Opening Statement of Ranking Member Burr

Veterans' Affairs Committee Hearing

The State of VA Health Care

July 16,2014

Good morning, Mr. Chairman. I would like to welcome and thank Acting Secretary Gibson for being here. Today, the Committee is holding a second hearing on the state of VA healthcare.

Since our last hearing, there have been several developments related to the scheduling irregularities across the Veterans Health Administration and its negative impact on patient care. VA has begun to take the necessary steps to address the systemic problems and the "corrosive culture" that has been identified and substantiated by several independent sources. However, these changes will not happen overnight and this Committee must provide the critical oversight to ensure these changes occur and are effective.

Even with the steps VA has taken to improve access for many veterans, there will continue to be reports and allegations regarding VA healthcare. These reports will not only to highlight critical areas of needed reform, but identify the magnitude and breadth of the systemic issues facing VA. The ongoing internal evaluation by VA, as well as investigations currently being conducted by the Office of Special Counsel and VA's Office of Inspector General, are essential to rebuilding not only veterans' trust, but also the trust of stakeholders and employees.

To undertake the needed reforms within VA, the role of the Office of Special Counsel and the IG are even more crucial now than ever before. Both offices have been essential in identifying

systemic issues facing VA; I would like to highlight a few critical reports that have been released since the last hearing.

At the time of the May 15th hearing, there were several stakeholders who did not want to rush to judgment until the allegations surrounding Phoenix had been substantiated. Since that hearing, the IG released an interim report regarding the allegations of scheduling irregularities and a secret wait list at the Phoenix VA Healthcare System.

Not only did the IG substantiate scheduling irregularities and a secret wait list at Phoenix, but the IG identified roughly 1,700 veterans that were waiting for appointments and were not included on appropriate electronic wait lists. The IG found that scheduling irregularities are a systemic issue across VA's healthcare system and this was not an isolated event.

Additionally, the IG has received numerous allegations regarding (quote) "mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior- level managers at this facility." These allegations speak to the corrosive culture that has taken deep roots throughout the entire Department.

Within a 3 week period, the Office of Special Counsel released a statement on VA whistleblower reprisals and sent a letter to the President regarding VA's lack of responsiveness to OSC requests. In this letter, the OSC describes the Office of Medical Inspector's consistent use of (quote) "a 'harmless error' defense, where the Department acknowledges problems but claims patient care is unaffected."

The letter details ten cases of egregious patient care provided by VA facilities in which the OMI substantiates error in patient care but dismisses potential patient harm. In one case, two veterans who were admitted to an inpatient mental health ward at the Brockton VA facility didn't receive comprehensive evaluations for more than seven years after being admitted to the

facility. Another case in the letter describes how a pulmonologist copied previous provider notes in more than 1,200 patient medical records instead of recording current readings for these patients.

I want to be crystal clear; the culture that has developed at VA and the lack of management and accountability is simply reprehensible. And it will no longer be tolerated. Secretary Gibson, you have taken several actionable steps in the last month and a half. I commend the work you have done; however, what has happened over the course of years is a horrendous blemish on VA's reputation. And much more work will be needed to repair the damage.

As VA continues to move forward in improving veterans' access to care and changing the culture that has taken deep roots within the Department, this Committee has a lot of work to do. The Committee needs to take an active, vigorous oversight role to ensure the problems that have been identified over the last several months are effectively and appropriately addressed, and they aren't allowed to happen again.

I thank the chair, and I yield back.