or the establishment of regional cohorts of VA medical centers, which the current VHA leadership appears to be contemplating. However, the commission does, to its credit, call for the establishment of “leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.” This should address a persistent problem that plagues the VHA: too often, a directive flows from the Undersecretary to VISN and VAMC leadership, but does not filter down to the clinicians and support personnel who need to be informed. A case in point: the excellent “Military Health History Pocket Card for Clinicians” rarely gets circulated to the clinicians for whom it was created and updated. Nor does it get disseminated outside the VA, to clinicians who treat the majority of veterans, yet who get some of their training in VA medical centers. Better internal communications can remedy this situation, and can be instituted if the top management at the VHA prioritizes the need for vastly improved lines of communication.

Recommendation #13

This is essentially an extension of the previous recommendation. It assumes, however, that “core metrics” for “organizational performance measurement” in the

private sector are superior to any metrics and measures used by the VA. It is rife with linguistic pabulum. Still, its objective must be acknowledged: “VHA must effectively measure outcomes and hold leaders accountable for improvement.” Too often, an ineffective or venal medical center director is transferred, or even promoted, rather than be offered the opportunity to resign, or be fired.

Diversity and Cultural Competence/Recommendation #14

The commission deserves kudos for its acknowledgment of the need for “developing the cultural and military competence of [VHA] leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans.” Practitioners in VA healthcare facilities cannot help but gain an understanding of the unique healthcare needs of their veteran patients. The commission is on target in asserting that “cultural and military competency” must be among the criteria for “credentialing” external clinicians to treat veterans.

Workforce/Recommendation #15

The commission calls for the creation of “a simple-to-administer personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.” There can be little argument that “VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century.” Hence, the recommendation that “Congress create a new alternative personnel system . . . in collaboration with union partners, employees, and managers . . . that applies to all VHA employees and falls under Title 38 authority . . . and improves flexibility to respond to market conditions relating to compensation, benefits, and recruitment.”

On one hand, this makes eminent good sense: to obtain and retain top professionals in both medical treatment and hospital administration, the VA healthcare system needs to be competitive with the incentives in the private sector. In addition, certainly, VHA’s ability to hire qualified staff cannot continue to be hamstrung by bureaucratic constraints and ineptitude. While many clinicians choose to work at the VA because of job security and protected pensions, others also feel a calling to use their skills to care for the men and women who have served the nation in uniform, many of whom have special needs derived from their wartime experiences.

On the other hand, however, Congress quite likely will be skeptical at best about setting precedent by creating an alternative personnel system. Convincing you in Congress to in effect turn the VHA into a quasi-governmental entity while continuing to fund its operations will be the ultimate hard sell. It was the wait-time access issue, a long-time reality in many VA medical centers, which raised the ire of Congress, *not* the quality of health care delivered by VAMC personnel. Integrating additional healthcare providers into the VA system, where appropriate and when needed, is part of the rejuvenation of the VHA under the current undersecretary. This makes sense.

The conceptualization of the commission to create a new entity, one in which VA and private-sector clinicians, many with similar skill sets, in essence “compete” to treat veterans will not materially improve health care for those veterans who obtain their care at a VA facility. It is likely to dramatically increase the costs of providing care; and it is likely to lead to the underutilization of certain VA medical centers and community-based outpatient clinics and the subsequent shuttering of several of them, with the consequent turmoil in staff morale and, eventually, the loss of tens of thousands of jobs. Still, the VA must resolve a situation that continues to plague it: “Hiring timelines [for medical professionals] can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.”

Recommendation #16

This, too, is more or less an extension of the previous recommendation. However, it is difficult to quibble with aligning “HR functions and processes to be consistent with best practice standards of high-performing health care systems.” You should, however, reject the underlying assumption of the commission that VA clinical staff provides less efficient, poorer quality health care than private “high-performing health care systems.”

Eligibility/Recommendation #17

Finally, a relatively radical recommendation that warrants congressional consideration: “Provide a streamlined path to eligibility for health care for those with an other-than-*honorable* discharge who have substantial honorable service.” The commission recognizes, rightfully, that some former service members in fact “have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic

brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service,” thus rendering them ineligible for VA health care and other benefits. “This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides” – care that they vitally need.

The commission recommends that “VA revise its regulations to provide *tentative* eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.” This may not be simply a matter of the VA revising regulations – Congress will need to enact legislation to enable the VA to treat these veterans – but it is an idea worthy of merit, one that the VSO and MSO communities should grab the baton and run with.

Recommendation #18

Prefacing this recommendation, the commission acknowledges that the capacity of the VA to provide care “is constrained by appropriated funding.” In its recommendation that Congress or the President charge some entity with examining the “need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria,” the commission opens the door to initiating pilot projects “for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.”

The 1996 eligibility reform act created eight “priority” groups of veterans eligible for VA health care. Priority 7 and Priority 8 veterans, who are not afflicted with service-connected conditions, must agree to a co-pay for the care and prescription drugs they receive from the VA. They account for around 40 percent of third-party collections by the VA. In addition, the Vet Centers do, as a matter of course, treat the family members of veterans, a necessity to successfully treat many of the mental health maladies suffered by the veterans they love.

To open a beleaguered health care system to non-vets seems counter-productive. In addition, it also would dilute the very essence of what should be a *veteran-centric* system. Because there is a certain specialness inherent in receiving care in a place where your service is acknowledged, where an array of conditions – traumatic amputations, spinal cord injuries, mental health afflictions – are

understood, where you are among your peers. On this, a monetary value cannot be placed.

Conclusion

The commission acknowledges the *raison d'être* for its own creation by the same act of Congress that initiated the so-called Choice Program: the issue of access. Yet it also acknowledges, "Access is not a problem for VHA alone: Delivering timely care is challenging for many civilian providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals."

The commission notes the key question with which Congress must grapple: Does the VA healthcare delivery system, despite the wait-time scandal, require "fundamental, dramatic change – change that requires new direction, new investment, and profound reengineering"? This is a question VVA and other VSOs and MSOs and veterans across the country need to consider: Can the VA, given the impetus generated by the issue of access, fix itself, or does it require a radical reformation, one that can conceivably result in its demise?

We believe that the VA, specifically the Veterans Health Administration, can fix itself and in fact *is* fixing itself, in great measure because of the impetus generated by passage of VACAA. We would hope that you in Congress would monitor what VA leadership is accomplishing; and that members of the media who cover veterans issues would focus less on dramatically highlighting the problems and more on what is being done to correct them. When the VA messes up, by all means report it and let Congress call VA leadership on the carpet. However, report, and so acknowledge, some of the good things that the VA has been doing, e.g., making what is now a cure for hepatitis C available to all veterans enrolled in the VA healthcare system. Thousands of lives are being saved, and this, too, ought to be reported.

Senators, Vietnam Veterans of America thanks you for your attention to our position and our conclusions *vis a vis* the recommendations of the Commission on Care. In addition, we thank you for all that you have done, and are doing, for veterans and our families. I would be pleased to respond to any questions you might care to put to me.

VIETNAM VETERANS OF AMERICA
Funding Statement
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The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For further information, contact:

Executive Director for Policy and Government Affairs
Vietnam Veterans of America
(301) 585-4000, extension 127

Richard F. Weidman

Richard F. (“Rick”) Weidman is Executive Director for Policy and Government Affairs on the National Staff of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo as statewide director of veterans’ employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor’s Advisory Committee on Veterans Employment & Training, the President’s Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on Veterans’ Entrepreneurship at the Small Business Administration, and numerous other advocacy posts. He currently serves as Chairman of the Task Force for Veterans’ Entrepreneurship, which has become the principal collective voice for veteran and disabled veteran small-business owners.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., 1967), and did graduate study at the University of Vermont.

He is married and has four children.