MICHAEL PARRISH, CHIEF ACQUISITION OFFICER AND PRINCIPAL EXECUTIVE DIRECTOR FOR THE DEPARTMENT OF VETERANS AFFAIRS OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION

Michael Parrish has over 37 years of senior leadership experience in military, government, corporate and nonprofit organizations. In his current role, he leads some 17,000 Department of Veterans Affairs (VA) acquisition professionals, is responsible for the procurement budget, oversees major programs and manages major construction and leasing, all in support of the largest integrated health-care system in the United States.

The VA has historically lacked the formalized structures and processes that the Department of Defense (DOD) uses for resource allocation and major acquisitions. You've worked with both agencies. What do you bring in your current position with the VA to address these challenges?

One of the biggest challenges I've had as chief acquisition officer is to apply what I call major acquisition reform. So, when I first got to the VA, there was a general perception that acquisition was just contracting. And in taking not only from my DOD experience but also my corporate experience with GE and teaching engineering management, acquisition processes are really cradle to grave, from the innovation — the original idea — all the way through to disposal or termination. The policies and processes I'm putting in place are really around the fundamental aspects of program management and acquisition: cost, schedule and performance risk. We have an obligation in federal acquisition to deliver what we promise, deliver it on time, deliver it on or under budget.

Now, having been here almost two years, one of the big changes we've made in VA acquisition is putting in a governance structure that really has enterprise visibility, transparency and jointness, so that we all have an input throughout different levels and different layers of the process while maintaining focus on our mission of delivering improved access and outcomes to our veterans. We're establishing a more formalized acquisition review process with transparent milestones and decisions. These are a lot of the fundamentals that come from Defense Acquisition University [DAU] and Defense program management in a traditional sense. But we also want to try to accelerate the processes and not make it overly bureaucratic. Generally, what we're trying to do in governance is to create an acquisition lifecycle framework that encapsulates all these concepts into a structure that is repeatable, sustainable and enforceable as we mature our acquisition systems.

Where we've overlaid a governance structure, we've also overlaid what I call the Easy-to-use, Integrated and Intelligent [EII] Doctrine. Every new process, product or program we do in the VA must be EII. It must be easy to use — where it shouldn't take an advanced degree for someone to be able to understand and learn whatever the new widget, technology or process is out of the box. It should be like our iPhones: we can figure it out on our own, you don't necessarily need to have an advanced degree or weeks of training to begin using it. Part two is the integrated approach that's applicable to all 171 different hospital systems, 200-plus cemeteries and all of the Veteran Benefits Administration. It can't be a single-thread, single-siloed solution; it needs to be a solution that applies across the VA enterprise. The third part of the doctrine is being intelligent. Intelligent in today's terms — with big data, artificial intelligence, machine learning etc. — means we should be able to have tools, systems and technologies that enable predictive analytics to help the decision maker be more efficient and more proactive, as opposed to reactive. So that's the general scope of what I've been helping to apply in the VA: easy-to-use, integrated and intelligent.

The VA is currently undertaking several large modernization initiatives simultaneously, with the added complexity that a lot of these systems are interdependent or at least interfaced with each other. You have recently pivoted towards a technology-as-a-service approach. I was wondering if you could just explain your vision for this approach?

Our biggest challenge in the VA is operating an analog bureaucracy in a digital world. We all know taking on a single big major complex system is a very difficult and challenging undertaking in itself. But the VA's not just doing one through our electronic health record modernization [EHR] effort, or not just two in terms of our financial system modernization. But now we've added on supply chain and human resources modernization.

We can no longer buy a piece of hardware that's ultimately going to be obsolete as soon as we purchase it, like a car off the lot. What we would like is technology as a service, where we're buying the services of a solutions provider, whatever it may be, and they then will have the obligation over 5, 10 or 20 years to continue to modernize and upgrade the system as necessary. These systems ought to be cloud-based, they ought to be modular plug and play and they ought to be able to meet the needs of our people, with the ultimate goal of increasing access and positive outcomes for our veterans because that's our ultimate VA mission.

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The pandemic revealed why modernization is so important going forward. We realized that the difficulties of having situational awareness or enterprise-wide visibility of things around supply chain, inventory management or visibility of health-care utilization in our data was extremely difficult. I need to give a shout-out to our 300,000 teammates across VA who did a great job performing with less-than-ideal tools and technology. Going forward, we want to make sure that we give them the best tools and best technologies available. Ultimately, that's why modernization is so critical for us: giving teammates the best-in-class tools and technology to take care of veterans.

In preparing for this interview, we've read that you're planning to pilot technology solutions in the future as part of the acquisition. What would that piloting or demonstration process look like?

I'm sure your readers realize that industry folks in IT [information technology] sales are great at generating the "pitch." They can give us shiny [Microsoft] PowerPoint presentations, which sound great and wonderful; that is until you actually test the tech and prove it in real-world practice. The intent of piloting is to find out very early if our

users will actually adopt the technology or the solution, and does that solution integrate with our current systems. We've seen challenges across DOD and elsewhere. Were the requirements correct? Is there scope creep? What we're doing is changing the game a bit inside VA around that technology-as-a-service concept to better understand what we're buying earlier in process to give the best value to the taxpayer and the best solution to our teammates.

The Promise to Address Comprehensive Toxics (PACT) Act has significantly expanded care eligibility for veterans. This could potentially strain enterprise IT systems, physical infrastructure, and human capital. From your perspective, how is the VA planning to manage the anticipated influx of veterans? How are you and your office contributing to the efforts?

The PACT Act has been one of the largest expansions of VA benefits in over 40 years. It has drastically increased the universe of eligible veterans due to presumptive conditions associated with military service. The two key areas I'm focusing on are facilities modernization and IT modernization, because both of those are necessary and needed for this influx of new veterans. VA is aggressively engaged in outreach and marketing to inform our veteran population to sign up and to be more aware of what PACT Act is all about.

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have the infrastructure in place to be able to support and care for those heroes. We're hiring more people for care delivery, IT support, benefits administration and human resources management to be able to absorb and accept that influx of veterans. Concurrently, we also need to modernize, as I mentioned earlier, our IT tools and our physical facilities to be better prepared for a larger veteran population.

The average age of a VA facility is 60 years old, with the average age of a civilian facility at approximately 16 years old. Although the AIR [Asset and Infrastructure Review] Commission was, in essence, canceled by Congress, we still have a need to make sure that these facilities are the right size and properly aligned with what I call the nomadic nature of our veteran population, who migrates across the nation after military service. Wherever they end up living, we want to make sure that we are there to give them the best benefits possible. The administration has pledged to invest in our veterans. We've asked for record increases in health-care infrastructure funding. Our job is to make sure that we invest in the right places at the right times to improve access and quality of care. The opportunities for investment include building new facilities, replacing aging facilities, conducting renovations and establishing partnerships using authorities granted in the PACT Act. We're listening to and applying feedback from our veterans, veteran service organizations, our workforce and communities to ensure decisions are well-informed. And with the continued support of the administration and Congress, we'll continue to make significant investments and improvements in our VA health system infrastructure.

Like facilities, IT modernization is a critical component of the VA as well. But as a result of the PACT Act and the anticipated increase in the claims backlog, efforts are currently being planned to include automation initiatives aimed at streamlining claims processing. IT automation will deliver feedback to claimants faster, streamlining the creation of requests for additional claims-supporting evidence and reducing the need for claims

administrators to manually create requests. The logic baked-in on that concept increases the number of claims that digital systems can fulfill and reduces the need for a manual review while maintaining accurate processing. Our vision for benefits delivery is that veterans get their benefits in minutes, not in months, where only the most complicated claims require additional human engagement in claims processing. That's our stretch goal!

Switching over to the Electronic Health Record (EHR): the Cerner EHR platform, Millennium, is largely an off-the-shelf software product based on commercial care models. One could argue you're wedging a commercial workflow into quite a different VA health-care model. If we were to step back in time and take a look at this again, what would you advise be done differently from your point of view?

The EHR business need for VA is absolutely still valid. That seamless transition from DOD to VA remains necessary. Had we applied the governance processes discussed earlier and taken a holistic enterprise view, I think we would've found a couple key things.

One is that the main mission of DOD is to fight and win our nation's wars. As you look at medical support, it's a secondary mission, whereas it's our main mission in VA. Plus, DOD has a much younger population versus the VA. And so, it's usually after the fact in an older population with additional comorbidities and other types of issues that these warriors come to the VA, which means we have different demographics, which also means we have different care processes. So, we shouldn't try to duplicate DOD's EHR solution in VA. From a health-care provider's perspective, the new EHR can feel like trying to fit a square peg into a round hole when compared to VISTA [Veterans Health Information System Technology Architecture]. We're fixing a lot of these things by working with the Oracle team closely to make sure that these variances or differences in care delivery are being corrected.

In hindsight, I think our first approach would be to outline the VA care model with Cerner and DOD to more fully understand the differences. Then, it's about involving the field in the acquisition process. I think we spent a lot of time on workflow analyses with Cerner, but less on broadly understanding user adoption challenges. And that's where some of our current game changers in VA contracting come into play. By making sure that we have all the requirements properly understood and established up front with a definition of what success looks like from the user's perspective, not from the leadership perspective, I think early implementation would have been different. At the end of the day, it's going to be the folks in the field that will be using the EHR, not program managers in Washington.

OPPORTUNITIES FOR PURCHASED CARE CONSOLIDATION IN THE DEPARTMENT OF DEFENSE AND VETERANS HEALTH ADMINISTRATION

Jamie M. Lindly

Could a single managed-care support contract across the Department of Defense (DOD) and Veterans Health Administration (VHA) improve care delivery effectiveness and efficiency for both agencies? RAND researched this question and raised several concerns about the feasibility of an integrated approach to purchased care. Among the factors that came into play were differing eligibility criteria, inconsistent care needs, and shared oversight responsibilities between DOD and VHA.

But it may be time to ask this question again given that all of DOD's treatment facilities are now under centralized management in the Defense Health Agency and, they may soon be using the same electronic health record as the Department of Veterans Affairs (VA). The new opportunities for broader population risk-sharing in service delivery models are ripe for demonstrating to the benefit of both DOD and VHA.

Opportunities for Improved Care Integration

Managed care support contractors (MCSCs) or third-party administrators (TPAs) develop networks of community providers to deliver services to eligible beneficiaries. Foundational activities include developing robust networks and encouraging community physicians to sign up, processing claims efficiently so that participating providers get reimbursed directly, and better administrating the provider-payor relationship. Having a single fee schedule with standard processes for reimbursement, managed by a single MCSC for a large geographic region, would remove overhead redundancy across both departments.

Additional efficiencies may be possible in care delivery by harnessing shared resources such as ancillary services or provider specialties currently available to one but not both systems. A single network administrator could channel patients back into the direct care system of choice or invest in resource-sharing opportunities that make sense with the larger combined population of the two agencies. If sustained and reinforced over time, such a consolidated arrangement has the potential to directly improve the long-term health of future veterans. Critics of consolidation are quick to point out that less than 20% of
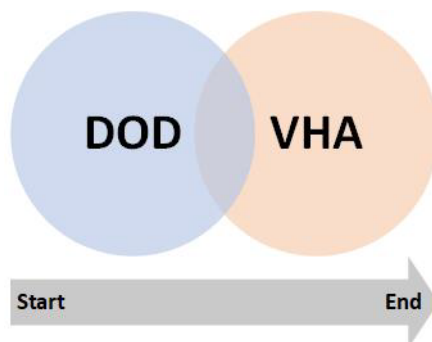
System beneficiaries over time

veterans are eligible for both VA and DOD care. What they miss is that many veterans start on active duty and eventually transition to VA care. If considered over an adult lifetime, opportunities abound for better risk pooling of preventive services and value-based care initiatives across longer periods of combined active duty and eventual veteran eligibility. Experiences on active duty, such as routine training, overseas combat operations or long-duration deployments at sea, all produce injuries, exposures or medical conditions that may not manifest while in uniform. Those experiences directly affect the level of demand for care and benefits veterans seek later in life from VHA. A single MCSC with proper health screening and incentives to promote healthy lifestyles and prevent disease could spread investment risk for such programs across a larger risk pool of beneficiaries. Further, better patient outcomes could result if these steps are taken earlier in life.

Risks

Combined DOD-VA medical facilities have been tried in the past, with mixed success. Previous federal partnership integration initiatives have been challenging because of operating disparities in patient access priorities, administrative requirements or resource allocation. Fortunately, purchased care from community providers may be a less resistant path to improving DOD-VA integration, while being mostly indistinguishable from the patient perspective.

If both departments are operating on a common EHR, network care partners should have an improved patient history regardless of where that care is provided. However, centralization of EHR functions may present risk if the operational and clinical data are held captive by a single vendor unwilling to support the myriad interfaces that will inevitably be necessary to support robust purchased-care management across both departments.

Additional risk may manifest from institutional differences that force redundancies in purchased-care administration. Would DOD and VA agree to a shared oversight and operations framework for claims processing, provider network development, reporting and customer service functions? Depending on the degree of alignment, both would stand to benefit from a single agreement by spreading costs for support functions over the larger combined population. Those cost savings erode the more each agency mandates specific administrative processes not required by the other. Benefits to both departments would be measured in how well these functions can be consolidated under a single agreement.

Lastly, funding of purchased care from two different federal appropriations may be difficult. Care referral and authorization processes would need to clearly delineate the funding source responsible to make sure reimbursements are not misapplied for beneficiaries across appropriations — not an easy task, but a critical process that would need to be strictly developed and followed in any joint claims-processing activities under a combined agreement.

Unique Opportunity to Explore the Possible

With the December 2022 award of the contract for TRICARE's West Region to TriWest Healthcare Alliance, the opportunities for exploring and piloting combined network administration have never been better. Now is the time to start examining potential operational synergies, improved care-management strategies, lifetime health improvement opportunities and purchased-care overhead efficiencies that could come to both DOD and VHA. With a single TPA now responsible for beneficiaries of both systems in a large geographic market, the demonstration opportunities to improve patient care access, quality and outcomes are primed for the taking.

COMMENTARY: APPLICATIONS OF AN "AS-A-SERVICE" APPROACH IN THE DEPARTMENT OF VETERANS AFFAIRS

Mallory B. Thompson

Pitfalls of Strategic Change

Since its inception, the Department of Veterans Affairs (VA) has continually provided a growing number of diverse services to an increasingly dynamic veteran population. With the passage of the Promise to Address Comprehensive Toxics (PACT) Act in 2022, VA now faces the single largest benefit expansion in its recent history. Today's VA is not only responsible for offering health, education,

Summary of VA benefits and services

disability, funerary, housing and financial benefits to an expanding pool of qualified veterans, but it is also challenged with managing medical facilities and modernization efforts amid the tailwinds of a global pandemic. Thus, the volume and variety of VA's management responsibilities warrant reflection. Should the VA choose to take on new responsibilities to provide more comprehensive services, or should it focus on its core strengths?

Strategic consultant and Massachusetts Institute of Technology professor Elsbeth Johnson wrote about the topic in the early 2020s. In one article, she notes that organizations can establish long-term, strategic organizational change by focusing on a few key priorities and avoiding "quick win" projects. Quick wins are only temporary solutions to long-term, complex problems. For organizations like VA that want to be a one-stop shop for their customer base, it can be easy to overcommit to a diverse project portfolio. However, by culling competing priorities, an organization can focus resources on standout services. In another article, Elsbeth discusses how quick win solutions are also tempting because they help build organizational momentum and can rapidly address pressing problems, but their impact is ultimately temporary. Choosing long-term solutions that require multiple iterations based on lessons learned from feedback loops may take longer in the short term but will have positive and lasting effects down the road. Thus, adopting an "as-a-service approach" could help VA focus on its core strengths while implementing long-lasting solutions to its ever-expanding management responsibilities. VA has already pivoted its logistics modernization program to an as-a-service approach, which could set a precedent for other VA domains, such as health IT and facilities management.

Health Information Technology: Providing Quality Care

Modern health care is increasingly complex. Digital transformation of health systems offers the promise of a suite of patient-centered improvements to the delivery of care, empowering clinicians to be more efficient and effective. However, as technology becomes integral to the doctor-patient relationship, health systems are burdened with simultaneously operating a traditional health care business in addition to an information technology (IT) business line.

Consider VA's scale. With a fiscal year (FY) 2024 budget request calling for $142 billion for medical care and $6.4 billion in IT appropriations, VA is being asked to run the nation's largest integrated health system while also running the equivalent of a mid-sized IT company. An as-a-service approach to health IT services, which could include expansions to connected care, dynamic scheduling, telehealth and telesurgery services, better equips VA to focus on its core mission of providing high-quality patient care. Recent struggles to implement VA's new Defense Medical Logistics Standard Support system should be viewed as a necessary part of the feedback loop toward a long-lasting solution, rather than an indication of system failure. Continuing to pivot this modernization effort toward an as-a-service approach would allow VA to focus on its stalwart health system and divest nonessential functions that are best managed by vendors with the operational expertise to efficiently run health IT.

Medical Facilities: Expanding Care Access

Similarly, VA can improve access to quality care by bringing VA facilities closer to the veteran communities they serve through an as-a-service approach to facilities management. Civilian health systems are undergoing a retail revolution, opening outpatient clinics where patients frequently spend time, including in malls, town centers and near shopping outlets. A similar approach within the VA system would help bring care to veterans rather than requiring that veterans — a quarter of whom live in rural areas of the U.S. — travel to use the VA system.

A comprehensive review of VA's physical footprint through the Asset and Infrastructure Realignment Commission was canceled by Congress last year. Nevertheless, over the next several decades, VA plans to close dozens of outdated medical centers and replace them with more than a hundred new clinics. The department has historically struggled to efficiently build new facilities due to leasing issues, cost overruns and time delays.

What's more, the new buildings are projected to cost $98 billion more over the next 30 years than simply maintaining the department's current infrastructure. In fact, VA's FY 2024 budget request alone included $4.1 billion to repair ten VA hospitals. Rather than continuing to build and rebuild its medical facilities, VA should look to private companies for a more efficient facilities-as-a-service model. Several private companies have adopted an as-a-service approach to facilities management, particularly for long-

term care facilities or skilled nursing facilities. The facilities provider offers turnkey flexible rental solutions, while the clinical partner (in this case, VA) provides the skilled clinical labor. This cheaper, long-term approach would not only allow maximum flexibility to changes in the veteran population but would also help VA focus on patient care.

Short-Term Housing: Homeless Veteran Access to Care

Social assistance, paired with quality, accessible health care is key to addressing veteran homelessness. Therefore, VA can better serve homeless veterans by adopting a facilities-as-a-service approach to maintain short-term housing options across the country. VA now focuses on finding permanent housing for homeless veterans; however, these efforts can delay homeless veteran access to health care and other social services. Conversely, short-term housing solutions provide homeless veterans with a stable living situation that strengthens their ability to formulate a more effective, long-term plan and eventually find permanent housing.

VA could pursue multiple as-a-service models. One model would be to contract to rapidly build or renovate and then operate short-term housing. VA could work with a community-based organizations that currently lack the ability to scale but that understand how to effectively incorporate social programs to help individuals qualify for credit and social benefits. Key to this approach is the colocation of clinical, counseling and benefit-management services along with short-term housing. This centralization of support services for veterans in need not only sets them up for long-term success but also allows VA to focus on effective veteran care rather than on facilities management.

Conclusion

VA must continue to adjust its operational strategy in order to effectively adapt to expanding department responsibilities. Current efforts among senior VA leadership already point to the applicability and effectiveness of an as-a-service approach to various VA responsibilities. By divesting some of these functions and avoiding quick-win solutions, VA can focus on its core mission: providing quality, accessible and inclusive care to veterans throughout the United States.