

**STATEMENT OF  
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DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. SENATE  
PHOENIX, ARIZONA**

**DECEMBER 14, 2015**

Good morning, Senator Sullivan, Senator McCain, and Senator Flake. Thank you for the opportunity to discuss this important topic regarding the improvement of access to and timeliness of Veterans' health care at the Phoenix VA Health Care System (PVAHCS). I am accompanied by Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health for Clinical Operations, Kathleen Fogarty, Acting Director, Veterans Integrated Service Network (VISN) 18, and Dr. Darren Deering, PVAHCS Chief of Staff.

**PVAHCS**

The Veterans Health Administration's (VHA) mission is to honor America's Veterans by providing exceptional health care that improves their health and well-being. By extension, this is also PVAHCS' mission and providing timely access to that care is critical. Access enables VHA to provide personalized, proactive, patient-driven health care; achieve measurable improvements in health outcomes; and align resources to deliver sustained value to Veterans.

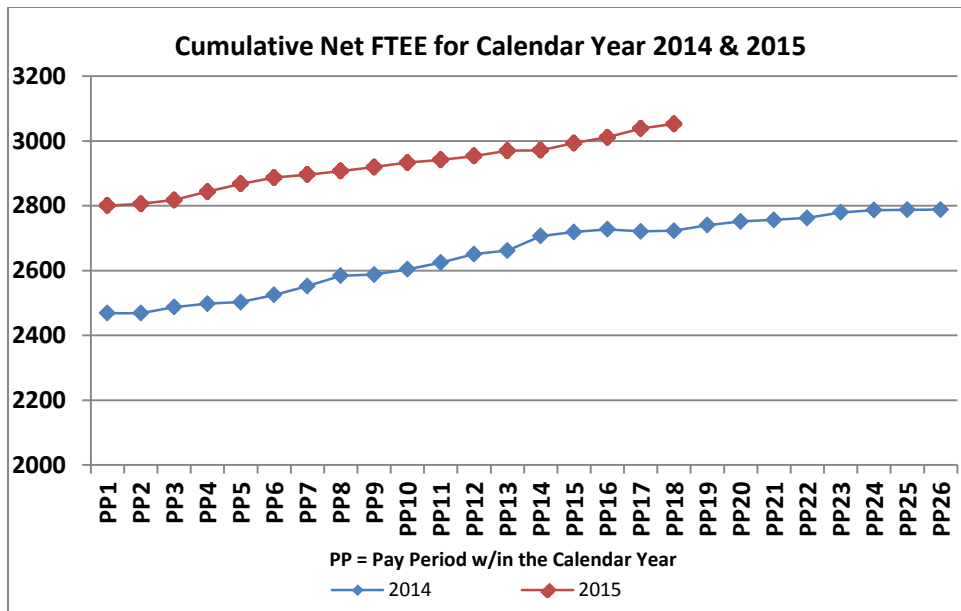
VHA has taken a number of actions in response to events in Phoenix, such as building partnerships with Care in the Community providers, reducing wait times, holding a National Stand Down, and adding over 500 employees. In November 2014, the former Medical Center Director was terminated by VA and on November 20, 2015, Ms. Deborah Amdur was appointed as the permanent Director of PVAHCS. As previously mentioned, Ms. Kathleen Fogarty serves as the Acting Director for VISN 18 while VHA continues to recruit for a new VISN Director.

VHA is continually monitoring wait times and making adjustments, as needed, to ensure that Veterans have access to the best care they rightfully deserve. During Fiscal

Year (FY) 2015, PVAHCS increased completed primary care appointments by 7.72 percent, mental health appointments by 18.38 percent, and specialty care by 15.25 percent. This means that during this period, PVAHCS completed over 680,600 outpatient appointments. Through September 2015, the contractors have created over 9,100 Choice authorizations for approximately 7,200 Veterans. Additionally, Phoenix created nearly 43,000 authorizations for Veterans to receive care in the private sector from October 1, 2014 through September 30, 2015 – a 45 percent increase in authorizations when compared to the same period in previous years. Overall, PVAHCS completed 95 percent of all patient appointments in FY 2015 within 30 days of the date the Veteran preferred and the average wait time for all patients in primary care has decreased to 6 days (as of December 7, 2015). This means that PVAHCS is serving more Veterans and providing this service when they need it.

On November 14, 2015, VA medical centers (VAMC) across the country participated in the first ever National Access Stand Down. Prior to this Access Stand Down, there were 1,650 open priority level 1 consults at PVAHCS (as of November 6, 2015). After the Access Stand Down, there were 91 priority level 1 consults that still needed to be addressed (as of November 16, 2015) and were authorized for care in the community. Although the intent of this effort was to reach those Veterans with the most urgent needs, we will not rest until we fix our system in order to better serve the health needs of those who need our help most.

PVAHCS opened a new Community-Based Outpatient Clinic (CBOC) in northeast Phoenix in May 2015. Additional CBOC locations have been identified in southwest and central Phoenix, with both activations planned for August 1, 2016, and reassigned specialty care clinic space to the second floor of the Community Living Center. Vacated space in the Ambulatory Care Center has been reallocated to primary care for additional exam rooms and future growth. PVAHCS is also improving access through extended clinic hours into evenings and weekends to leverage limited space and enhance convenience for Veterans. Designated Patient-Aligned Care Teams (PACT) perform extended hours on a rotational basis on Saturdays at the main facility and Southeast Clinic for a full shift. A limited number of PACTs also provide extended hours on Thursdays.



Since January 2014, PVAHCS has seen a net gain of 630 full time employee equivalents (FTEE), or an increase of 25.5 percent. As of October 2015, PVAHCS increased primary care staffing of physicians, nurses, and clerks by 77 additional full-time employees from April 2014 to present. PVAHCS has approximately 160 FTEE on board, who are funded through the Veterans Access, Choice, and Accountability Act (Choice Act). The graph above shows a history and foundation for sustained high-production hiring for the local Human Resource (HR) office. We are confident that PVAHCS leaders are monitoring operations closely and are in position to continue making HR improvements throughout the facility.

**Veterans Choice Program (VCP)**

Implementation of VCP, established by the Choice Act, has helped generate an 87-percent increase in the number of PVAHCS consults going out to the community for Veteran care from FY 2014 to FY 2015. PVAHCS is located in the same metro area as the TriWest Healthcare Alliance. PVAHCS has used this geographic access to develop strong working relationships with TriWest leadership and staff. As a result, PVAHCS has undertaken initiatives such as actively participating in the redesign of the TriWest Portal; enabling streamlined communication of records between the agency and vendor for all VAMCs served by TriWest; discussing potential new initiatives with TriWest to

physically locate two to three TriWest staff members within PVAHCS to address Veteran/vendor issues more promptly; and holding periodic meetings and teleconferences between the leadership and staff of PVAHCS and TriWest to address issues raised directly from Veterans.

In October, VHA delivered to Congress a plan for how VA could consolidate all purchased care programs into one New Veterans Choice Program (New VCP) to deliver care in the community more seamlessly. With the New VCP, enrolled Veterans will have greater choice and ease of use in access to health care services at VA facilities and in the community. The New VCP will clarify eligibility requirements for care in the community, build on existing infrastructure to develop a high-performing network of community providers, streamline clinical and administrative processes, and implement a continuum of care to improve coordination of services. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve Veterans' experience and access to health care. As VA continues to refine its health care delivery model and examine how the Veterans Choice Program interacts with other VA health programs, we look forward to providing more detail on how to convert the principles outlined in the New VCP Plan into an executable, fiscally-sustainable future state. In addition, we plan to receive and potentially incorporate recommendations from the Commission on Care and other stakeholders.

### **VA Office of Inspector General (OIG) Report**

In August 2014, VA OIG published its final report, "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices, the Phoenix VA Health Care System," which noted delays in care and quality of care concerns. Of the 24 recommendations, OIG agreed to close three by the time the report was published and VHA has completed action leading to OIG closure on another 15 as of November 25, 2015. Six are still in progress. We will continue to focus on rebuilding employee commitment and morale and moving forward to provide accelerated, timely access to the high-quality health care Veterans have earned—when and where they need it.

## **U.S. Government Accountability Office (GAO) Report**

In September 2014, GAO issued its report, "Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care." GAO found that VHA's management of the consult process had not ensured that Veterans always receive outpatient specialty care in a timely manner. VA concurred with all six recommendations and is taking actions to address the concerns raised by GAO. During the past year, VHA completed a national assessment of progress note completion and created technical capability to assess for incomplete consults. VHA implemented an interim consult standard operating procedure that standardizes consult management processes and developed a comprehensive compliance audit tool and protocol for robust oversight.

Additionally, VHA established business rules outlining appropriate use of cancellation and discontinuation and defined the circumstances requiring clinical determination and documentation of the reasons for discontinuation. VHA standardized the procedures for future care consults and authorized future care consults as the only approved method for managing consult requests for care intended to take place beyond 90 days from the date the consult was created. Facility level consult steering committees were established to identify and share best practices for managing consults. VHA also developed national guidance for management of patient no-shows and cancelled appointments. Solutions were implemented by extensive national consult training with all VISNs, weekly national consult best practice/training calls, and creation of a consult training module.

Although VHA has greatly increased access through more hires and expanded clinic hours, demand has also significantly increased, resulting in Veterans waiting longer for care longer than VA's wait time performance standards. As mentioned above, on November 14, 2015, VAMCs across the country participated in the first ever National Access Stand Down. A team of clinical leaders, administrators and volunteers was on site at every VAMC to reach out to all Veterans identified as having the most important and acute needs to make sure that VHA is meeting their health care needs immediately. VHA's efforts to fix access issues will continue until our system can improve the health needs of those that need our help most.

## **VA OIG Office of Healthcare Inspections (OHI) Access to Urology Report**

On October 15, 2015, VA OIG's Office of Healthcare Inspections (OHI) delivered its evaluation of access to care concerns in the Urology Service at PVAHCS. OHI determined that PVAHCS suffered a significant urology staffing shortage, and its leaders did not have a plan to provide urological services during the shortage of providers in the Urology Service. To fill this need, VHA has hired six Urology employees since January 2013.

OHI also determined that non-VA providers' clinical documents were not consistently available for PVAHCS providers to review in a timely manner. OHI concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to these Care in the Community clinical records. Even in the event that further recommendations were not needed, or there were no critical findings, this disconnect between the referring provider and the specialist compromised the overall management of the patient.

OHI also concluded that PVAHCS Urology Service and non-VA Care Coordination staff did not provide timely care or ensure that timely urological services were provided to patients needing the care. OHI identified 12 patients who experienced significant issues that may have affected their clinical outcomes. Two were quality of care issues and the other 10 were wait time issues. Such delays placed patients at unnecessary risk for adverse outcomes. Of these, VHA conducted further reviews and found eight requiring institutional disclosure, six of which are already complete.

VHA concurred with all three of OHI's recommendations and provided acceptable improvement plans. To address OHI's recommendation that PVAHCS ensures that resources are in place to deliver timely urologic care to patients, the facility has hired additional staff to provide urologic care. Currently, PVAHCS has a Chief of Urology, two full-time urologists, and one part-time urologist, a nurse practitioner, and three physician's assistants. Recruitment continues for another staff urologist, which is the only unfilled position in Urology Service. According to data on PVAHCS as of December 7<sup>th</sup>, the Urology Service has no patients waiting on an Electronic Wait List (EWL); 3 consults aged greater than 90 days (all with scheduled appointments); and 99 percent of new patients are seen within 30 days. Appointment volume doubled from the

previous year while the average wait time from preferred date was at 3days – 8 days lower than it was 1 year ago. Urgent appointments are available within 1 day.

To address OHI's recommendation that PVAHCS ensure that Care in the Community providers' clinical documentation is available in the electronic health records in a timely manner for PVAHCS providers to review, PVAHCS meets with TriWest leadership on a monthly basis to improve communication and assess the timely availability of records. PVAHCS developed a system by which patient records are downloaded from the TriWest portal on a daily basis. As the patient records are taken from the TriWest portal, they are placed in a facility folder where they are uploaded to Document Manager and linked to complete the Care in the Community consult in the Computerized Patient Record System (CPRS) in portable document format (pdf). The completion of the consult notifies the Ordering Provider automatically via CPRS Alert that the non-VA care consult results are available. All TriWest non-VA care providers are obligated by contract to provide medical records within 14 days. TriWest is obligated by contract to load those records into the portal within 48 hours of receipt so VA staff can retrieve the information.

To address OHI's final recommendation of ensuring that the cases identified in this report are reviewed and for patients who suffered adverse outcomes and poor quality of care, PVAHCS conducted in-depth quality of care reviews of the 12 identified cases and determined that 8 protected peer reviews and 8 institutional disclosures were warranted. Additionally, external reviews are being conducted to validate these findings.

### **Human Resources Restoration and Revitalization (HR3) Site Evaluation Report**

As part of the HR3 Report, VA conducted a needs assessment for the PVAHCS human resources (HR) team, and the resulting report focused on 65 actions needed for improvement. The most notable finding of the assessment was the poor state of the office culture which was having a negative impact upon HR operations, ultimately impacting their core mission of hiring those who could provide access to care. Action plans were developed and implemented locally which provided a framework for PVAHCS HR operations.

## **MyVA**

At the enterprise level, the work that is underway to transform VHA operations also supports an effective response to past events in Phoenix. MyVA is our transformation from VA's past way of doing business to one that puts Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider. It will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. The MyVA vision provides a seamless, unified Veteran experience across the entire organization throughout the country.

One of the five pillars of MyVA is improving the Veteran's experience. At a bare minimum, every contact between Veterans and VA should be predictable, consistent, and easy. But we are aiming to make each touch point exceptional. This means that Veterans should be able to make appointments for timely treatment. Events such as the National Stand Down and practices such as extended care hours improve the accessibility of health care in Phoenix and the Veteran's experience.

Another of the five pillars is to enhance strategic partnerships that will allow us to extend the reach of services available for Veterans and their families. We are making it easier for Federal, state, and local government, as well as private sector organizations, to partner with VA by standardizing our partnership processes. This improves health care for enrolled Phoenix Veterans by making it easier for a Veteran to access Care in the Community, when VA care is inconvenient or unavailable.

## **Conclusion**

VA is committed to providing the highest quality care our Veterans have earned and deserve. Our work to effectively and timely treat Veterans continues to be a top priority at PVAHCS and throughout VHA. We appreciate Congress' support and look forward to responding to any questions you may have.