

# THE STATE OF VA HEALTH CARE

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## HEARING

BEFORE THE

### COMMITTEE ON VETERANS' AFFAIRS

### UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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SEPTEMBER 9, 2014

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## THE STATE OF VA HEALTH CARE

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TUESDAY, SEPTEMBER 9, 2014

U.S. SENATE,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, DC.*

The Committee met, pursuant to notice, at 10:02 a.m., in room SH-216, Hart Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders, Murray, Tester, Begich, Blumenthal, Hirono, Burr, Johanns, Moran, Boozman, and Heller.

### OPENING STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Chairman SANDERS. Good morning and welcome to what I believe will be an important and productive hearing. Today we will be discussing some of the very serious issues facing the Department of Veterans Affairs on the heels of the Inspector General's findings related to long wait times and poor patient care at the Phoenix VA.

The IG's report provides troubling details about a facility that failed to meet our Nation's obligation to provide timely, high-quality care to veterans. What happened in Phoenix is inexcusable and must never happen again at any VA facility.

I was especially disappointed to learn the extent to which Phoenix VA executives and senior clinical staff knew about inappropriate scheduling practices.

In a telling exchange, when asked by a physician in Hawaii to share best practices about how the Phoenix VA had presumably been able to reduce its patient wait time from 238 days down to 7 days—quite a feat—the chief of primary care e-mailed one of his fellow colleagues in Phoenix and stated, “Wonderful. Not sure how to answer this. Can I just say, ‘smoke and mirrors?’” And, of course, that is what it was. It was all smoke and mirrors.

The people who lied, who acted dishonorably, who manipulated data in Phoenix and elsewhere clearly must be held accountable. The endemic nature of this problem, as identified by the IG, cannot be tolerated.

The IG's report detailed numerous cases of poor patient care. In fact, several of those cases raise serious concerns about two of Phoenix's specialty care clinics. Reviews of patient files found problems with continuity of mental health care, delays in assignment to a dedicated psychiatrist or mental health nurse practitioner, and limited access to psychotherapy.

Additionally, the IG also discovered the urology department struggled to provide timely care. In fact, the IG has launched a separate investigation into this service. A report regarding the findings will be released in due course.

While the results in the IG's report paints a troublesome picture, the IG was "unable to conclusively assert" that patients died because of long wait times, as news media reports had speculated.

I also understand, as a result of the attention focused on Phoenix, the IG has opened additional investigations at 93 sites of care as a result of receiving approximately 445 allegations regarding manipulated wait times at other VA facilities. This Committee will continue to monitor the results of these investigations and use this information to inform the Committee's oversight efforts in the future.

Like most Americans, I have concerns about the inability of veterans in various locations across the country to access care in a reasonable period of time. I will not go through all of the data, but the bottom line is that the reports worked on by VA and the work done by the IG tells us that tens of thousands of veterans were unable to get the care they needed in a timely manner.

What I hope we will learn today from our new Secretary, Mr. McDonald, and the ideas of the Inspector General, Mr. Griffin, is, in fact, how that problem developed. I do not believe that anybody joins VA in order to manipulate data. How did it happen? What were the causes? How do we make sure this never happens again? What do we do? And how quickly do we get rid of dishonorable employees? We gave the new Secretary tools. We will want to hear how he is utilizing those tools.

Maybe most importantly, we want to learn how we go forward into the future to make sure these problems never occur again.

I noticed in the paper yesterday the Secretary held a press conference talking about—and I want to discuss it with him—his need to aggressively go out and bring new physicians, new nurses, new medical personnel into VA so we do not have these wait times again. And during this hearing, I look forward also to talking with our new Secretary about how he is going to implement the legislation that was recently passed.

So, there is a lot to go over in this hearing. We thank the Secretary for being with us. We thank the Inspector General for being with us as well.

Senator Burr.

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,  
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Well, good morning, Mr. Chairman. I would like to welcome to Secretary McDonald and Acting Inspector General Griffin, and I thank them for being here, as well as the other witnesses for today.

Today the Committee is holding another hearing on the state of health care within VA, specifically focusing on the final IG report released last month as it relates to Phoenix. And when I say "final," Mr. Griffin, I realize that there are many more yet to come, and this will be absolutely crucial to the agency's ability to continue to get a handle on the problems.

Since our last hearing on the state of VA health care, Congress has moved forward with historic legislation that will improve access to health care to veterans across the Nation, which was signed into law in August. This legislation is a first step in providing veterans with the ability to choose where they receive care if VA is unable to provide care within a timely manner or if they live greater than 40 miles from a VA facility.

While this is an essential first step in addressing the systemic issues facing the Department of Veterans Affairs, there is still much more work to be done. The work of this Committee has just begun. As we move forward, it will be crucial for this Committee to conduct aggressive oversight to ensure that veterans are able to receive the health care they need and, more importantly, that they deserve.

The IG report is instructive because it demonstrates critical breakdowns in the system that allowed systemic issues to take root not only in Phoenix but throughout the entire VA system. I would like to highlight two specific issues that were identified in the final IG report on Phoenix.

First, the IG report describes the care received by 45 veterans who faced either clinically significant delays in care or questionable care from the Phoenix facility. Additionally, the IG reviewed 77 suicides that occurred between January 2012 and May 2014 and found that nine veterans experienced a delay in care. One veteran experienced a clinically significant delay, and five veterans experienced other substandard quality of care.

Many veterans experiences obstacles while trying to establish needed care after hospitalization or being treated in the emergency room. The lack of follow-up, coordination, quality, and continuity of care that many of these veterans experienced is troubling and, quite frankly, unacceptable.

Second, the most troubling issue described in the report was VA's awareness of the ongoing scheduling challenges that many facilities faced. Furthermore, VA had opportunities to address the systemic culture of inappropriate scheduling practices. VA did not act to address inappropriate scheduling practices or manipulation of wait-time data. This lack of accountability was further ingrained by VA's decision to waive the fiscal year 2013 annual requirement for facility directors to certify compliance with VA scheduling directives. Why would the requirement be waived when VA knew that there were questions scheduling practices occurring within medical facilities?

The magnitude of scheduling irregularities is demonstrated by the roughly 225 allegations at the Phoenix Health Care System and the more than 445 similar allegations at VA facilities across the Nation that the IG has received through numerous sources, including the IG hotline, Members of Congress, employees, veterans, and their families. Currently the IG is actively investigating 93 sites, as the Chairman stated.

In the coming weeks, months, and years, VA will continue to take swift and firm action to dismantle the corrosive culture that has taken hold within the VA and make sure it is not able to resurface. No matter what steps VA takes to address the challenges it faces delivering health care, VA will not be able to move forward

if this corrosive culture is not effectively addressed. I have said this before but I want to reiterate that the culture that has developed at VA and the lack of management and accountability is simply reprehensible.

I commend the work that has been done over the last several months; however, there is much more work to be done to repair veterans' trust in the system. I look forward to working with you, Mr. Secretary, as this Committee works on implementing and passing legislation that is needed for you to accomplish what I believe is a very significant reform pathway for veterans and for the VA itself.

I thank the Chair.

Chairman SANDERS. Thank you, Senator Burr.

Senator Tester.

**STATEMENT OF HON. JON TESTER,  
U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Chairman Sanders. I will be brief.

First of all, great to have you here Secretary McDonald, your first appearance in front of this Committee as the confirmed Secretary for the VA. Thank you for being here. I know the last 6 weeks have been busy for you, and hopefully productive.

The IG, thank you folks for what you have done. Thank you for what you are going to do. Thank you for the recommendations that you are putting forth. I think these are critically important for the VA and for us as we look to improve the VA.

We passed an important bill before we left for the August recess. That important bill was signed by the President. I agree with the Ranking Member, it is a first step. And I hope it is not a first step to privatize the VA. I hope it is a first step to make the VA stronger so that it can give the services to our veterans that they have earned.

With that, I look forward to your testimony and look forward to the opportunity to question you on that testimony as we move forward.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Tester.

Senator Johanns.

**STATEMENT OF HON. MIKE JOHANNNS,  
U.S. SENATOR FROM NEBRASKA**

Senator JOHANNNS. Thank you, Mr. Chairman. Mr. Chairman and Ranking Member Burr, let me just start out by saying thank you for convening what I also believe will be a very important hearing today.

I also want to express my appreciation to Mr. Griffin and your staff for being here today to hopefully offer some insight into the issues that we are looking at.

Mr. Secretary, I also welcome you. It is good to have you on board. You have taken over during a difficult time, but your body of experience I think is going to serve our Nation well. I do want to say I thank you for taking swift action. I hope there is more to come.



The Inspector General report we are here to discuss today has confirmed disturbing allegations about secret wait lists and barriers to health care for our veterans. It is amazing to learn of widespread examples of failures and outright coverup by VA employees. At present, if I have this right, there are 93 other sites where care is provided that are under investigation. That is amazing to me. That is a remarkable number.

I am pleased to see that the VA agreed with all 24 recommendations that were made by the Office of Inspector General. My hope is that VA's plans to address the recommendations are not empty words, that there will be follow-through on what they have agreed to. Without the recommended changes, reports of mismanagement, fraud, and substandard care at the VA will continue.

While tackling the issues identified in the report, the VA must also keep in mind other important initiatives. The VA must work quickly to implement the Veterans Access, Choice, and Accountability Act that was signed into law. The Choice Card provision is critical to our Nation's veterans to allow them the freedom to seek care outside of the VA if they choose to when it is needed. Other programs that ensure VA has the space to provide quality care to our veterans are also critical, programs for construction of State veterans homes and medical centers, just to name a few.

As I mentioned in this Committee many times, the VA construction backlog should be a major concern to all of us. We just simply have to find a solution to replace 1950s-era hospitals—we have one in our State—and ensure that these priorities are not lost in the shuffle.

Again, I look forward to hearing how the VA intends to repair the damage that has been done by this scandal to regain the trust and confidence not only of Congress but, more importantly, our Nation's veterans and their families.

Mr. Chairman, again, thank you. I yield back.

Chairman SANDERS. Thank you very much.

Senator Hirono.

**STATEMENT OF HON. MAZIE HIRONO,  
U.S. SENATOR FROM HAWAII**

Senator HIRONO. Thank you, Mr. Chairman.

Secretary McDonald and Acting Inspector General Griffin, thank you very much for being here with us this morning.

The revelations over wait times at the Department of Veterans Affairs and other systemic problems at the VA have severely shaken the trust that veterans, their families, and the general public should have in the VA health care system. Over the last decade, we have sent over 2 million men and women to fight the wars in Iraq and Afghanistan, and some of the problems that we see in the VA are due to shortcomings in three major areas, as I see it:

First, ensuring that veterans are aware of and receive access to VA health care and other services that the VA provides;

Second, Congress providing sufficient resources, effective oversight, and ensuring accountability for the VA; and

Third, improving the transition from military service to civilian life.

I realize that today we are focusing once again on the veterans health care system. To provide effective oversight and accountability, in May of this year, this Committee convened its first hearing in response to the allegations of wait-time irregularities at VA. And in response to testimony from that first hearing and other hearings in this Committee, the Veterans Access, Choice, and Accountability Act of 2014 was passed. Once again, I want to commend the Chair for his efforts in getting this law enacted.

Our goal in passing this legislation was to provide VA with the tools needed to address the serious problems veterans were facing in accessing care, and this law not only granted the VA money to build internal capacity in the form of additional hiring, but also provided the VA the authority to lean upon the private provider community to ensure timely access to quality care. And I am sure, Secretary McDonald, you will tell us how you are implementing that part of the new law.

During the August recess, I held a field hearing on the State of VA health care in Hawaii, and during that hearing I heard from veterans in my State, local VA staff, and Washington-based VA staff on what they were doing to improve veterans' experience with the VA. The lack of providers was a common refrain heard throughout the hearing. The VA must do more to recruit and retain high-quality health care professionals within the VA system.

You know that the veterans are a unique patient population with specific needs. But based on my field hearing and the previous hearings this Committee held this past summer, the Inspector General's findings in his final report were not a surprise. We know that problems relating to patient wait times at the VA have been reported by the IG since at least 2005, without major action by the VA until this year.

VA granted medical facility directors waivers in certifying compliance with VA's scheduling directive regarding wait times. While Congress for its part has continued to increase VA's budget, clearly congressional oversight is critical, as is VA's efforts to increase accountability within its system.

For example, the lack of national standardization in procedures and practices, while not in itself troubling, has led to this decentralized control, leading to a broad avoidance of accountability within the VA system.

I look forward to working with my colleagues, the Inspector General, and Secretary McDonald in ensuring that we make the appropriate improvements. Thank you.

Chairman SANDERS. Senator Hirono, thank you very much.  
Senator Heller.

**STATEMENT OF HON. DEAN HELLER,  
U.S. SENATOR FROM NEVADA**

Senator HELLER. Thank you, Mr. Chairman, and also to the Ranking Member for holding this hearing today. I want to thank the Secretary and also Mr. Griffin for being here today. Thank you for taking time and updating us.

In the many times we have met in my office and in this Committee and in Reno just a few weeks ago, Secretary McDonald has

showed he is committed to bringing a new vision and reforms to the VA to better serve Nevada and the Nation's veterans.

But the task ahead will be VA's most difficult challenge after having failed our veterans in delivering quality health care and timely benefits. The gross mismanagement, poor treatment of veterans, long delays revealed in Phoenix and elsewhere have shocked Congress and our Nation and is a significant crisis to overcome. My hope is that the Secretary's goals will not get lost in the bureaucracy, and I expect consistent communication and honesty about what the VA needs from Congress to restore faith in the VA and achieve the best care possible for our veterans.

Just last week, I had the privilege to meet with our veterans in Pahrump, NV. In the past 15 years, Pahrump has grown from a small town outside Las Vegas to a community of 36,000. In Pahrump and all of Nye County, there are about 9,000 veterans, which is why this community has fought long and hard for a larger VA clinic as more veterans flock to this community.

When visiting, I told them about the promise that I made to you, Mr. Secretary, when we first met, and that was that every time I see you, I will always bring up several key issues to Nevada veterans, of course, building the VA clinic in Pahrump, improving the Las Vegas VA hospital, and eliminating the disability claims backlog that we have in Reno.

Bob, you deserve credit for quickly approving the Pahrump clinic as soon as you were confirmed, and I also appreciate Director Duff and Associate Director Caron for working closely with my office to keep me informed.

But there is a lot of work to be done on this clinic. A contract must be awarded, the clinic must be constructed, and then it must be fully staffed. I will be looking closely at each of these steps to determine if there are unnecessary bureaucratic barriers that delay projects like this and will hold the VA accountable.

I also hope to see improvements in the Las Vegas VA hospital. There have been discussions about how to do this, and I would like to share a few key improvements that I think need to be made.

First, members of the Disabled American Veterans in Nevada want to improve transportation of rural veterans to this hospital. Right now DAV, Disabled American Veterans, have a transportation program, but they are not allowed to take veterans confined to a wheelchair. Now, stop and think about that for a minute. DAV, their transportation program is forbidden to take veterans confined to a wheelchair or utilizing an oxygen tank to the hospital. There needs to be greater partnership and coordination with the VA to expand the VA's own transportation service for these disabled veterans in rural areas.

Second, appointment wait times in the Vegas hospital must be improved. New patients in Vegas wait 25 days on average for specialty care appointments and 16 days on average for mental health appointments. Director Duff has assured me her team is working to improve these wait times, and part of this improvement will be an enhanced scheduling system the VA is currently seeking. Every VA hospital needs modern processes and technology that will give directors the information they need to determine where resources are missing.

Next, a point that the Secretary has brought up to me is the differences in regions and management structure among the three VA Administrations—Health Care, Benefits, and Cemeteries. I look forward to working with you to improve the current structure and believe that reorganizing these Administrations should be a positive step forward to enhanced coordination and improved care to our veterans.

And, finally, I remain committed to addressing the VA disability claims backlog. For years now, Nevada is the worst in the Nation with claims being completed in 334 days on average. As co-chair of the VA Backlog Working Group, I will be hosting a roundtable later today, along with Senator Casey, to discuss the need to overhaul the outdated claims processing system; I believe there is no better time to reform the claims process as while the VA transforms under Secretary McDonald's leadership. And the working group's legislation is a strong platform for some of the changes that need to be made. I look forward to hearing more about the changes and progress of improving care and benefits at the VA. Again, I thank you, Mr. Secretary and Inspector General Griffin, for being with us today.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Heller.

Senator Blumenthal.

**STATEMENT OF HON. RICHARD BLUMENTHAL,  
U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you and the Ranking Member, as well, for holding this hearing today. Thank you to Secretary McDonald and Inspector General Griffin. We are here to listen to you, not so much to talk, but even more important is that we listen to our veterans across the country who have firsthand experience beyond the Inspector General reports, beyond the polling, beyond the hearings that we conduct here.

I had a town hall meeting in Newington last Friday night for a couple of hours and welcomed William Streitberger, the Director of the Hartford VA Regional Office, as well as Gerald Culliton, the Director of the VA Connecticut Health Care System, to listen to our veterans, and not just about the delays but the more fundamental gaps in care that we have right now that we are all working hard to fill.

Just one example, K. Robert Louis, a veterans service officer from the Veterans of Foreign Wars, shared with the audience very compellingly his understanding that many veterans with the VFW have received outstanding service, but that there is a lack of providers—nurses, doctors, staff—that has caused the delays and hindered veterans' access to care.

I know that the Veterans Access to Care Act authorized \$5 billion to enable the VA to hire additional health care providers and clinical staff, but, Secretary McDonald, you have identified the practical obstacles to meeting the needs and hiring more doctors and other professionals, and that is one of the central challenges of our time. And I hope that this Committee will play a constructive role in that task and so many others that face you in this very challenging time, as well as rebuilding the facilities, the infrastruc-

ture, as at the West Haven hospital, where not just renovation but rebuilding are necessary to replace a 1950s structure that cannot accommodate the most modern technology, the equipment that is necessary to care for people in 21st century fashion.

I want to say that I hope that we will continue to be of a mind that this health care system is in crisis. I know that “crisis” is an overused word in Washington, but it should give us the impetus and sense of urgency that we all feel as to the need, the immediate need, because health care delayed is health care denied. People need it now when they need it.

So, Mr. Secretary, I want to thank you for your determination and the management experience that you will bring to this task.

Finally, we all know that we are going to see a surge of veterans coming out of our military in the next months and years as the Army and the Marine Corps downsize. Many of them will have the horrific invisible wounds of war that we now have diagnosed as Post Traumatic Stress or Traumatic Brain Injury.

I want to thank the VA for its support in efforts that I and others have made to correct the records of veterans of past wars at times when Post Traumatic Stress was undiagnosed and untreated and caused many of them, particularly from the Vietnam era, to be given less than honorable discharges. Those bad-paper discharges have been a stigma and a black mark on their records, and caused many of them to be homeless and jobless. I want to thank Secretary Hagel for now initiating a new era when those records can be corrected.

At our side, as we sought this change in policy, was the VA, and most especially General Shinseki, who served in that war. I want to thank all of the dedicated men and women of the VA for their service in so many ways, most especially in the help that they provided to initiate this change in policy. And, thank you to Secretary Hagel for his awareness and his courage in taking this very, very important step to give honor and respect to veterans who were unfairly treated when they received less than honorable discharges, when they suffered from Post Traumatic Stress that led to those kinds of discharges.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Blumenthal.  
Senator Moran.

**STATEMENT OF HON. JERRY MORAN,  
U.S. SENATOR FROM KANSAS**

Senator MORAN. Mr. Chairman, thank you. Thank you to you and Senator Burr for having this hearing. Secretary McDonald, thank you for your presence but, more importantly, thank you for your willingness to serve. I hope that you will hit the ground running. I hope that you utilize your tenure as the Secretary to make remarkable improvements at the Department of Veterans Affairs on behalf of America’s veterans.

I hope to explore with you during my time of questioning a couple of things, in particular—with you and the Inspector General, I would like to hear about what the consequences to employees at the VA have been as a result of their misconduct. Are those currently on leave, on leave with pay, or without compensation? And

has anyone been discharged or is there a plan to discharge anyone as a result of what has occurred at Phoenix or elsewhere within the Department of Veterans Affairs?

In the broader sense of the legislation that we have passed, my understanding is—and I think I know this sufficiently well to say this—that many of the authorities that are given the VA, in fact, directives given to you in the Veterans Act, are already things that you have the ability in your discretion to do related to providing care outside of VA. I would love to hear about what is transpiring now as we wait for the implementation of this Act. How are we caring for veterans who are, either through lack of timeliness or geography, having difficulty accessing veterans' medical services? In particular, I would like to hear how you intend to utilize ARCH, the pilot program in the five States across the country. And the authorities given to you in the new legislation allow you to not only extend that program but to expand that program. So, I would like to make certain there is nothing that stands in the way of either one of those things happening from the VA's perspective, and to make certain that that Program ARCH is used while we are transitioning the authorities given you in the legislation.

A couple of examples where this hits home. A gentleman in Smith Center, KS, who needed a colonoscopy, was told he needed to drive 4 hours to Wichita to do that. The VA, upon our prodding, changed their mind and allowed for this service to occur near home. He apparently qualified because of the issue of timeliness, not because of geography.

Another veteran who has to have cortisone shots is told by the VA he must drive 3½ hours to the VA. Apparently he does not qualify for the lack of timeliness and, therefore, he ought to qualify, in my view, for geography. But, again, the VA has said no. So, how we implement this act in regard to timeliness and geography and what authorities you have in the interim to make certain that no one falls through the cracks while we wait is of great importance.

It has been discouraging to me on the one hand and impressive on the other, the significant changes that have been made at the VA. The discouraging part is if you could react this quickly and accomplish what has been accomplished in the last month or so, why was it not being done in the first place? If we can come up with ways to solve the problems of how we get veterans in to see a physician and be treated, why was it not occurring all along when you have been able to accomplish so much in a short amount of time?

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Moran.

Senator Begich.

**STATEMENT OF HON. MARK BEGICH,  
U.S. SENATOR FROM ALASKA**

Senator BEGICH. Thank you, Mr. Chairman. Thank you for holding this hearing. Secretary McDonald, thank you very much for our meetings and conversations we have had, and for the IG being here also.

Let me just say a couple things. First, I am very glad that the piece of legislation passed, as it did a month or so ago, but the reality is, as we know—and I guess for Senator Moran, in Alaska, we

have been doing this for 3-plus years. We dragged the Obama administration along, but they now understand, and we have been doing it for 3 years. We deliver health care to 30 different tribes around the State through our Indian Health Services program, which is administered by Alaska tribes, delivering health care to veterans, both native and non-native, no matter where they live. It does not matter if you are living up in Nome or you are living all the way down in Ketchikan. We can deliver care if the veteran so chooses, with the existing rules. And it was not easy. There was a little bit of back-and-forth between the VA and the Health and Human Services Department to get them to understand that this is about delivering care with the same tax dollars. It does not matter who was spending it. It was coming from the same kitty that we have to allocate.

So, from my perspective, you know, I am anxious to see how and what you will do with these recommendations, but the reality is—and to be very frank, I am sure, Mr. Secretary, you would prefer not to keep coming to meetings like this but to actually go do the work that needs to be done. And I am glad we are doing oversight. It is important to make sure that you, the administration you are now in charge of, the Obama administration, all of them are focused on this issue of delivering health care at the greatest level possible.

But I think we have some great examples already that exist that we could utilize as I gave for Alaska. For example, in Anchorage, which is 43 percent of the State's population, you can go to the VA clinic or you have a choice. You can go to the Anchorage Neighborhood Health Services clinic or the Alaska Native hospital. And in those two facilities, those last two I mentioned, if you are on the list, you get in the same day, as long as it is not major medical. That is an amazing step. We did that before this new piece of legislation.

To be very frank with you, I am not sure what some did in their own States. I know what I did. I had to pound away on the VA, because I remember my first memo I put out on this idea, within 6 months after coming into office; they said it cannot be done, not possible, unrealistic, it is two different agencies. I remember the long laundry list that I got, both from the agency and veterans organizations. Nonetheless, we just pushed the pedal down all the way, because I think they just spelled "yes" wrong. They spelled it "N O." We just had to work on it. The end result is today we are delivering care all across the State of Alaska, which is one-fifth the size in mass, of this country. So, if we can do it there, we can do it anywhere. I think in a lot of ways, the piece of legislation we passed only re-emphasizes what can be done, plus we gave more money.

The challenge you are going to have is making sure we have enough professionals. As we know, in Alaska, the Matanuska Valley, the Mat-Su area, had a problem, still has a problem recruiting primary care doctors. That is going to be a problem not only in the VA system, but in the Indian Health Services, the private sector, and you name it, it is a problem everywhere. But what did we do there? Again, we used a tribal agreement to use South-Central clin-

ic to admit almost 500 veterans for care, because we had access and capacity there.

So, as you look at how to solve this problem and continue to move forward, look at the assets that are out there. I do believe, as proven before this legislation passed, we have the authority, you have the authority, you have the capacity to push the pedal all the way down. The VA, the Obama administration, can make these things happen if they want. So, I think what we are saying here today is we are glad the bill passed, we are glad we are having oversight, but just go do it. Make it happen. And then when there are problems and challenges, you need to let us know right away.

My guess is recruitment is going to be a continual problem, not only for your system but for every medical system in this country, because it takes years to get a primary care doctor into the system.

One of the things we want to make sure is with the VA, for example, mental health providers, which is a huge gap, are universally still not certified in cooperation with the VA to make sure our counselors are being able to be used. They do not have the exact credentials, but they are available. So, we need to make sure the VA makes this happen, because they are ready, they are able. There are huge gaps in mental health services. We want to make sure certification is possible. I want to make sure you have that on your list.

But, again, you'll have some big challenges in recruitment. The administration is moving forward. You have a huge task ahead of you, and I want to make sure that we are not always going to meetings but we are hearing results, and that is what I am looking for.

Thank you.

Chairman SANDERS. Thank you very much, Senator Begich.  
Senator Boozman.

**STATEMENT OF HON. JOHN BOOZMAN,  
U.S. SENATOR FROM ARKANSAS**

Senator BOOZMAN. Thank you, Mr. Chair, and thanks to you and Ranking Member Burr for the hearing. I think in the interest of time I would like to hear the testimony, though I may put a statement in the record.

Chairman SANDERS. Thank you very much.  
Senator Murray.

**STATEMENT OF HON. PATTY MURRAY,  
U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Well, thank you, Mr. Chairman, for holding this really important hearing. I want to start by thanking the Inspector General, Richard Griffin, and the Department's Office of Inspector General for all the work that has been done to conduct this review. Your investigators and staff have put together an incredibly important report on what happened at Phoenix. And completing the other investigations at nearly 100 medical centers is really an enormous task. So, I want to thank the OIG and all of your staff for the incredible dedication it is taking and will take to get this done.



After a lot of years of making critical contributions to veterans' care and benefits, the IG, rightly, has the reputation of being objective, reliable, and thorough in your work, so we all do thank you. Your findings are going to be really vital as we work forward through this, so I appreciate it.

I also appreciate how Secretary McDonald has hit the ground sprinting in his new role and has taken immediate steps to get the veterans off wait lists and into care. And while the VA's latest data continues to show patient accessibility improving across the Department, I want you to know I still am concerned about some of the facilities in my homestate of Washington. Veterans receiving primary and specialty care within the Puget Sound Health Care System continue to wait longer than national averages for primary and specialty care. And at Spokane, the new mental health care patients wait over twice as long—75 days for their appointments—and that has got to change.

As the VA continues to focus on providing veterans with timely access to care, it also has to ensure veterans receive the highest quality of care, and as the IG report showed, that was all too often not the case in Phoenix. They found that the Phoenix Health Care System struggles with many of the basic quality-of-care issues, things like leaving routine physical examinations and evaluations incomplete, or failing to conduct them at all, or releasing mental health care patients before their medications were properly stabilized, and struggling to provide dedicated mental health care providers to patients.

So, when we are talking about caring for our Nation's heroes and their families, we all expect excellence. And I want to note, as I have said repeatedly, as transparency and accountability increase at the VA, so will investigations and reports of additional concerns requiring even more action from the VA, the administration, and this Congress.

Today, Mr. Chairman, I hope to hear how the VA is going to address the findings of the IG, the VA access audit, and the White House review, and I want to hear how the VA will implement the Veterans Access, Choice, and Accountability Act.

Yesterday we heard the Secretary speak about VA recommitting itself to core values. Today we need to know how the Secretary will turn those commitments into real action and to improve care for our Nation's heroes.

Thank you, Mr. Chairman.

Chairman SANDERS. Senator Murray, thank you very much.

I think we have heard from all the Senators. Let me bring Mr. Griffin and his staff to the table.

Let me welcome Richard Griffin and his staff. Mr. Griffin is the Acting Inspector General for the Department of Veterans Affairs at today's hearing. Let me also make a comment. Normal protocol is for us to have the Secretary go first, and I want the Secretary to know that there is no disrespect in us breaking that protocol. But I thought it would be more important to hear what the Inspector General had to say and what his staff had to say and then see the Secretary respond to that.

Mr. Griffin was appointed as Deputy Inspector General in 2008. He previously served as the VA Inspector General from 1997 to

2005, so he brings an enormous amount of experience and knowledge to his position.

He is accompanied today by Dr. John Daigh, Jr., Assistant Inspector General for Healthcare Inspections; Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen Regan, Counselor to the Inspector General; and Mr. Larry Reinkemeyer, Director of the Inspector General's Kansas City Audit Office.

Mr. Griffin, thank you so much for your work and thank you for being with us. The mic is yours.

**STATEMENT OF RICHARD J. GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS; LINDA HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS; MAUREEN REGAN, COUNSELOR TO THE INSPECTOR GENERAL; AND LARRY REINKEMEYER, DIRECTOR OF THE INSPECTOR GENERAL'S KANSAS CITY AUDIT OFFICE**

Mr. GRIFFIN. Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to discuss the results of the IG's extensive work at the Phoenix VA Health Care System. Our August 26 report expands upon information previously provided in the interim report and includes information on the reviews by OIG clinical staff of patient medical records.

The OIG examined the medical records and other information for 3,409 veteran patients, which included 293 deaths, and identified 28 instances of clinically significant delays in care associated with access or scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 cases of care deficiencies that were unrelated to scheduling or access issues. Of these 17 patients, 14 were deceased.

The 45 cases discussed in the report reflect unacceptable and troubling issues in follow-up, coordination, quality, or continuity of care. The identity of these 45 veterans has been provided to VA. Decisions regarding VA's potential liability in these matters lie with the Department and the judicial system under the Federal Tort Claims Act. Information on the qualifications of the OIG physicians who conducted these reviews can be found in the curriculum vitae submitted for the record with our written testimony.

We identified several patterns of obstacles to care that resulted in a negative impact on the quality of care provided by Phoenix, and as of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the Phoenix electronic wait list. However, as our work progressed, we identified over 3,500 additional veterans, many of whom were on what we determined to be unofficial wait lists, waiting to be scheduled for appointments but not on Phoenix's official electronic wait list.

Urology Service was also unable to keep up with the demand for services. During our review, it became clear that the Urology Service at Phoenix was in turmoil during the 2012 to 2014 timeframe. There were a number of urology physician staffing changes, delays

in the procurement of non-VA purchased care, and difficulties coordinating urologic care. The OIG is currently working from a list of 3,526 patients who may be at risk for having received poor-quality urologic care. As a result, urology services at Phoenix are the subject of an ongoing OIG review.

Since July 2005, OIG has published 20 oversight reports on VA patient wait times and access to care, yet VHA did not effectively address its access-to-care issues or stop the use of inappropriate scheduling procedures.

When VHA concurred with our recommendations and submitted an action plan, many VA medical facility directors did not take the necessary actions to comply with VHA's program directives and policy changes.

In April 2010, in a memorandum to all VISN Directors, the then-Deputy Under Secretary for Health for Operations and Management called for immediate action to review scheduling practices and eliminate all inappropriate practices.

In June 2010, VHA issued a directive reaffirming outpatient scheduling processes and procedures.

In July 2011, an annual certification of wait times was mandated.

In January 2012 and May 2013, the VISN 18 Director issued reports that found Phoenix did not comply with VHA's scheduling policy.

Finally, in May 2013, VHA waived the annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait-time data integrity and compliance with appropriate scheduling practices.

The IG opened investigations at 93 sites of care in response to allegations of wait-time manipulations. The investigations continue in coordination with the Department of Justice and the Federal Bureau of Investigation. While most are still ongoing, these investigations are confirming that wait-time manipulations were prevalent throughout VHA.

This report cannot capture the personal disappointment, frustration, and loss of faith individual veterans and their family members had in the health care system that often could not respond to their mental and physical health needs in a timely manner. Immediate and substantive changes are needed. The VA Secretary has acknowledged the Department is in the midst of a serious crisis, and he has concurred with all 24 recommendations in our report and submitted acceptable corrective action plans.

Mr. Chairman, this concludes our statement, and we would be pleased to answer questions any of the members may have.

[The prepared statement of Mr. Griffin follows:]

**STATEMENT OF  
RICHARD J. GRIFFIN  
ACTING INSPECTOR GENERAL  
OFFICE OF INSPECTOR GENERAL  
DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
HEARING ON  
"THE STATE OF VA HEALTHCARE"  
SEPTEMBER 9, 2014**

Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to discuss the results of the Office of Inspector General's (OIG) extensive work at the Phoenix VA Health Care System (PVAHCS), as outlined in our report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (August 26, 2014). I am accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections; Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General; and Mr. Larry Reinkemeyer, Director, OIG Kansas City Audit Operations Office.

**BACKGROUND**

The OIG reviewed allegations at the Phoenix VA Health Care System (PVAHCS) that included gross mismanagement of VA resources, systemic patient safety issues, possible wrongful deaths, and we are continuing to review possible criminal misconduct by VA senior hospital leadership. We initiated this review in response to allegations first reported through the OIG Hotline. We expanded our work at the request of the former VA Secretary and the Chairman of the House Committee on Veterans' Affairs (HVA) following an HVA hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. We also received requests from this Committee, as well as individual Members of Congress.

On May 28, 2014, we published our report, *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System – Interim Report*, substantiating serious conditions at the PVAHCS. We provided VA leadership with recommendations for immediate implementation to ensure all veterans receive appropriate care.

Our August 26, 2014, report provides more extensive information previously provided in the interim report to reflect the results of our review and includes information on the reviews by OIG clinical staff of patient medical records. We addressed the following questions in our August report:

- Were there clinically significant delays in care?
- Did PVAHCS omit the names of veterans waiting for care from its Electronic Wait List (EWL)?

- Were PVAHCS personnel following established scheduling procedures?
- Did the PVAHCS culture emphasize goals at the expense of patient care?
- Are scheduling deficiencies systemic throughout VHA?

#### **SCOPE OF REVIEW**

Due to the multitude and broad range of issues, a multidisciplinary team comprising board-certified physicians, nurses, health care inspectors along with special agents and auditors evaluated the many allegations to determine their validity and assign individual accountability if appropriate. The team interviewed numerous individuals to include the principal complainants: Dr. Samuel Foote, a retired PVAHCS physician, and Dr. Katherine Mitchell, the Medical Director of the PVAHCS Operation Enduring Freedom/Operation Iraqi Freedom/and Operation New Dawn (OEF/OIF/OND) clinic. In addition:

- We obtained and reviewed VA and non-VA medical records of patients who died while on a wait list or whose deaths were alleged to be related to delays in care.
- We reviewed two statistical samples of completed primary care appointments to determine the accuracy of patient wait times based on our assessment of the earliest indication a patient desired care.
- We reviewed over 1 million email messages, approximately 190,000 files from 11 encrypted computers and/or devices, and over 80,000 converted messages from Veterans Health Information Systems and Technology Architecture emails.

#### Patient Care Reviews

Board-certified physicians and nurses in the OIG Office of Healthcare Inspections conducted a review of VA medical records for 3,409 veterans to identify delays and/or lapses in providing quality care. We also requested death certificates for 166 veterans and subpoenaed medical records from non-VA facilities for three veterans. We reviewed Medicare and other records to determine whether these veterans received care by non-VA providers.

The delays described in the report show that access barriers resulted in delays in providing quality primary and specialty care at the PVAHCS. In the course of patient care reviews, we also identified other quality of care issues unrelated to delays. These delays and lapses in care may have had or could have had a negative impact on the health and welfare of the veteran. However, we did not conclusively assert that the absence of timely quality care caused the deaths of these veterans.

In conducting our reviews, we did not apply the medical negligence standard applicable to care provided in the State of Arizona. The OIG has no authority or responsibility to make determinations as to whether acts or omissions by VA constitute medical negligence under the laws of any state or to compensate veterans or their families if the veteran suffered an injury as the result of the provision of health care. Making such determinations is a Department program function and the OIG is prohibited by statute from making program decisions to preserve its independence to conduct oversight of

VA's programs and operations. Decisions regarding VA's liability in these matters lie with the Department and the judicial system under the Federal Tort Claims Act.

Dr. Foote first contacted the OIG in September 2013 and met with OIG representatives in December 2013. In February 2014, Dr. Foote alleged that potentially 40 veterans died waiting for an appointment, and these alleged deaths were widely reported in the media. We pursued this allegation and interviewed Dr. Foote, but he was unable to provide us a list identifying by name 40 specific patients. He provided HVAC the names of 17 deceased patients, which we received from the Committee and reviewed. Based on our own review of PVAHCS electronic records, we were able to identify 40 veterans who died while on the EWL during the period April 2013 through April 2014. These veterans were included in the review of records for 3,409 patients derived from multiple sources, which included 293 deaths.

During our review, we were provided with numerous lists of PVAHCS patients. These patient lists were obtained by OIG staff while onsite at PVAHCS; obtained from the PVAHCS Quality Management office and other similar offices; submitted to the OIG Hotline; and obtained from external sources such as the HVAC, other congressional sources, and media reports. In all, OIG Office of Healthcare Inspections physicians and clinical staff examined the electronic health records (EHR) and other information for 3,409 veteran patients on the following lists:

- Veterans Health Administration (VHA) EWL – The EWL was used to list patients waiting to be scheduled for an appointment. It is a VHA-sanctioned list described in a June 9, 2010, Under Secretary for Health Directive. Patients on PVAHCS's EWL could be waiting for scheduling for either primary or specialty care.
- PVAHCS Physician List – Two PVAHCS physicians provided the names of patients for whom substandard care due to scheduling delays was alleged.
- HVAC – On April 9, 2014, the HVAC provided to the OIG a list of 17 PVAHCS patients, all deceased, who allegedly had both excessive and harmful waiting times.
- Hotline List – OIG's Hotline received numerous contacts concerning PVAHCS. Many alleged poor quality of care or harm to individual patients.
- Media – Print and electronic media reported allegations of substandard care at PVAHCS. Many reports identified and described individual patients' issues.
- Schedule an Appointment Consult List – Clinical staff at PVAHCS wanted to ensure that inpatients who did not have a primary care physician (PCP) would have primary care follow-up post-discharge. They began using the system's "Schedule an Appointment" consult function to accomplish this. Usually a clinical consult request is for an additional opinion, advice, or expertise. Emergency Room clinicians and some specialty services staff also adopted this practice.
- Institutional Disclosure List – PVAHCS patients for whom institutional disclosures had been made to patients or their families for any care-related reason. Institutional disclosures include discussions of events not associated with substantial harm. For example, PVAHCS would disclose that a patient's temperature was taken using an oral probe without a protective cover, a minor

surgical procedure had to be interrupted because of a power failure, or an x-ray was performed on the wrong patient.

- Newly Enrolled/Appointment Requested (NEAR) List – During the enrollment application process, a veteran may indicate on the enrollment form that he/she would like to be contacted to schedule an initial appointment. The NEAR list is a tool used by enrollment staff to tell schedulers that a newly enrolled veteran has requested an appointment. The NEAR list is used for initial appointments only.
- Suicides – PVAHCS patients known by either the facility or the Maricopa County, Arizona, Medical Examiner's Office to have committed suicide.
- Backlog Never Completed – 544 patients who were to be scheduled through the new patient backlog redistribution process but who never received an appointment.
- Urology Service – Partial list of patients from the closed consult and paper lists.
- Helpline Paper Printouts – From March–April 2014, patients who called the PVAHCS's Helpline requesting an appointment were placed on a paper screenshot.
- Helpline Paper Printouts – Paper screenshots found by an employee in June 2014.

The OIG examined the EHRs and other information for the 3,409 veteran patients, including the 40 patients we found on the EWL who were deceased, and identified 28 instances of clinically significant delays in care associated with access or scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 cases of care deficiencies that were unrelated to access or scheduling. Of these 17 patients, 14 were deceased. During our review of EHRs, we considered the responsibilities and delivery of medical services by PCPs versus specialty care providers (such as urologists, endocrinologists, and cardiologists). Our analysis found that the majority of the patients were on official or unofficial wait lists and experienced delays accessing primary care, although in some cases, patients were receiving specialty care through VA or non-VA providers for pressing clinical issues. For example, a patient was being seen by a VA cardiologist, but was also on the wait list to see a PCP at the time of death. The 45 cases discussed in the report reflect unacceptable and troubling lapses in follow-up, coordination, quality, or continuity of care.

The review process included an evaluation of the medical records of 3,409 patients from the sources discussed above. The OIG staff who conducted the reviews are physicians and clinicians. Reviewers used clinical judgment to determine whether, in their professional opinion, an identified delay resulted in a harmful outcome or a potentially harmful outcome. OIG physicians reviewed 743 patients. If a physician's review of the records identified deficiencies in the quality of care provided to the patient, the case was reviewed by a second OIG physician. If the two physicians agreed, the case was included in the report. Information on the qualifications of the OIG physicians who conducted these reviews can be found in the attached curricula vitae.

Several patients in cases reviewed opted for non-VA care at critical junctures. As needed, but not in all cases, we obtained and reviewed the relevant private sector

medical records. For 166 deceased patients reviewed in a second-level physician review, we requested death certificates from Maricopa County and the State of Arizona, whom we would like to acknowledge for their cooperation and expedience in meeting our requests. Supplementing the data gathered from the EHR, we also analyzed information, when available, from sources that included Medicare, non-VA health records, death certificates, media reports, and interviews with VA staff. Approximately 23 percent of the patients we reviewed received private sector medical care funded by Medicare or Medicaid, and 35 percent had insurance coverage beyond VA.

### **OBSTACLES TO CARE**

We identified several patterns of obstacles to care that resulted in a negative impact on the quality of care provided by PVAHCS. Patients recently hospitalized, treated in the emergency department, attempting to establish care, or seeking care while traveling or temporarily living in Phoenix often had difficulty obtaining appointments. Furthermore, although we found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services.

#### Panel Size

Primary care was one important medical service that was not able to keep up with demand. A primary care provider's target panel size is locally determined as it is dependent on such factors as disease complexity, number of support staff, number of clinic rooms available for a provider's use, whether a provider is a new hire, and time available for direct patient care versus other activities. When a provider's panel size exceeds a clinic's target panel size, the capacity to add new patients becomes limited. Constrained panel capacity can lead to increases in the length of time it takes new patients to get an appointment. While onsite, we obtained individual provider appointment grids and panel assignments and the targeted panel capacities for April 2014. The target panel size at the PVAHCS is 1,260 patients. For the PVAHCS as a whole, the aggregate primary care panel capacity used was 98 percent. When PCPs left VA employment and their unassigned patients were factored in, aggregate panel capacity used was greater than 100 percent.

The number of unassigned patients represents a demand for established clinic spaces and panel capacity that is masked when these patients remain unassigned for extended periods. If a new provider has been hired and is known to be coming on-board within a tenable time frame, this may be practical. However, in situations where recruiting is difficult and on-boarding fairly lengthy, or for other reasons (e.g., a series of provider medical illnesses) primary care clinics routinely have substantial numbers of unassigned patients, access and continuity of patient care suffer.

Actions that can be taken to increase primary care access include increasing the number of providers, increasing target panel size, optimizing the match between variations in appointment demand and supply, expanding clinic hours, and increasing the use of non-VA purchased care. Increases in staff or panel size may be contingent



on having necessary space, the ability for providers to simultaneously use multiple exam rooms, efficient scheduling processes, sufficient support staff, or other process changes such as support for streamlining medical record documentation. For example, in several primary care clinics, available space at the PVAHCS is only able to support 1 room per clinician while the VHA recommended target panel size (1,200) assumes the availability of 3 rooms per provider.

#### Urology Service

Urology Service was also unable to keep up with the demand for services. During our review, it became clear that the Urology Service at PVAHCS was in turmoil during the 2012 to 2014 timeframe. There were a number of urology physician staffing changes, delays in the procurement of non-VA purchased care consults for urology, and difficulties coordinating urologic care. The OIG is currently working from a list of 3,526 patients who may be at risk for having received poor quality urologic care. As a result, urology services at PVAHCS is the subject of an ongoing review. In addition, non-urology cases whose evaluation could not be completed within the time constraints of the August 2014 report will be included in the upcoming final review.

#### Mental Health Services

We found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization. However, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services. When a facility becomes reliant on a walk-in clinic structure to increasingly provide daily routine or ongoing mental health services because of diminished access to the regular outpatient mental health clinic, issues with provider continuity, care transitions, and provider assignment arise. Since coming to PVAHCS in October 2013 from outside the VA system, the Chief of Psychiatry has taken several steps to address these issues. Thirteen additional mental health prescribing clinicians were recently hired to provide the ability to assign patients to a mental health provider and increase the availability of new and established patient appointments. The mental health clinic has recently been re-organized to help improve both access to and continuity of care.

We identified prolonged waits for access to types of individual psychotherapies. In April 2014, 105 patients were waiting to be seen by a non-VA provider; as of September 4, 2014, 24 patients are waiting to be seen.

#### Patients Waiting for Care

As of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the PVAHCS EWL. However, as our work progressed, we identified over 3,500 additional veterans, many of whom were on what we determined to be unofficial wait lists, waiting to be scheduled for appointments but not on PVAHCS's official EWL. These veterans were at risk of never obtaining their requested or necessary appointments. PVAHCS senior administrative and clinical leadership were aware of unofficial wait lists and that access delays existed but did not effectively address these issues. Throughout the course of our review, we

promptly provided PVAHCS leadership the names of all veterans we identified as being on an unofficial wait list to enable them to take the necessary actions to get veterans the care they needed.

#### Inappropriate Scheduling Practices in Use at PVAHCS

From interviews of 79 PVAHCS employees involved in the scheduling process, we identified the following types of scheduling practices not in compliance with VHA policy. Some schedulers identified multiple inappropriate scheduling practices.

- Thirty staff stated they used the wrong desired date of care, resulting in appointments showing a false 0-day wait time.
- Eleven staff stated they “fixed” or were instructed to “fix” appointments with wait times greater than 14 days. They did this by rescheduling the appointment for the same date and time but with a later desired date.
- Twenty-eight staff stated they either printed out or received printouts of patient information for scheduling purposes. Staff said they kept the printouts in their desks for days or sometimes weeks before the veterans were scheduled an appointment or placed on the EWL.

PVAHCS executives and senior clinical staff were aware that their subordinate staff were using inappropriate scheduling practices. In January 2012 and later in May 2013, the Veterans Integrated Service Network (VISN) 18 Director issued two reports that found PVAHCS did not comply with VHA’s scheduling policy. Our review also determined PVAHCS still did not comply with VHA’s scheduling policy. Specifically, according to VISN 18 staff, PVAHCS had not completely trained their clerks or established EWLs in the clinics. As a result of using inappropriate scheduling practices, reported wait times were unreliable, and we could not obtain reasonable assurance that all veterans seeking care received the care they needed.

The emphasis by Ms. Sharon Helman, the Director of PVAHCS, on her “Wildly Important Goal” (WIG) effort to improve access to primary care resulted in a misleading portrayal of veterans’ access to patient care. Despite her claimed improvements in access measures during fiscal year (FY) 2013, we found her accomplishments related to primary care wait times and the third-next available appointment were inaccurate or unsupported. After we published our interim report, the Acting VA Secretary removed the 14-day scheduling goal from employee performance contracts.

#### **HISTORY OF VHA SCHEDULING AND DATA RELIABILITY PROBLEMS**

Since July 2005, OIG published 20 oversight reports on VA patient wait times and access to care yet VHA did not effectively address its access to care issues or stop the use of inappropriate scheduling procedures.

When VHA concurred with our recommendations and submitted an action plan, VA medical facility directors did not take the necessary actions to comply with VHA’s program directives and policy changes.

In April 2010, in a memorandum to all VISN Directors, the then-Deputy Under Secretary for Health for Operations and Management (DUSHOM) called for immediate action to review schedule practices and eliminate all inappropriate practices. The memorandum stated that in order to improve scores on assorted access measures, certain facilities have adopted the use of inappropriate scheduling practices that were not in line with patient-centered care.

In May 2013, the then-DUSHOM waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. This annual certification requirement was initiated in January 2011. Additionally, the breakdown of the ethics system within VHA contributed significantly to the questioning of the reliability of VHA's reported wait time data.

#### **NATIONWIDE SYSTEMIC PROBLEM**

Inappropriate scheduling practices were a nationwide systemic problem. We identified multiple types of scheduling practices in use that did not comply with VHA's scheduling policy. These practices became systemic because VHA did not hold senior headquarters and facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures.

Since the PVAHCS story first appeared in the national media, we received approximately 225 allegations regarding PVAHCS and approximately 445 allegations regarding manipulated wait times at other VA medical facilities through the OIG Hotline, from Members of Congress, VA employees, veterans and their families, and the media.

The OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. The investigations focused on whether management ordered schedulers to falsify wait times and EWL records or attempted to obstruct OIG or other investigative efforts. Investigations continue, in coordination with the Department of Justice and the Federal Bureau of Investigation. While most are still ongoing, these investigations are confirming that wait time manipulations were prevalent throughout VHA.

As of August 2014, among the variations of wait time manipulations, our ongoing investigations at the 93 sites have, thus far, found many medical facilities were:

- Using the next available date as the desired date to "0-out" appointment wait times.
- Canceling appointments and rescheduling appointments to make wait times appear to be less than they actually were. We substantiated that management at one facility directed schedulers to do this.
- Using paper wait lists rather than official EWLs.
- Canceling consultations (consults) without appropriate clinical review.
- Altering clinic utilization rates to make it appear the clinic was meeting utilization goals.

Wherever we confirm potential criminal violations, we will present our findings to the appropriate Federal prosecutor. If prosecution is declined, we will provide documented results of our investigation to VA for appropriate administrative action. We will do the same if our investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, we have also kept the U.S. Office of Special Counsel apprised of our active criminal investigations as they relate to their numerous referrals to VA of whistleblower disclosures of allegations relating to wait times and scheduling issues.

Prior to our work at PVAHCS, we initiated an audit of the Health Eligibility Center. Soon after, the OIG Hotline received complaints that the Health Eligibility Center purged over 10,000 veterans' health care applications to improve performance metrics. The same complaint also identified that VHA had a backlog of over 600,000 unprocessed enrollment applications. We have expanded our work to assess the merits of these allegations, as processing veterans' applications for enrollment in VA health care is a first and important step to ensuring access to care is available and meeting veterans' needs.

#### **CONCLUSION**

The VA Secretary has acknowledged the Department is in the midst of a serious crisis and has stated VA must work to get veterans off wait lists, address cultural and accountability issues, and use their resources to consistently deliver timely health care. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans.

Our findings and conclusions provide VA a major impetus to re-examine the entire process of setting performance expectations for its leaders and managers. Along with a rigorous follow up to ensure full implementation of all corrective actions, we plan on initiating a series of reviews based upon allegations received of appointment scheduling irregularities, barriers to access to care, and other issues that affect medical care, quality, and productivity. These reviews will provide us the opportunity to determine whether senior VA medical facility officials have implemented the Secretary's action plan.

If headquarters and facility leadership are held accountable for fully implementing VA's action plans, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide timely access to the high-quality health care veterans have earned—when and where they need it.

Mr. Chairman, this concludes our statement and we would happy to answer any questions you or other Members of the Committee may have.

Chairman SANDERS. Mr. Griffin, thank you very much for your testimony and for the work that you and your staff have undertaken over the last few months.

Let me begin by asking you a question that arises from some media reports which have troubled me. There has been some suggestion that the IG, the Office of Inspector General for VA, is really not independent. And I would like to provide you with the opportunity to describe the process the IG utilizes when preparing over-

sight reports, including the draft report review and comment process. In other words, are you being heavily influenced by VA? Are they editing the reports that you give us? Or, in fact, are you an independent entity finding the truth as best you can?

Mr. GRIFFIN. Thank you for that question. Our organization over the last 6 years has issued over 1,700 reports addressing oversight issues in the Department of Veterans Affairs. We have testified at over 60 congressional hearings in the last 6 years about our reports. Every one of our draft reports and every draft report of anybody in the Inspector General community is submitted as a draft to the Department for purposes of guaranteeing accuracy of all reporting. If the Department has information that we missed in doing our work that they can point out to us that would be factual and convincing, then we may come to realize, well, we have got this one part wrong.

We do not accept from the Department or from anyone else a dictated response that is based on opinion as opposed to fact.

Chairman SANDERS. OK. Thank you very much.

Let me ask you this: every Member of this Committee is outraged by what happened in Phoenix. We are outraged in general by unacceptably long wait periods for veterans to access health care. We have seen with disgust the manipulation of data, lying, et cetera. What I would like you to do is explain in plain English, how does this happen?

Now, you pointed out just a moment ago that we have heard from VA time and time again their concerns about the appointment process, and yet nothing seemed to happen. So, take us to Phoenix and describe to us exactly how it happened that we had these long waiting periods that were disguised and how we had some people not on any waiting list at all. And all of this went on while nobody did anything about it. How does this happen?

Mr. GRIFFIN. That happens when there is a failure of leadership. We are not just talking about Phoenix. We have reported on this problem for 9 years. Excellent policies were, in fact, published and sent out. I alluded to some of them in my oral statement. You have to follow it through. Wait times is not the only issue that we have reported on where VHA has promulgated policies to address our recommendations, sent them out, and were supposed to be certified that they were followed, and they were not.

It is hard to explain the why of that, but when people do not follow the directive from their headquarters leadership and mislead them about it, there has to be a consequence.

Chairman SANDERS. All right. Two brief questions.

Number 1, to what degree did the 14-day directive impact the immediate problems?

And, number 2, how can a facility provide timely care if they do not have enough doctors, nurses, space, and staff? And how does that not get up to the general office? How does it not happen that somebody says, "I cannot do it in 14 days. I just do not have the doctors; I do not have the staff?" Explain that process to me.

Mr. GRIFFIN. I believe there was an awareness in Phoenix, based on some of the e-mails that we pulled and that are included in our report, that many people in the Phoenix hierarchy were aware that it was not doable. I am sure you recall the e-mail from our interim

report where someone asked for an ethics review because our “Wildly Important Goal” in the success that is being reported is smoke and mirrors, as was mentioned earlier.

I think a big part of the equation for the fix, as opposed to what we all know happened, when you look at the initial point where a veteran has contact at the medical center, very often you have the lowest-graded employees who might not be equipped to be able to triage this veteran who really needs to get seen in 14 days or 7 days, or tomorrow or today, versus this veteran can wait 30 days.

I think in the private sector you would probably have somebody with a little more clinical background to try and make that evaluation, so you know who really does need to come in and who does not.

Chairman SANDERS. My time has expired, but the bottom line is if you do not have the staff, if you cannot do it, how come that is not transmitted up the channel?

Mr. GRIFFIN. It should be. I believe in Phoenix it was, and the outcome is documented in our report that no action was taken to fix it.

Chairman SANDERS. OK. Thank you very much.

Senator Burr.

Senator BURR. Mr. Griffin, thanks to you and to your staff for the job you have performed, for the undertaking that you are already in process with. I do not think any of us would wish it on anybody that they had to make the reviews that you are having to do.

Let me just ask, had the VA listened to prior IG reports and fixed the problems you had pointed out, would we be here today talking about Phoenix or talking about any facility?

Mr. GRIFFIN. No.

Senator BURR. The problems within VA seem to be rooted in two things. One is the culture that has been created, and I think that culture has been created because there was a lack of accountability, which was evidenced by these waiting lists that operated outside of the electronic system and by other things. Had they just addressed those, we probably would not be here investigating Phoenix to the degree that we are. Is that an accurate statement?

Mr. GRIFFIN. That is accurate, and as I mentioned previously, even in other areas, we would not close a recommendation unless we believed that they had taken the appropriate steps to resolve the issue.

When you get a copy in 2010 of this mandate to knock off the manipulation and then 3 months later you get an updated scheduling procedure as a VHA directive, at that point you would believe that people got it, that it would be implemented, and it would be implemented to the letter.

Senator BURR. What do you conclude—how could somebody conclude within VA not to require certification last year based upon all the warning signs you had provided for them?

Mr. GRIFFIN. I think the next panel can probably better explain what the rationale was. I think there has been plenty of warning that this was going on, and I thought the certification was an excellent thing to make people declare, yes, I have reviewed it in my facility, and, yes, our waiting times are according to the policies and procedures of the Department.

Senator BURR. Now, you have been involved for 6-plus months investigating the current list of things, and I know you cannot get into specific takeaways, but let me ask: what have you learned about the VA over that period of time, not down to the specifics?

Mr. GRIFFIN. Referring to the 93 other facilities? Well, we have some initial reporting on those. As of yesterday, we have given the Department 12 individual reports for them to examine and determine what action would be appropriate in view of the specifics of each of those reports.

The rest of our 93 are still very much active, but I can tell you that at 42 different facilities of those 93, we found the practice of using the next available date as the desired date. It is something that was reported on in our interim report and in the final report. We have 19 facilities where an appointment was canceled and re-scheduled on the same day for the same appointment time for the sole purpose of giving the appearance of a shorter waiting time.

We have had 16 facilities that had paper wait lists as opposed to being on an EWL. We had 13 facilities where managers lied to my investigators about what was going on at their facilities.

Senator BURR. Did your investigators conclude that all of these individuals came up with these deceptive practices on their own? Or was there some overarching initiative that some level of management actually pushed?

Mr. GRIFFIN. It is a combination. Frankly, when something is going on for as many years—not everywhere but at a number of the facilities—it almost becomes the accepted way of doing scheduling. And, again, when you have lowest level employees involved in scheduling and they come in as a new hire and somebody says, “This is how we do it,” they may not realize that someone is telling them the improper way to do it. So, it is a combination of things.

The bottom line is: who is in charge? And when you get a policy directive from VHA, do you enforce it, or do you ignore it? I think that is the bottom line.

Senator BURR. My time has expired, but let me say once again I thank you and your staff for the process you are going through. It is invaluable to our country’s veterans and to the agency.

Mr. GRIFFIN. Thank you.

Chairman SANDERS. Senator Burr, thank you very much.

Senator TESTER?

Senator TESTER. Thank you, Mr. Chairman, and I, too, want to thank you, Inspector General Griffin, for your work and for your professionalism. I very much appreciate it. It is very helpful to us, so thank you for that work.

Your investigations, whether it be Phoenix or whether it is the other 93 facilities, are focused on scheduling, correct?

Mr. GRIFFIN. That is what we go in to look at, but along the way you sometimes become aware of other activities that you need to look at that might be tangentially related. You know, so principally they are on scheduling and manipulation of wait times, but there are some places where it has expanded.

Senator TESTER. Is it fair to say that—I mean, the investigation started out in Phoenix because of some pretty damning things that were being said about Phoenix. Is it fair to say that the scheduling problems are pretty pervasive throughout the VA?

Mr. GRIFFIN. Absolutely.

Senator TESTER. OK. Specifically for Phoenix, is—look, I mean, a good portion of Montana heads down there in the wintertime. Were there parts of the year where the scheduling was worse than other parts of the year? Or was it just that way all the time?

Mr. GRIFFIN. You know, we did not try to carve out the snowbird aspect that might impact Phoenix, but we—

Senator TESTER. I was just curious.

Mr. GRIFFIN. We did not find a good quarter in any of the quarters we looked at.

Senator TESTER. OK. Would you say—in the conference committee opening statements we heard a lot from the members of the conference from both Houses that talked about that this is not a workforce issue. In your investigations, what would you say to that?

Mr. GRIFFIN. I would say it is a complex issue with many aspects. One of those aspects is performance standards for the physicians that you do have. Without those standards, it is hard to determine exactly how many doctors and nurses you need. It is a clinical space issue. VHA guidance talks about a panel of 1,200 patients for primary care. But it assumes that there are three separate offices for each doctor so that you can have your patients ready to go when you come in, and in Phoenix, there was only one office per doctor.

I think it is a combination of, yes, in some facilities they are understaffed, both nurse and doctor staffing. We have sought the implementation of staffing standards for years. We did a review in 2012 on specialty care staffing standards and found that only 2 of 33 specialties had standards. I think you need to know how many veterans can we anticipate this specialist seeing in a given day and then make sure the schedule is properly structured so you can fill those slots.

Senator TESTER. You have got a number of MDs on your staff, and you may, in fact, be an MD. I am not sure. I cannot remember. You are?

Mr. GRIFFIN. No.

Senator TESTER. OK. When you are talking about staffing standards, do you use the private sector for your standards then? And maybe this should be reflected to one of the MDs on the staff. And I will tell you why I ask this. I am not an MD either, but it appears to me that if you try to apply private sector staffing standards to the VA it is unfair, because these folks are coming back with multiple problems, plus ones that are unseen, too. So, do you guys apply the staffing standards, or do you say, VA, you need to set up the staffing standards?

Mr. GRIFFIN. We have said that we believe they should have standards so that if you are in a like-size VA facility in one part of the country or another, the expectation is a certain level of productivity.

I would ask Dr. Daigh if he would like to elaborate upon that.

Dr. DAIGH. Sir, we have advocated that VA create their own standard, aware of civilian standards, but without that data, I do not know how you can make proper business decisions about what you are going to make or what you are going to buy.



Senator TESTER. That is good. Thank you very much.

There are 1,700 health care facilities in the VA; 93 are being investigated by you at this point in time. Can you give me any idea— or is it pretty evenly distributed between hospitals, CBOCs, and small clinics?

Mr. GRIFFIN. I would be guessing to give you that number, but it is a mix.

Senator TESTER. Can you give me that number?

Mr. GRIFFIN. We can. Yes, absolutely.

Senator TESTER. I would like to get that.

Mr. GRIFFIN. And if someone at the table here has it, I will give it to you right now.

Senator TESTER. That is fine. There is nobody nodding yes, so we will—one more, because my time just ran out.

Mr. GRIFFIN. We will get it to you.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Type of Facility	Number
VA Medical Center .....	68
Community Based Outpatient Clinic .....	13
Outpatient Clinic .....	8
Health Eligibility Center .....	1
Health Care System .....	1
Ambulatory Care Center .....	1
Multi-Specialty Outpatient Clinic .....	1

Senator TESTER. When can we expect a report from you guys on these 93 facilities, a full report?

Mr. GRIFFIN. As we finish each individual report—and to be finished, if it is a criminal matter, we have to present it to the U.S. Attorney’s Office for a prosecutive decision. If it does not meet the threshold for prosecution, we give the report to the Department so that they can take administrative action, where appropriate.

Senator TESTER. Would it be fair to say—and I do not want to box you in—these would be done by the end of the year?

Mr. GRIFFIN. I hope so.

Senator TESTER. Thank you very much.

Thank you, Mr. Chair.

Chairman SANDERS. Thank you, Senator Tester.

Senator Heller?

Senator HELLER. Thank you, Mr. Chairman.

I want to go back to your initial comments on the report, the draft report versus the final report, and some of the changes that were made in that report, to get some clarification as to timelines.

It was reported that a line was inserted, and if you are the VA, this is the line you would want inserted in that report. That line says, “While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.” Obviously that was pertaining to the Phoenix hospital.

Just some timelines. Was this line included in the draft report?

Mr. GRIFFIN. There are many versions of the draft report. The majority of the changes in our draft report came about as a result of further deliberations by the senior staff of the Inspector General's office. No one in VA dictated that sentence go in that report, period.

Senator HELLER. Was the line included in the draft report that was sent to the VA?

Mr. GRIFFIN. It was not included in the first version of that draft report. What I would like to do, if I may, is provide a timeline in writing to the Committee—

Senator HELLER. I would like that.

Mr. GRIFFIN [continuing]. That, you know, can make it very clear what is going on with that allegation.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DEAN HELLER TO RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

**Chronology of OIG Draft Report  
Phoenix VA Health Care System**

6/24/14 thru 7/25/2014	<p>Draft circulated to OIG senior staff for comment.</p> <p>Comments back included:</p> <ul style="list-style-type: none"> <li>• <i>I am wondering if we should have a caveat here that we make no legal determinations of cause of death.</i></li> <li>• <i>Same as earlier comment—believe we have to state how many have died here.</i></li> <li>• <i>For balance we should add that not everyone who died on the EWL died because they were on the EWL and we should mention that the factors and difficulties assessing causes of deaths in these patients.</i></li> <li>• <i>Should we note that 6 of these were deceased patients?</i></li> <li>• <i>Did we identify any deaths attributed to significant delays? If we can't attribute any deaths to the wait list problems, we should say so and explain why.</i></li> <li>• <i>Somewhere in the Exec Summary, can we include some sort of recognition that even if patients did not die BECAUSE of a delay in care, the delays they did have were not the level of service – the comfort, support, and relief from pain – the veterans and their families deserved. Families need to know that we heard them.</i></li> </ul>
7/28/14	1 <sup>st</sup> Draft Sent to VA
7/31/14	2 <sup>nd</sup> Draft Sent to VA
	<p>Changes to the report included:</p> <ul style="list-style-type: none"> <li>• Changed report to address recommendations to VA Secretary rather than Acting VA Secretary.</li> <li>• Revised Recommendation #23: We recommended the VA Secretary conduct a nationwide review of the Veterans Health Administration to assess its ethical culture and make recommendations that ensure its workplace culture is based on integrity, fairness, and respect.</li> <li>• Original Recommendation # 23: We recommended the Acting VA Secretary ensure the Veterans Health Administration's Chief Ethics Officer for Health Care conducts a nationwide review of the Veterans Health Administration to assess its ethical culture and make recommendations that ensure its workplace culture is based on integrity, fairness, and respect.</li> </ul>

8/6/14	<p>3<sup>rd</sup> Draft Sent to VA</p> <p>Changes to the report included:</p> <ul style="list-style-type: none"> <li>• Added sentence: <i>The PVAHCS electronic records reflect that 40 patients died while on the EWL during the period April 2013 through April 2014.</i></li> <li>• Added sentence: <i>The death of a veteran on a wait list does not demonstrate causality.</i></li> <li>• Page 72 reflects consolidated recommendation on Ethics Program (now 24 total recommendations)</li> </ul>
8/7/14	<p>4<sup>th</sup> Draft Sent to VA</p> <p>Changes to the report included:</p> <ul style="list-style-type: none"> <li>• OIG rejected VA's request to make the changes regarding the 40 deaths.</li> <li>• Made minor technical edits to three case summaries <ul style="list-style-type: none"> <li>○ Case 9: Corrected numbers related to the patient's blood pressure (changed 175 to 191, and 191 to 175)</li> <li>○ Case 19: Changed "referred to" to "evaluated that day by"</li> <li>○ Case 29: Changed "In later winter of 2014..." to "In early 2014..."</li> </ul> </li> </ul>
8/14/14	<p>5<sup>th</sup> Draft Sent to VA</p> <p>Changes to the report included:</p> <ul style="list-style-type: none"> <li>• Added sentences: <i>In February 2014, a whistleblower alleged that 40 veterans died waiting for an appointment. We pursued this allegation, but the whistleblower was unable to provide us with a list of 40 patient names.</i></li> <li>• Removed sentence: <i>The death of a veteran on a wait list does not demonstrate causality.</i> Replaced with: <i>While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.</i></li> <li>• Changed number of sites under review from 88 to 92</li> </ul>
	<ul style="list-style-type: none"> <li>• Added sentence to Case 1: A death certificate obtained from the State of Arizona indicates the patient died at a local non-VA hospital after the PVAHCS ED visit.</li> <li>• Added sentence to Case 4: Following a 1-week hospitalization, he was discharged to a skilled nursing facility for rehabilitation. He died 5 weeks later.</li> <li>• Added sentence to Case 41: A death certificate obtained from the State of Arizona indicates that the patient was found dead in April 2014. The cause of death was listed as "hypertensive and arteriosclerotic"</li> </ul>
8/26/14	Issued final report

Senator HELLER. OK. I guess the question that needs to be asked, did the VA play any part in the inclusion of this line?

Mr. GRIFFIN. No.

Senator HELLER. In your report, you obtained a list of 171 patients who were waiting to seek services. Most of them were mental health therapies. You also noted in your report that, between January 2012 and 2014, you identified 77 suicides. These patients did not have their appointments scheduled or were yet to be scheduled. What I am trying to get to is: would a reasonable person come to the conclusion that wait-time manipulation contributed to patient deaths? Would a reasonable person come to that conclusion, that the manipulation of these wait times contributed to an individual's death?

Mr. GRIFFIN. I am going to ask Dr. Daigh to describe the clinical process review, but what I would say in general, we are not in the business of making odds on whether something did or did not cause a death, whether it is likely, unlikely, 50 percent, 30 percent, 80 percent. That is not our purpose. Dr. Daigh will describe how we conducted those reviews.

Dr. DAIGH. We looked at the fact pattern of each of the cases that we described for you. So, one of the issues you have to understand is that because you are on a wait list for audiology and you happen to die of a cardiac problem, the wait-list factor was not very important.

If you were under the care of a urologist intensively but you were on a wait list to see primary care, then we may have concluded

that, yes, you were on a wait list, yes, you died, but we do not see a relationship there.

So, for each of these cases we have reported, we wanted the fact pattern to demonstrate that a delay in care we thought would have led or dramatically impacted the likelihood that that patient would die, and we did not see that. We saw harm. We saw 28 cases described where delay negatively impacted care. But I could not say delay caused the patient to die.

Senator HELLER. So, of the 171 patients that were delayed in mental health therapy, and you identified 77 suicides, you see no link between delayed care and these—

Dr. DAIGH. I did not say no link. I said that if you are trying to say that—

Senator HELLER. You see, I am in the business of trying to find conclusions and figuring out what reasonable people would believe. We had a female veteran, a blind veteran with diabetic problems in Nevada, who had to wait 6 hours to get care. Two weeks later she died. I have to believe that there is a link between the kind of care she was getting at that hospital and her death 2 weeks later. And I think any reasonable person would come to that conclusion.

Dr. DAIGH. So, we looked, again, at the fact pattern for each of these cases. We had two physicians on my staff agree on the cases and the fact pattern and the conclusion we came to on each of these cases. When we began this review, I thought we would find patients with delayed care leading to death. I agree, that is a likely outcome. I just did not see it. All I can do is report the news that I find, and this is what we find.

Senator HELLER. See, I do not want to give the VA a pass on this, and I believe that that is what this line does. It exonerates the VA of any responsibility in past manipulation of these wait times.

Dr. DAIGH. I just have to disagree. I described 45 cases, 28 of which were negatively impacted because of delays. The only argument is, I cannot say that those that died, died because of a delay. In addition, I found that there was care that did not meet the standards of care that we would expect of the VA for an additional 17 cases. I have laid those fact patterns out in the report, so I have a conclusion, and the reader can come to their own conclusion.

Senator HELLER. Dr. Daigh, thank you.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Heller.

Senator HIRONO?

Senator HIRONO. Thank you, Mr. Chairman.

Just following up on the previous question, Mr. Griffin, would you agree that attribution of negligence as a result of delay in care as a causation of death is basically an adjudicatorial process that needs to be undertaken?

Mr. GRIFFIN. That is correct.

Senator HIRONO. You noted in your testimony that wait times are not the only issue that you were focusing on, and that when people do not follow headquarters directives and mislead the headquarters, there have to be consequences. You are investigating

some 93 facilities. Have you completed those investigations on any of those facilities?

Mr. GRIFFIN. We have completed 12. We have turned over 12 files to the Department for their—whatever action they deem appropriate. All the others are in process.

Senator HIRONO. As a result of these 12 files, has the VA undertaken any criminal or administrative proceedings, disciplinary proceedings?

Mr. GRIFFIN. Well, the criminal decision lies with the U.S. Attorney's Offices that we are working with around the country. VA owns the decision on administrative action. And, in fact, shortly after our first report was sent to the VA, they did take administrative action.

We are trying to get these done as quickly as possible so that they can move out in every instance where they need to, but we have to make sure we have all the facts right prior to declaring that we are through and this is the final product. We are working diligently on that, but we have a lot of other prosecutions outside of wait-time areas which have led to over 500 arrests a year for the last 6 years that you cannot just drop. A lot of them are threat and assault cases, drug diversion cases, abuse of fiduciary veterans.

We are working very seriously to try to get through the wait time investigations, but all these other investigations that were already in progress need to be seen through to fruition.

Senator HIRONO. Thank you for giving us a fuller context in which the VA is undertaking these kinds of proceedings.

You mentioned in your testimony and in your conclusion that the VA must address cultural changes, cultural issues. Can you talk a little bit more about how a system as vast as the VA can make cultural changes? What sort of cultural changes are you talking about? And what do you suggest that they do to implement these kinds of cultural changes?

Mr. GRIFFIN. Well, I think if you have a culture where it is OK to disregard directives from the most senior people in your administration, you need to come to realize that that is not acceptable behavior, and perhaps you will no longer be employed by the Department.

When people realize that it is a new day in that respect, I think they will be a little more vigilant in how they receive directives from their senior leaders in Washington. And I believe that the efforts that are undertaken in the various town hall meetings and feedback sessions with the VSOs and so on can also make the entire organization realize that these are the types of things we need to be doing.

Senator HIRONO. Do you think that the provisions in the law that was recently passed—the veterans bill, that would allow for more expeditious processes for disciplining—would help to change the culture in the VA in a positive way?

Mr. GRIFFIN. I think that in a number of personnel areas in the Federal Government, it can be frustrating at the pace that it requires in order to go through all of the due process activities. I think the ultimate impact that it will have on the Department is to be determined. It will depend on, you know, how frequently it is used, whether there are any challenges, being that VA is the

only department in the Government with the new abbreviated timeframes and so on.

Senator HIRONO. Your report put forth a number of recommendations. I am particularly looking at Recommendations 17 to 23, and the VA has said that they will meet those recommendations by September 2015.

Are there any of those recommendations that you consider more a priority than others for the VA to meet?

Mr. GRIFFIN. Well, there is a reason why our number 1 recommendation was that the Department had to get with the Regional Council in Phoenix and with VHA medical professionals to look at the names of the 45 veterans we identified and to take appropriate action regarding potential liability or institutional disclosures and so on. I think that is very important.

Senator HIRONO. So, basically your recommendations are in the order of priorities that you—

Mr. GRIFFIN. No, it is in the order of the presentation of the report, but I personally would have to say that I think that is one of the most important items. I would also say that as we were doing the work and we discovered 3,500 veterans that were not on an official list anywhere, we immediately turned those over to the Phoenix staff so they could be seeking out those veterans and not delay their care any more than it had already been delayed.

Senator HIRONO. Thank you.

Mr. Chairman, my time is up.

Chairman SANDERS. Thank you, Senator Hirono.

Senator BOOZMAN?

Senator BOOZMAN. Thank you, Mr. Chairman.

I do appreciate the hard work, Mr. Griffin, of you and your staff. I think you have done a very, very good job. The report that you came out with is very helpful as we try and solve some of these problems.

I would like to ask a little bit from both of you, you and Dr. Daigh, normally when you see a—when a patient goes to see a provider, the provider becomes the responsible person in the situation. If you sign a chart and say, “Come back in 2 weeks,” sometimes there are situations where perhaps he is going to be out of town or this or that or somebody is not available. I cannot imagine a situation where the scheduler would not ask the one that was scheduling, you know, “This cannot be done. What do you want to do about it?” Can you elaborate on that? What happens in the VA? When the provider actually writes on the chart, or however they do it, does the scheduler overrule that?

The other problem I have got is when the provider sees somebody back, say inherit a patient like this, the cardiologist or whatever, and you see on the chart that he was supposed to come back in 2 weeks and now it is 2 months, where is the outrage from the provider at that point as to why this was not done in the normal fashion?

Dr. DAIGH. Sir, I think what we found at Phoenix was that—what you talk about are very reasonable steps an office has to have in order to maintain both the trust of their patients and deliver quality care. So, what we found was that, for example, a person would go to the emergency room as the point of care. The emer-

gency room physician would provide appropriate care and, for example, diagnose diabetes and say, "You need to go see your primary care provider." At Phoenix, there simply were not enough—there was not enough access in primary care to accommodate patients who needed to go to the primary care provider.

So, what would happen was the patient would be given a consult, it would be put in a space that was not acted upon, and you would next see the patient show back up in the emergency room with diabetes again, with more problems with diabetes. So, you could track that. A consult was referred, did not get acted upon. You see the patient re-enter the system at a point that was not appropriate. It was what they needed to do, but it was not what should have happened.

So, what I think you have when you do not have primary care properly structured, both with respect to the way they schedule, the way they staff the office, the efficiency with which they run the office, you get chaos. I think that is what we were experiencing, was you are looking in on a group of people who all knew they could not get it done correctly; they are all struggling to save patients who they thought would be at harm; and you see schedulers trying to schedule patients into slots that do not exist. It was just quite a horrible view of what was going on there.

Senator BOOZMAN. Well, not just there, though. I mean, has that happened multiple other places?

Dr. DAIGH. Well, I think this would be the worst example I have seen of—

Senator BOOZMAN. I guess what bothers me is that ER doctor—I can understand, you know, turning him over in the first place, then not getting seen, you know, in 2 weeks, or whatever the timeframe is. And sometimes it is appropriate that—you mentioned audiology. You know, that might stretch on without any problem at all or just a routine follow-up. But when the ER doctors see them again in the ER and they see that that consult has not been done, there has to be—it is the responsibility of that physician. I mean, where is the outrage from the doc that was seeing them, knowing that they had not been seen—

Dr. DAIGH. I think there was outrage, and they expressed their complaint to the leadership at the facility. And, again, if people are not hired or money is not put to address the problem you speak to, then after a while you realize that nothing is going to happen. And if the facility talks to the national leadership and says, "I have a problem," and you do not get a response, then people get conditioned to think, well, this is just the way it has to be, this is the way it is going to be in this system. And that is unacceptable.

So, in hearing the physicians and providers on the ground, nurses and docs on the ground, I think they were all anxious and upset at what they saw, trying to deal with it the best they could.

Senator BOOZMAN. I know this is about scheduling, and, you know, you mentioned that you felt like there were not any deaths involved as a result of the scheduling. But in looking at some of the cases that you present, there might not be deaths, but there was certainly very poor quality of care in some of those. Poor quality of care means malpractice. Are we following up on that? Are we

in the process of doing an IG study regarding quality of care with these cases and other cases?

Mr. GRIFFIN. We already concluded that there was poor quality of care on those. The problem as far as tort claims activity, as was previously stated, those are adjudicated in a court of law, and the experts that have to be involved in that adjudication, in the case of the State of Arizona, have to be people who have practiced in that area of specialty in the State of Arizona. And it is a program function of the Department to address allegations of malpractice, which is why we provided them with the 45 names and said that you need to look into these 45 cases with your attorney staff and with your medical staff and determine whether there is something that needs to be done for these people.

Senator BOOZMAN. No, I understand, and the Chairman is going to rap me in a second. But I guess my concern is when you see these cases in that particular situation, we have a culture of, again, breakdown in scheduling, breakdown in communication among the physicians and the schedulers or whatever. My concern is that this sort of activity is throughout the system, and that is what I was referencing. Are we going to investigate to see if we have this quality of care throughout the system.

Chairman SANDERS. Thank you, Senator Boozman.

Senator Blumenthal?

Senator BLUMENTHAL. Thanks, Mr. Chairman, and thanks again to all of our witnesses here today.

I know that in response to Senator Tester's question, Inspector General Griffin, you mentioned that these individual cases will be turned over to prosecutors if criminal violations are found. Is that correct?

Mr. GRIFFIN. That is correct.

Senator BLUMENTHAL. And they will be turned over on an individual basis?

Mr. GRIFFIN. Right, because they are in different judicial districts around the country.

Senator BLUMENTHAL. And they involve different facts.

Mr. GRIFFIN. Right.

Senator BLUMENTHAL. Who will make the decision about whether those cases should be turned over to criminal prosecutors?

Mr. GRIFFIN. When we have evidence of potential criminality, it is our job to take it to the Assistant U.S. Attorney or the U.S. Attorney in that district, present the facts, and they make a determination whether or not it rises to the level of the types of things that they are presently involved with prosecutions of.

Senator BLUMENTHAL. In effect, the prosecutors will be making those decisions, just as they would with any investigative agency, whether it be the FBI or the Drug Enforcement Administration.

Mr. GRIFFIN. Correct.

Senator BLUMENTHAL. What is the timing for beginning to turn over those investigative results?

Mr. GRIFFIN. Turn over to the Department or to the——

Senator BLUMENTHAL. I am sorry. I was unclear in my phrasing. What is the timing for presenting those cases for judgments by the prosecutors——

Mr. GRIFFIN. The timing is when——



Senator BLUMENTHAL [continuing]. Given that there is potential criminality?

Mr. GRIFFIN. When we feel that we have developed the evidence that would support a criminal charge.

Senator BLUMENTHAL. Has the prosecutor in any of those jurisdictions said to you, "We need that evidence as soon as possible"? Have they given you a timeline?

Mr. GRIFFIN. No. No, we are working feverishly to accomplish these things. Another point that I had made in your absence was our criminal investigators make over 500 arrests a year. We have had a number of cases that were already in the investigative and prosecutive pipeline before this happened. And as you know, it takes—it can take forever to work it through the prosecutive system.

Senator BLUMENTHAL. Well, hopefully not forever.

Mr. GRIFFIN. Well, it can sometimes feel like that.

Senator BLUMENTHAL. I know that much well.

Mr. GRIFFIN. Sure. So—

Senator BLUMENTHAL. When I was a U.S. Attorney, I would say to investigative agents, some of the best in the Nation, "Here is my timeline." Not that the world would fall apart if they did not meet it, but there would be timelines for completing investigations. I gather you have not been given any.

Mr. GRIFFIN. No, but I can tell you that the Assistant Attorney General for the Criminal Division sent out a memo to every U.S. Attorney's Office and all the chiefs of Criminal basically giving them his point of view on what potential charges under Title 18 could be brought for the various types of manipulations or different things—

Senator BLUMENTHAL. Falsification of records, destruction of documents.

Mr. GRIFFIN. Right, absolutely.

Senator BLUMENTHAL. Obstruction of justice.

Mr. GRIFFIN. Right.

Senator BLUMENTHAL. I am going to sort of segue to the next area of questioning, which you and I have talked about. I appreciate you have some very skilled and experienced investigators working for you. But my feeling is there simply are not enough. Do you disagree with me?

Mr. GRIFFIN. I would say that we are fully engaged and could probably put twice as many people to work as we have assigned to the organization.

Senator BLUMENTHAL. You could put twice as many to work, and they would all be very busy.

Mr. GRIFFIN. Yes.

Senator BLUMENTHAL. And they would be busy doing very, very important work, which would lead me to the conclusion that there are not enough of them, because criminal investigations here serve a vitally important purpose. I do not need to tell you because you are a very skilled and able investigative officer and Inspector General and watchdog. But the deterrent purpose of a criminal investigation, prosecution, and conviction is irreplaceable. There is nothing like the deterrent effect of a successful criminal investigation to deter criminality. We are not talking about deterring careless-

ness or even negligence, which can be serious enough in their consequences, but real criminality.

So, I simply would urge you to be as aggressive as possible in asking for resources that are necessary for the VA to really do its job and deter criminality, assuming that it existed here and may be ongoing elsewhere in the agency, as it may be in any agency of our Government—State or Federal.

Thank you for your service. My time has expired.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Blumenthal.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman.

Mr. Griffin, I was really deeply disturbed to read your findings about how many cases of suicide and veterans with serious mental health problems were affected by delays in care and substandard care. Many facilities in my homestate of Washington are facing staffing problems and long wait times for mental health care, and I just wanted to say, if hospitals in Washington State are on your list of facilities for further investigation, I really hope your team will look very closely at the mental health care problems like they have done in Phoenix.

I wanted to ask you, the Phoenix report really criticized VHA's resistance to change, and both your report and the White House review found serious cultural and ethical failings across the system.

What do you think the VA should be doing to make these kinds of systemwide changes?

Mr. GRIFFIN. I think you have to hold people accountable when they ignore directives on how to do business. And I think after awhile people will begin to toe the line rather quickly—

Senator MURRAY. And that has not been done?

Mr. GRIFFIN [continuing]. When they realize there is a price to be paid.

Senator MURRAY. And that has not been done.

Mr. GRIFFIN. No. I mean, how can you have a certification requirement that you abolish because some of the managers in the field are pushing back about it, because they might not be sure if their scheduling staff is doing it right, and the IG staff might come after them for asserting something that was not true or certifying something that was not true. You just do not tolerate that.

Senator MURRAY. Yes, OK. You have mentioned several times here that you are following on 93 facilities' investigations, and the results are confirming some of the things you found at Phoenix, meaning wait times are being manipulated.

Mr. GRIFFIN. Right.

Senator MURRAY. When your reports are completed, I really expect the VA to implement your recommendations quickly and to hold people accountable, as you just referred to. But I wanted to ask you this morning, is your impression that the motivation for these inappropriate practices more to show false information or is it more just a lack of training?

Mr. GRIFFIN. I think it is a combination of a number of factors. In each of our reports going back to 2005, one of the recommendations was to ensure that the schedulers were properly trained in

the way it was supposed to be done. I mean, that was a repeat recommendation.

Senator MURRAY. So, they have been hearing this for a long time?

Mr. GRIFFIN. Oh, yes, as you know from your previous time with the Committee. 2005 was the first time and the first report that we had that. As I mentioned earlier, I think you have to have a person working the scheduling side that has some clinical knowledge of being able to triage: how bad does this veteran need to be seen today as opposed to somebody else. So, that is not currently the case and my belief at a lot of facilities.

Senator MURRAY. Yes, and I know some of the facilities are saying, well, this is low level. We have a lot of people coming in. It is hard to keep up with it. Is that an excuse?

Mr. GRIFFIN. No. I mean, I do not think there is an excuse for—I mean, I believe that over the years, VA's budgets have pretty much been matched or exceeded by Congressional appropriators. But if you do not know what your demand is and how many people are on secret lists and you do not know, gee, we need 30 percent more clinicians, or whatever the number is—

Senator MURRAY. They cannot ask for it.

Mr. GRIFFIN [continuing]. Then they cannot even ask for it.

Senator MURRAY. Yes.

Mr. GRIFFIN. I think the responsibility is, you have to do a serious strategic analysis, not just of your clinicians, but also the blend with fee-basis care and come up with a solid number that you can hang your hat on and say, in order for us to treat veterans in a quality manner and in a timely manner, we need this number of doctors and we need this amount of money for fee-basis for rural areas, or what have you.

Senator MURRAY. Mr. Chairman, I know you have heard me say it a million times. This Congress, the country wants to be there for our veterans, but if we do not know what the need is accurately, we do not know what to provide. I echo that point.

Let me just ask you one other thing. You have been doing this a long time. We have been hearing this for a long time. You have been doing a lot of investigations. Have you found any facilities or networks that have done a good job of regularly and thoroughly checking for scheduling gimmicks?

Mr. GRIFFIN. We found a number of facilities out of our 93 where we concluded that there was no manipulation occurring, which is a good thing, maybe one-fourth. The bad news is on the other three-fourths, we are pretty confident that it was knowingly and willingly happening—

Senator MURRAY. That is a pretty high percentage.

Mr. GRIFFIN [continuing]. And we are pursuing those.

Senator MURRAY. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Murray.

Senator MURRAY. And thank you and all your team.

Chairman SANDERS. Let me thank Mr. Griffin not only for being here, but for the excellent work that he and his department are doing. We thank all of his staff for being here as well. Thank you very much.

Mr. GRIFFIN. Thank you, Mr. Chairman.

[Posthearing questions to Richard J. Griffin follows:]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO  
RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS  
AFFAIRS

COMPLIANCE WITH RECOMMENDATIONS

*Question 1.* Please provide detail on the process the IG uses to ensure VA complies with its recommendations.

Response. Because ultimate responsibility to ensure implementation of corrective actions rests with VA senior officials, the OIG cannot force compliance with report recommendations. We track VA's progress in implementing our recommendations through the OIG Follow-Up process, which is described below, and provide the VA Secretary and Congress with quarterly reports on the status of recommendations that remain unimplemented for more than 1 year. These reports are contained in the OIG Semiannual Reports to Congress and in letters from the Acting Inspector General to the Chairmen and Ranking Members of the U.S. Senate Veterans' Affairs Committee and U.S. House Veterans' Affairs Committee. We believe that keeping the VA Secretary and Congress informed of these delays is the best leverage the OIG has to ensure VA compliance with our recommendations.

The OIG follows up on VA's implementation of recommendations by:

- Approximately 90 days after the OIG issues a final report (and every 90 thereafter until report closure), the OIG will send a status update request to the action office(s) at VA to which the recommendations are addressed.
- Each VA office is expected to submit a response to this request to the OIG within 30 days.
- Responses need to contain supporting documentation to substantiate stated actions.
- The OIG will analyze the response and determine whether the action office implemented any recommendations to the satisfaction of the OIG.
- We will not close a recommendation unless supporting documentation indicates corrective action has occurred or action has sufficiently progressed to close the recommendation as implemented. For example, the OIG will not close a recommendation to train employees on a particular issue on a mere promise by the VA action office to conduct the training. The VA action office will need to submit documentation of completed training or, at a minimum, be able to demonstrate through documentation (e.g., a directive, training syllabus and schedule, etc.) that it has established a training program and begun the training in a systematic fashion—thereby indicating it is meeting the intent of the recommendation.
- The Follow-up cycle will repeat until the action office implements all open recommendations.

The OIG may conduct reviews, including unannounced visits to facilities, to determine if the action VA said was completed was actually completed.

*Question 2.* Given a number of reoccurring issues in IG and GAO reports over the past decade, such as VA scheduling practices and data integrity concerns, does the IG anticipate reviewing its compliance process?

Response. As stated in response to the first question, the OIG's best leverage to ensure compliance with report recommendations is keeping the VA Secretary and Congress informed of delays identified through our follow-up process on a quarterly basis. We also conduct follow-up inspections and audits to assess compliance on a selective basis. We plan to continue both practices. Moreover, there are a number of sources that we use to periodically assess VA's compliance with their stated action plans. Among these sources are OIG and GAO's previously published reports and information from our criminal and administrative investigations. Another source is our analysis of allegations received through the OIG Hotline. These allegations provide us with data to identify trends on specific VA program issues as well as identify potential problems with particular Veterans Health Administration and Veterans Benefits Administration facilities. This analysis provides a basis for planning and scheduling future work and results in annual updates of the most serious management challenges facing VA in VA's Performance and Accountability Report.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 3.* Inspector General, during your investigations, what comments stood out to you from the VA staff that would help improve the scheduling system or access to care concerns.

Response. Our investigations found that manipulation of wait times was systemic in VA. Desired dates for appointments were routinely manipulated to incorrectly appear that veterans were not required to wait longer than 14 days for an available appointment. Many employees advised that they did not see the harm in “zeroing out” the wait times since the date selected was the first available date for an appointment. The actual length of wait times was hidden by this process. Decisions regarding proper allocation of medical staff to meet the needs of veterans could not be properly made when the true need for services was disguised by the manipulation of wait times.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE HIRONO TO RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 4.* Given the numerous changes that need to be made how would you suggest VA prioritize the implementation of each given the one year deadline it has promised? Which recommendations are most urgent?

Response. In regard to the twenty-four recommendations made within our Phoenix report, VA provided an action plan containing a written response, status, and expected completion date for each recommendation. VA began to address some of these recommendations prior to publication of our final report. For example, throughout our review we identified veterans waiting for care. As these veterans were identified, we provided VA the names of these veterans. These veterans were contacted by VA and appointments made for those who desired care.

Of the recommendations not yet implemented, those which directly impact patient care are the most pressing and time-sensitive. However, supporting recommendations, such as those pertaining to performance plans and facility goals are just as critical in ensuring future accountability as changes across the system are implemented, and should not be given less consideration by VA leadership.

*Question 5.* Your testimony outlines that you office’s investigations have confirmed that wait time manipulations are prevalent throughout VHA at many facilities across the country. When do you anticipate completing these investigations and will you keep my staff informed related to any issues arising at the VA Pacific Islands Health System when they are completed?

Response. The OIG is aggressively investigating the alleged manipulation of wait times at 93 sites of care. We completed reports of investigation regarding alleged manipulations at 18 of the 95 sites. We referred cases to the appropriate U.S. Attorneys’ Offices for prosecutive determinations when evidence corroborated allegations of potential criminal activity. After exhausting the potential for criminal prosecution, these reports were provided to VA’s Accountability Review Team for any administrative action deemed appropriate. We made these allegations a priority and have devoted the resources to ensure that all wait times cases are worked thoroughly. In many of these cases, timelines involve decisions from the U.S. Department of Justice. Investigations involving multiple complex matters often require serious contemplation before prosecutive opinions are rendered. As a result, we are not able to give an exact expected completion date for the cases under active investigation. However, the need to expeditiously investigate these cases is routinely conveyed to our staff. We will contact your staff when our investigation at the VA Pacific Islands Health System is finished.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR ON BEHALF OF HON. JEFF FLAKE TO RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 6.* On August 26, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) submitted a report of its review of allegations of mismanagement and misconduct at the Phoenix VA Health Care System (PVAHCS). This report stated that there were ongoing investigations regarding potential criminal violations. Sharon Helman, the former director of PVAHCS, may be among those being

examined by OIG and, understandably, the details of these ongoing inquiries cannot be disclosed for fear of compromising the investigation.

a. Does OIG have an estimation regarding a completion date for these ongoing investigations, which may confirm criminal violations?

Response. We have made these allegations a priority and devoted the resources to ensure that all wait times cases are worked thoroughly and expeditiously. In many of these cases, timelines involve decisions from the U.S. Department of Justice. Investigations involving multiple complex matters often require serious deliberation before prosecutive opinions are rendered. As a result, we are not able to give an exact expected completion date for the cases under active investigation. The VA Office of Accountability Review tracks administrative action resulting from investigations of wait times manipulations.

b. Does OIG have any plans to expand the number of investigations regarding potential criminal investigations?

Response. We will thoroughly examine any referral of alleged criminal activity related to manipulation of wait times. Inquiries will be opened upon receipt of credible allegations of such conduct. Full investigations will be opened when evidence indicates that manipulation was directed by VA supervisors or managers. We notify the Federal Bureau of Investigation when we open investigations as described in the Attorney General Guidelines for Offices of Inspector General With Statutory Law Enforcement Authority.

*Question 7.* As you know, the Veterans Access, Choice, and Accountability Act of 2014 was recently passed by Congress and signed into law by the president. Among other things, the purpose of this legislation is to provide the VA with increased latitude to remove agency employees when necessary.

a. Do you believe that this legislation provides the VA with adequate authority to remove underperforming employees?

Response. Until it is fully implemented, the impact is unknown.

b. Will the added hiring and firing flexibility enable the VA to significantly improve the quality of care that it delivers to veterans?

Response. Additional flexibility in the hiring process has the potential for VA to bring health providers on board in a timelier manner thus increasing timelier access to care. The OIG is playing a role in this regard by identifying the five VA health provider occupations with the greatest staffing shortages on an annual basis, which will allow VA to use Title 5 direct hire authority for these occupations. The impact of firing flexibility with respect to senior executives cannot be evaluated at this time.

Chairman SANDERS. Mr. Secretary, thank you very much for being with us. Again, my apologies for putting you on second, but I thought it would be important for you and for the Committee to be hearing from the Inspector General first. The floor is yours and please take as much time as you need.

**STATEMENT OF HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CAROLYN M. CLANCY, M.D., INTERIM UNDER SECRETARY FOR HEALTH**

Secretary McDONALD. Thank you, Chairman Sanders. Obviously, we thought it was important as well that the Inspector General go first, so we are very pleased to be here after the Inspector General.

Chairman Sanders, Ranking Member Burr, and distinguished Members of the Committee on Veterans' Affairs, thanks for the opportunity to discuss with you VA's response to the recent VA Office of Inspector General report regarding wait times and scheduling practices at the Phoenix VA Hospital. I said at the time of my confirmation hearing that I will put veterans at the center of everything that we do at VA.

So, let me begin by offering my personal apologies to all veterans who experience unacceptable delays in receiving care. It is clear that we failed in that respect, regardless of the fact that the report

on Phoenix could not conclusively tie patient deaths to delays. I am committed to fixing this problem and providing timely, high-quality care that veterans have earned and that they desire. That is how we regain veterans' trust and that is how we regain your trust and the trust of the American people.

The final IG report has now been issued and as the Inspector General said, we have concurred with all 24 of the report's recommendations. Three of the recommendations have already been remediated and we are well underway in remediating many of the remaining 21 because we began work when the IG's interim report was first issued in May.

For accountability, we have proposed the removal of three senior leaders in Phoenix. As we learn more about individual supervisors' and employees' roles in the problems there, we may find that additional disciplinary actions are warranted and we will take them.

We are grateful for the Committee's leadership in establishing the recently passed Veterans Access, Choice, and Accountability Act of 2014. This important act streamlines the removal of VA senior executives and the appeals process if misconduct is found. However, it does not guarantee VA's decisions will be upheld on appeal or allow VA to fire senior executive officers without evidence or cause.

We have taken many other actions in Phoenix and the surrounding areas to improve veterans' access to care, including, first, putting in place a strong acting leadership team, good people with a proven track record of serving veterans and solving problems. They are in place, they are operating in Phoenix now, and I have visited them on site.

Increasing Phoenix staffing by 162 people and implementing aggressive recruitment and hiring processes to speed recruiting. Reaching out to all veterans identified as being on unofficial lists, or the facility electronic wait list, and completing over 146,000 appointments in 3 months. As of September 5, there are only ten veterans on the electronic wait list at Phoenix.

Where VA capacity did not exist to provide timely appointments, we referred patients to non-VA care. From May through August, Phoenix made almost 15,000 referrals to non-VA care. We have secured contracts to utilize primary care physicians from within the community in the future.

Since my confirmation as Secretary, I have traveled to VA facilities across the country speaking to veterans and VA employees, as well as visiting and speaking with Members of Congress, veteran service organizations, and other stakeholders. During these visits, I found VA employees to be overwhelmingly dedicated to serving veterans and driven by our strong VA institutional values of integrity, commitment, advocacy, respect, and excellence. The acronym we use is I-CARE and I am wearing that button here today.

Our people are making a difference. Nationally, they have enabled the following critical achievements: as of August 15, VHA has reached out to over 294,000 veterans to get them off of wait lists and decreased the veterans on the electronic wait list by 57 percent. VHA has developed the Accelerating Care Initiative to increase timely access for care for veteran patients, decrease the number of veterans on the electronic wait list longer than 30 days,

and standardized the process and tools for ongoing monitoring and access management at all VA facilities.

Where we have not been able to increase capacity, we have increased the use of community, non-VA care. Between May and August, we have made almost a million total referrals for non-VA care, over 200,000 more referrals than for the same period in 2013. The 14-day access measure has been removed from all employee performance plans to eliminate any incentive for inappropriate scheduling. Over 13,000 performance plans have been amended. We are simultaneously updating our antiquated appointment scheduling system and working to acquire a comprehensive, state-of-the-art commercial, off-the-shelf scheduling system.

VA medical center directors and VISN directors are completing in-person reviews of their facilities' scheduling practices that can be completed by the end of this month. So far, 3,000 of these reviews have been conducted nationwide. We have restructured VHA's Office of the Medical Inspector to better serve veterans and to create strong internal audit function.

On August 7, I asked all VA employees to reaffirm their commitment to both our mission and our I-CARE values: integrity, commitment, advocacy, respect, and excellence. I intend this reaffirmation to be repeated by each and every employee each year on the anniversary of our establishment as a department. If an employee refuses to recommit, I want to meet with them personally and will decide actions after that.

We are building a more robust continuous system for measuring patient satisfaction to provide real-time site-specific information, collaborating with VSOs in this effort and learning what other leading health care systems are doing to track patient access information. We are working hard to create and sustain a climate that embraces constructive dissent, that welcomes critical feedback, and then ensures compliance with legal requirements. That climate mandates commitment to whistle-blower protections for all employees.

Yesterday we announced the beginning of our Road to Veterans Day, our 90-day plan, which begins with our mission to better serve and care for those who have borne the battle and for their families and for their survivors. We will focus our efforts over the next 60 days to rebuild trust with veterans and the American people, to improve service delivery, and to set the course for long-term excellence and reform.

As we move forward, we will continue to work with the IG and other stakeholders to ensure accountability. As you heard, there are over 100 ongoing investigations at VA facilities by the IG, by the Department of Justice, by the Office of Special Counsel, and by others. In each case, we await the results and will take appropriate disciplinary actions when all the facts and evidence are known.

But we will not wait to provide veterans the care that they earned and that they desire. We are going forward. We will focus on sustainable accountability in the future. More than just adverse personnel actions, sustainable accountability means ensuring all employees understand how their daily work ties back to that mission of caring for veterans. We want them to understand how it ties back to the mission, how it ties to our values, and how it ties



to our strategies, and we want to make sure that everybody's behavior every single day is guided by those values and that mission.

We also want to make sure that every employee understands it is their responsibility to provide feedback to their supervisor when they are asked to do something that is impossible to do. We want to make sure that feedback loop is daily and that every employee is getting daily feedback from their supervisor and that every supervisor is giving daily feedback to their manager.

Sustainable accountability requires we do a better job of training our leaders. We need to flatten our hierarchical culture, we need to encourage innovation, we need to encourage collaboration, and we need realistic ratings of everyone's performance. Everyone cannot be the best. With sustainable accountability, employees fulfill their responsibility to veterans and to the Department to provide feedback and input on how we can better serve veterans. Who better than to help us improve our Department than the employees who every day are interacting with our veterans?

We will judge the success of all these efforts against a single metric and that is the veterans outcomes. We do not want VA to meet a standard; we want VA to be recognized as the standard in providing health care and benefits. I know we can fix the problems we face and I will utilize this opportunity to transform VA to better serve veterans.

Mr. Chairman, Members of the Committee, thanks for your unwavering support of our Nation's veterans. I look forward to working with you in implementing the law and in making things better for all of America's veterans. Dr. Clancy and I are prepared to take your questions at this time.

[The prepared statement of Secretary McDonald follows:]

PREPARED STATEMENT OF HON. ROBERT A. McDONALD, SECRETARY,  
U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Senate Committee on Veterans' Affairs, thank you for the opportunity to discuss with you the Department of Veterans Affairs' (VA) response to the recent VA Office of Inspector General (OIG) report regarding wait times and scheduling practices at the Phoenix VA Health Care System (PVAHCS).

Let me begin by saying, I sincerely apologize to all Veterans who experienced unacceptable delays in receiving care at the Phoenix facility, and across the country. We at VA are committed to fixing the problems and consistently providing the high quality care our Veterans have earned and deserve in order to improve their health and well-being. We owe that to each and every Veteran that is in our care. We will continue to listen to Veterans, our VA employees, and Veterans Service Organizations (VSO) and use their feedback to improve access to quality care in Phoenix and across the country and we will work hard to rebuild trust with Veterans and the American public.

The VA OIG has released the final report of its review of issues with patient scheduling and access at PVAHCS. We have concurred with the recommendations in the final report and, in many cases, we have already taken action responding to the OIG's recommendations, improving processes and access to care for Veterans.

PVAHCS' IMPLEMENTATION OF OIG RECOMMENDATIONS

The final OIG report is an update of the information previously provided by the OIG in its Interim Report issued on May 28, 2014, and contains final results from their independent review of the PVAHCS. In response to the report recommendations, we have outlined key action plans that expand access to care, improve staffing for primary care, and ensure accountability measures. All cases identified by OIG were reviewed, and determinations regarding appropriateness of disclosures to patients and families are underway.

Currently at PVAHCS, we have a strong acting leadership team producing positive results. Glenn Costie is the Acting Medical Center Director and Elizabeth Freeman is the Acting Network Director. They are good people with a proven track record for serving Veterans and solving problems.

Based on the Interim report of the OIG, we began actions in Phoenix and across the country that have enhanced access for Veterans seeking care. In Phoenix specifically, we have taken the following actions:

*Primary Care Staffing*

PVAHCS leadership is increasing Primary Care staffing by 53 additional full-time equivalent employees. Aggressive recruitment and hiring processes have been implemented to speed this process. All services—physicians, nurses and clerks—have increased staffing in the clinics and Community-Based Outpatient Clinics (CBOC) and the facilities are securing contracts to utilize Primary Care physicians from within the community. Primary Care was recently added to the Patient-Centered Community Care contracts, and Health Net and TriWest are working to add Primary Care physicians to their networks nationwide including the Phoenix area.

*Access to Care (wait lists)*

PVAHCS, with support from the Veterans Health Administration's (VHA) Health Resource Center (HRC), has reached out to all Veterans identified as being on unofficial lists or the facility Electronic Wait List (EWL). PVAHCS completed 46,997 appointments in May, 48,970 appointments in June, and 50,629 appointments in July, for a total of 146,596 appointments completed at PVAHCS in three months.

As of August 15, 2014, there were 56 Veterans on the EWL at PVAHCS. PVAHCS is now scheduling the vast majority of patients directly into a Primary Care appointment when enrollment/registration occurs. Over 3,200 appointments have been made in Primary Care for new patients since this initiative began.

*Access to Care (scheduling)*

We announced on June 4, 2014, that the Department had reached out to all Phoenix, Arizona-based Veterans identified by the OIG as being on unofficial wait lists to immediately begin scheduling appointments for all Veterans requesting care. Nationally, VHA expeditiously deployed staff and resources from around the country to help PVAHCS identify patients waiting for care, clearing the way for them to get the care they needed. We have made progress and are publicly publishing data on our progress.

*Access to Care (non-VA Care)*

Clinical staff attempted to accommodate all appointments at PVAHCS. Where capacity did not exist to provide timely appointments, staff referred patients to non-VA community care in order to provide all Veterans timely access to care. From May 16, 2014 through August 28, 2014, PVAHCS has made 14,622 referrals for appointments to community providers of non-VA care.

Since the Accelerating Care Initiative (ACI) began, resources have been provided to continue to work down the number of open consults even further. Since the beginning of the ACI, \$24.9 million has been obligated as part of this initiative to provide community-based care for Veterans in the community.

*Access to Care (new enrollees)*

PVAHCS is hiring dedicated staff to complete on-line enrollment processing. VHA is developing an automated system for monitoring enrollment processing at PVAHCS and every VA facility. This monitor will track Veterans new to the VA and will assess the timeframe to their first appointment within the VA health care system. The data will be reviewed monthly with VISN 18 and PVAHCS leadership.

Locally, PVAHCS implemented process changes to ensure that Veterans receive appropriate care. To ensure continued success, patients waiting for care are reviewed daily and reported to facility and VISN leadership.

In July 2014, the Acting PVAHCS Director visited all CBOCs and local Clinics to observe the scheduling process and interact with scheduling staff to ensure all policies are being followed to deliver Veterans the timely care they have earned. These interactions are now happening monthly across the country.

VA NATIONWIDE

Since my confirmation as Secretary, I have traveled to VA facilities across the country speaking to employees and Veterans. I cannot overstate their enthusiasm for being part of the solution to our current challenges. Overwhelmingly VA employees are dedicated to serving Veterans. They are driven by strong institutional values that influence day-to-day behavior and performance: Integrity, Commitment, Advo-

cacy, Respect and Excellence, I-CARE. On my first day as Secretary I asked all VA employees to join me in reaffirming our commitment to these core values and I directed VA leaders to do the same with the people that work for them. As we continue to move forward, our values help cultivate a climate where all employees understand what the right thing is and then does it. VA's way of doing business must conform to how we expect employees to treat Veterans and how we expect employees to treat one another. It is clear that somewhere along the line, some people's behavior was at odds with VA's mission and core values. It is up to the Department to reaffirm its worth and regain Veterans' trust. Over the past months, we have been forced to take a hard look at ourselves and the way we do business, listening to Veterans, employees, Congress, VSOs and other stakeholders.

Using their input, VA is in the process of rapidly deploying and instituting an array of changes aimed at fixing VA's problems. Beyond culture issues, demand outstripped supply. This contributed to an environment that led to violations of our mission and our values. Demand was increased by new presumptive conditions, twelve years of war, the economy and significant VA outreach and education efforts. Peak application of care for wars is decades after the conflict ends as Veterans age. This issue will be with us a long time. We have to build the appropriate capacity now.

We have initiated development of a more robust process for continuously measuring patient satisfaction at each site, and we will expand our patient satisfaction survey capabilities in the coming year, to capture more Veteran experience data through telephone, social media, and on-line means. Additional VA-wide actions include:

#### *Access to Care*

- As of August 15, VHA has reached out to over 266,000 Veterans to get them off wait lists and into clinics.

VA has re-doubled its efforts to provide quality care to Veterans and has taken steps at national and local levels to ensure timely access to care. VHA has developed the Accelerating Care Initiative (ACI), a coordinated, system-wide initiative designed to increase timely access to care for Veteran patients; decrease the number of Veteran patients on the EWL waiting longer than 30 days for their care; and standardize the process and tools for ongoing monitoring and access management at VA facilities. As of August 15, VA has decreased the number of Veterans on the EWL 57 percent. As we continue to address systemic challenges in accessing care, we are providing regular data updates to enhance transparency and provide the immediate information to Veterans and the public on improvements to Veterans' access to care. Data updates can be found on the following link: <http://www.va.gov/health/access-audit.asp>

- VA health care facilities nationwide continuously monitor clinic capacity in an effort to maximize VA's ability to provide Veterans timely appointments appropriate for their clinical conditions.

- Where VA cannot increase capacity, VA is increasing the use of care in the community through non-VA medical care. From May 16, 2014, through August 24, 2014, 975,741 total referrals to non-VA care providers have been made. That is 203,637 more non-VA care referrals than the same time period in 2013.

- Each of VA's facilities continuously reaches out to Veterans waiting longer than 90 days for care to coordinate the acceleration of their care.

- Facility clinical staff continuously evaluates Veterans currently waiting for care to ensure the timing of their appointment is medically appropriate for their individual clinical conditions.

- VA is decreasing the number of Veterans on the EWL by standardizing the process and tools for ongoing monitoring and access management at VA facilities.

- VHA utilizes call monitoring in its large national call centers. These monitoring practices require adequate telephony systems. VHA will introduce new monitoring practices through the VA Health Resource Center to assess scheduling practices performed by VA staff.

#### *Scheduling*

- The 14-day access measure was removed from all employee performance plans to eliminate any incentive for inappropriate scheduling practices or behaviors. In the course of completing this task, over 13,000 performance plans were amended.

- VA has suspended the use of Desired Date Performance Accountability Report (PAR) performance plans. VA is currently evaluating the use of Desired Date as a mechanism to assess patient preferred appointment timeframes.

- The VSOs are actively engaged in the process. We are updating the antiquated appointment scheduling system, beginning with near-term enhancements to the ex-

isting system and ending with the acquisition of a comprehensive, state-of-the-art, “commercial off-the-shelf” scheduling system.

#### *Accountability*

- At VA, we depend on the service of employees and leaders who place the interests of Veterans above and beyond self-interest. Accountability, delivering results, and honesty are key to serving our Veterans.
- Where willful misconduct or management negligence is documented, appropriate personnel actions will be taken—this also applies to whistleblower retaliation, which is unacceptable and intolerable at VA.
- VA Medical Center Directors and VISN Directors are completing face-to-face audits of their facilities’ scheduling practices. The first round of face-to-face audits will be completed by September 30, 2014. So far, we have conducted 2,450 of these visits nationwide.
- On July 8, 2014, the Deputy Secretary announced that he ordered a restructuring of the Office of the Medical Inspector (OMI) to better serve Veterans and create a strong internal audit function. This restructuring will result in revisions to the policies, procedures, and personnel structure by which OMI operates and establish an internal audit group that will validate VHA’s critical national performance measures.
- On August 7, 2014, I asked all VA employees and leadership to reaffirm their commitment to both our mission and “I CARE” values—Integrity, Commitment, Advocacy, Respect and Excellence. I intend this reaffirmation to be the first of many, to be repeated by each employee each year in March, on the anniversary of our establishment as a Department.

#### *Patient Satisfaction*

- We are building a more robust, continuous system for measuring patient satisfaction to provide real-time, site-specific information on patient satisfaction. We will augment our existing survey with expanded capabilities in the coming year to capture more Veteran experience data using telephone, social media, and on-line means. Our effort includes close collaboration with VSOs to plan our efforts. We are learning what other leading healthcare systems are doing to track patient access experiences.

#### *Whistleblower Protections*

We have made great strides in improving care and services to Veterans in Phoenix and nationwide because employees in Phoenix and elsewhere had the moral courage to do the right thing. They made their voices heard about what they saw happening. Those employees are examples of I-CARE at its best. Our collective ability to deliver the best services and care to Veterans is inextricably linked to sustaining an organizational culture that protects and empowers the voices of all employees and leverages the diverse talent of all our human resources. This includes creating a climate that embraces constructive dissent, welcomes critical feedback and ensures compliance with legal requirements. As part of our commitment toward embracing this culture we have reinforced our commitment to whistleblower protections to all employees and VA recently registered for and published an implementation plan to receive certification from the Office of Special Council’s Section 2302(c) Certification Program.

#### *Accountability*

We will continue to work with IG and other stakeholders to take appropriate action, but accountability is about more than personnel actions. We must focus on sustainable accountability. Sustainable accountability means ensuring all employees understand how daily work supports our mission, values and strategy. Sustainable accountability is about more than top-down, hierarchical behavior modification. It is collaborative. Supervisors provide feedback, every day, to every subordinate to recognize what is going well and identify where improvements are necessary. In that same spirit, employees fulfill their responsibility to Veterans and to the Department to provide feedback and input on how we can better serve Veterans.

To achieve sustainable accountability we will do a better job training leadership, flatten our hierarchical culture to encourage innovation and collaboration and we will rate the relative performance of employees because everyone cannot be the best. We have strong institutional values: I-CARE. These are mission-critical ideals that must profoundly influence our day-to-day behavior and performance. In performance that mission, guided by those values, we will judge the success of our efforts against a single metric—customer outcomes, Veterans’ outcomes. We hold ourselves accountable to these standards. We do not want VA to meet a standard. We want VA recognized as the standard in health care and in benefits.

## CONCLUSION

Mr. Chairman, the health and well-being of the men and women who have bravely and selflessly served this Nation remains VA's highest priority. By recommitting, as a Department, to our values, I know we can fix the problems and utilize this opportunity to transform VA to better serve Veterans. This concludes my testimony. Dr. Clancy and I are prepared to answer questions you or the other Members of the Committee may have.

Chairman SANDERS. Mr. Secretary, thank you very much for being here, for your patience, and hearing the discussion with the Inspector General, and I think I am paraphrasing one of the other members who indicated that the perception is you have hit the ground sprinting, which is exactly what this Committee wanted from you and we appreciate that very, very much.

I want to reiterate a point that you just made, and that is that the vast majority of VA employees—I know this is the case in Vermont and all over the country—work tirelessly and work very hard to do everything they can for our veterans, and we should never forget that.

We should also not forget that while we are focusing today on the issue of timeliness and the need to make sure that every veteran in this country gets timely care, we also know that—I can tell you absolutely in Vermont that most veterans believe the care they are getting once they are in the system is of high quality. They appreciate the care they are getting and the work the staff is doing.

What I just want to do is—in a sense you talked about this in your opening remarks—but let us focus on three or four basic issues. Every Member of this Committee is outraged by the long wait periods veterans in various parts of the country are experiencing. Number 1, I want you to tell us briefly what kind of progress you have made in reducing those wait periods.

Number 2, we all agree it is unacceptable for VA staff or high ranking people to be lying, to be manipulating data. What have you done to get rid of people who are acting dishonorably? What plans do you have in the future?

Number 3—and this is tough stuff—how do we make sure—how do you lay the groundwork that what we have seen in Phoenix never happens again? How do you address, in fact, what is a national problem? I think Senator Begich raised the issue. It is no great secret that we have a serious crisis in the number of physicians we have, especially primary care physicians, the number of nurses that we have in various parts of this country.

We have given you some tools, and I am very proud of the work that came out of this Committee. We have given you tools, for example, in the Education Debt Reduction Program, which is similar to the National Health Service Corps, which now gives you the tool to go to medical schools. Maybe you could tell us a little bit about that.

And tell people who otherwise would graduate, young doctors deeply in debt, that we now have a strong debt forgiveness program in the VA. In other words, what are you going to do to address the very difficult issue of bringing more quality physicians, nurses, and other medical personnel into the system? Those are my questions.

Secretary McDONALD. Thank you, Chairman Sanders. First, in relationship to the first question, access to care, we have reached

out to over 294,000 veterans to get them off of wait lists and into clinics as of September 5. As a result, VA has decreased the electronic wait list by more than 32,000 nationwide since May 15. That is from over 57,000 in May to around 24,500 as of August 15. We have reduced the new enrollee appointment request list from nearly 64,000 to right now approximately 1,700, which is a reduction of about 62,000.

Chairman SANDERS. Mr. Secretary, this is a combination of expanding VA capacity and sending people out to the private sector?

Secretary MCDONALD. Yes, sir. It includes things like in Phoenix, we moved in three mobile units from around the region. We increased clinical hours. We worked on overtime. It is a matter of putting the resources where they need to be put. We collaborated with the Department of Defense in some sites, collaborating with Indian Health Service. These were the things that were done.

Also, we have had more people that we have put into the private sector; 246,300 more patients have gone into the private sector. And each one of those referrals actually has resulted in, on average, seven appointments. So, in a sense, that number understates the care that has actually been provided.

So, we are making progress there, but more work needs to be done, and obviously the bill that you mentioned is going to help us do that, by providing greater access points, 27 more new points, and the ability to hire more doctors and nurses.

You asked about disciplinary actions. I talked in my opening remarks about the three individuals in Phoenix who were seeking—who we have proposed disciplinary action for. We have a new acting director there in Phoenix. In my American Legion speech, I mentioned that we have over 30 actions that we have taken. Around five include members of the Senior Executive Service. About two dozen include medical professionals.

We are following up as quickly as we can. As soon as we get information that suggests we should take disciplinary action, we are taking it. We have stood up a separate team called the Accountability Team. I met with them as recently as yesterday. They report to me and their single job is to get after these as quickly as possible.

Chairman SANDERS. All right. Let me interrupt you—

Secretary MCDONALD. Yes, sir.

Chairman SANDERS [continuing]. Because I am running out of time. I just wanted to revisit the third question. The Inspector General made a good point, that it is hard to know what you need unless you have good information. I mean, in your judgment, how many more doctors, nurses, medical staff do you need, and how would you, at a time when this country is not producing enough primary care physicians, et cetera, are you going to get them?

Secretary MCDONALD. We need tens of thousands. Deputy Secretary Gibson said in his testimony, I think it was around 28,000. We are now going through a process—

Chairman SANDERS. Let me repeat that because that is an important point. You are telling us you believe you need 28,000 new medical staff?

Secretary MCDONALD. Including clinicians and other employees.

Chairman SANDERS. Wow.

Secretary MCDONALD. We are in the process of going through a big recruiting effort. I was at Duke University Medical School. I was with Senator Burr in Charlotte and I then went to Duke. We talked to over 500 members of the Duke medical community. I was in Philadelphia last Friday. I talked to members of the University of Pennsylvania Medical School.

We are trying to demonstrate to young people studying in the medical profession that VA is where they want to work. They want to work there because we have had three Nobel Prize winners. We have had seven Lasker Award winners. We do great up-front research. Did you know that the nurse worked at the VA who developed the use of the bar code for tracking patients and medication? We are known for innovation and young people should come work for us. The help that you gave us with student loan forgiveness, debt forgiveness, doubling the number is going to be very helpful to help us recruit.

Chairman SANDERS. All right. I have far exceeded my time.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman. Mr. Secretary, welcome and thank you for the role that you are filling. I have just got a couple areas, one on an item you just mentioned, that every private sector referral triggers seven additional visits. If you would, and you can have Dr. Clancy speak to this, I would love to see the data on that. I know that that is what VA actuaries have stated and what they believe.

I think we need to get to the bottom of it, figure out why. Is this a contractual problem where we have contracted with the private physician where they see an opening to bring a patient back seven times? Under Medicare, that would all be under a bundled payment. If we are going to utilize the private sector right, then we have got to figure out whether we are doing it right today.

But I cannot envision where every time we referred somebody to a private sector doctor, it triggers seven additional appointments, visits that we are going to pay for. And if that is the case, I would love to see the specifics on that when you are able to gather them.

With everything that you just went through, it is probably hard to believe that I would ask you this question, because you detailed greatly all the changes that we are making, but my question is this: how do you plan to change the culture at VA and how do you plan to measure it?

Secretary MCDONALD. First, we will get you data on those seven visits. As you know, many of our veterans have multiple illnesses, but we will get you the data and we will sit down together and talk about that.

[Responses were not received within the Committee's timeframe for publication.]

In terms of changing the culture, changing the culture is probably one of the most difficult leadership challenges, whether it is in the private sector or the public sector. I think the most important thing we have got to do is to open up the culture. As I described earlier, high performance organizations have the improvements made by the employees, not by the leadership.

The leadership certainly helps. They pick the strategies, they pick the leaders, and they help create the culture. But we have got

to get every employee involved. On the very first week I met with the union leadership. The majority of our employees are union members; about 65 percent are union members. I met with the union leadership three times in my first 5 weeks, and I am asking them to recommit themselves to our values, our mission, and to help me engineer the changes that we need to make.

Every time I go to a site, I meet with the union leadership as well. I include them in our leadership meetings. I also make sure I talk to the whistle-blowers from that site, and I always do a town hall where I explain to the employees that I want every employee to be a whistle-blower. I want every employee causing us to change.

I have used a diagram—I used it yesterday and I have used it with employees—that basically says that most people think of an organization structure like a pyramid. At the Proctor & Gamble Company, you would have a CEO. At the Department of Veterans Affairs, you would have a Secretary.

Well, I take that and I turn it on its head and I say, this is where our veterans are. Our veterans are at the broad base of this pyramid. The people caring for those veterans are the most important people in the organization. I am on the bottom. I am at the apex. What I have got to do is make sure the communication is flowing up and down that pyramid to make sure we care for those veterans.

So, the boss of this operation is the veteran. The boss is the person next to the veteran, serving the veteran. Frankly, some of the things that have happened in the past do not fit that picture. For example, we had some of our positions who serve the veteran downgraded and the annual salary is hundreds—is not hundreds—tens of thousand dollars less that we are able to pay them.

Well, those are important people. We have got to—so I have encouraged all of our leaders to seek exceptions to that policy and we have got to get back to putting the best talent up working and serving the veteran. Culture change is difficult, but I think we can do it.

Dr. CLANCY. May I just make one point?

Senator BURR. Go ahead, Dr. Clancy.

Dr. CLANCY. Just to make one point, the point about measurement. VA has a unique all-employee survey, which is now going out into the field to all employees, and it is much more thorough than other Federal departments. One of the areas that we can measure and do track closely is psychological safety. In other words, do people feel empowered to say, “We have got a problem here on the front lines. I need help. This is not working.” We will be keeping a very close eye on that.

Senator BURR. Good.

Secretary McDONALD. Yeah, we sent that out last week and I will be happy to share the results with the Committee when it comes back.

Senator BURR. Thank you. One last question. In the press release that VA sent out prior to the release of the IG’s report, the release stated that you had asked for an independent review at scheduling and access practices beginning this fall by a joint commission. I have got a very simple question. Why? Why do we need a joint



commission to look at the same thing that the IG is looking at in 93 facilities right now which the IG has reported on since 2005, and are we waiting until the fall to implement changes in that until we have got a joint commission's report back?

Secretary MCDONALD. I will ask Dr. Clancy to clarify my comments, but it is not just any commission. It is a commission that does this kind of work for a living.

Senator BURR. This town is full of commissions. As soon as we hear the word commission, we all start looking for who is hiding.

Secretary MCDONALD. Well, it is not about hiding. It is about bench-marking best practices and this Commission does this across the country and will help us understand best practices in all facilities, not just the 93 that the IG is looking at. So, we plan to use this Commission to improve. It is unfortunate their name is commission, but that is—

Dr. CLANCY. So, just to expand for one moment, they do accredit the vast majority of private sector hospitals. In fact, they cannot get paid by Medicare or Medicaid if they are not accredited. So, this is following a standard practice in the private sector. These are going to be unannounced surveys, so we have put a huge amount of effort into making sure that the schedulers are trained, that we have enough people hired.

We are looking for ways to get exceptions to get their grades increased, as the Secretary just indicated, but this is also going to be looking at, is it really working? How does patient flow work? What happens to people who wait in the emergency room then leave because they have been waiting too long and so forth. It is going to be an independent check for us and it will give us an opportunity to spread both good practices and opportunities for improvement across the system.

Senator BURR. Thank you. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Burr.

Senator TESTER.

Senator TESTER. Thank you, Mr. Chairman. Once again, thank you for being here, Secretary McDonald. Just as a sidebar, I would love to have you incorporate Montana into your travel plans. Some time by the middle of next month would be great. Next, highest number of per capita veterans in the country, and they are some of the best veterans in the country, too, but I am a little partial about that.

Let me ask you this. You said you removed three leaders from the Phoenix office. Were they reassigned or were they terminated?

Secretary MCDONALD. What I said, Senator Tester, is that we have proposed disciplinary action against three leaders. This is the process that has to be taken for leaders who are in that strata of employee. We have proposed the disciplinary action. It now goes to a board and there is a process that it goes through. Since we have proposed that action, we have taken the leaders I talked about, moved them to Phoenix, and they are in an acting role.

Senator TESTER. New leaders?

Secretary MCDONALD. Yes, sir.

Senator TESTER. I think one of the concerns we had was, I think, you have to protect employee's rights, but we also need to be able to terminate people when they deserve to be terminated.

Secretary MCDONALD. I agree with you entirely.

Senator TESTER. All right, good.

Secretary MCDONALD. And believe me, we are, as I said in my prepared remarks, we are following the disciplinary—we are following the investigations and as soon as we are capable, we are taking action.

Senator TESTER. The IG made many good points. One of the things he brought up was the analysis, because of the scheduling, really do not have a clear pattern on how many folks out there really need the kind of services they need. And then there is also the fee-based information that is out there. I do not know if that is better or not as good, or the same.

How can you make a determination that you need 28,000 medical staff? I mean, you are a wonder worker probably, but the fact is, that information still has not been hammered out.

Secretary MCDONALD. No. We are going through a process right now where we are going location by location, specialty by specialty to understand how many people we really need.

Senator TESTER. When do you think that process will be done?

Secretary MCDONALD. Let me ask Dr. Clancy to comment on that because she is leading that process.

Senator TESTER. Sure.

Dr. CLANCY. In response to a previous report from the Inspector General, and Dr. Daigh mentioned this briefly, we have been—we have created and are deploying a tool to assess productivity—

Senator TESTER. Got you.

Dr. CLANCY [continuing]. Which includes space and all that. I would guess by early—at the end of this calendar year, early next year.

Senator TESTER. All right. Then you will have a firm grip on how many medical staff you will need to have when that process is done because you will have already set up standards for doctors, because that is part of the thing, too, right?

Dr. CLANCY. Yes, in addition to how many support staff do they need to make them as efficient and productive as possible.

Senator TESTER. OK. Now I want to kick back to something else the IG said, because I tried to pin him down on the staffing thing and he said staffing is part of it. The other part of it is facilities. Where are you going to put these docs and medical staff if you hire them? Because quite frankly, I can tell you, in Montana facilities, I do not know if they are as big of a problem, but they are certainly pretty damn close to as big a problem as not having enough staff.

I mean, you will have docs there, but you are not going to have any examination rooms. Do you have a construction plan moving forward? I know it is unfair, since you have only been in the job 6 weeks. I am not trying to be critical.

Secretary MCDONALD. I think it is five actually.

Senator TESTER. That is good.

Secretary MCDONALD. Obviously, you are right. Facilities are very important and the action you took with the bill gives us the ability to have 27 more facilities. Not surprisingly, one of the facilities will go in Phoenix where, obviously, we have a need.

We have an issue right now that we are working. It is around leasing. We have been following an appropriate, I think, strategy

of leasing facilities rather than building them because the population, as you know, is moving, and you have talked about the increase in veterans in Montana.

Senator TESTER. Right.

Secretary MCDONALD. We are currently working through the GSA on this process because the GSA—

Senator TESTER. But to get down to it, Secretary McDonald, I appreciate you telling me what you are doing, but also what I want to know is, do you have a construction plan moving forward for the next year, 3 years, 5 years? So that you can come to us—some of us are appropriators on this Committee—and say, look, guys, we need this much money if we are going to be able to serve the veterans that are coming back.

Secretary MCDONALD. We have a construction plan, but we are going to be renewing our forecasting, as I mentioned during my confirmation hearing, because I am not happy. I am not satisfied that our forecasting is robust enough.

Senator TESTER. OK. I want to talk about the ARCH program very, very briefly because I do not have much time. It is pushed out for another 2 years. Is it open to all hospitals if they contact the VA? Let us say the Great Falls Hospital in Great Falls, MT, wants to get in on the ARCH program. What do they do?

Secretary MCDONALD. Let us know. Again, our principals will look at everything through the lens of the veteran—

Senator TESTER. OK.

Secretary MCDONALD [continuing]. And if it is good for the veteran, we want to do it.

Senator TESTER. OK. I think that in particularly rural areas, that is going to be critically important. With that, I have got some other questions I am going to put in the record, quite frankly, for you as we move forward. But know that I know you are committed to the job. I know you are surrounded with people who are committed to the job. Middle management has been a problem, not only with this Administration, but the previous one. I think that you need to hold them accountable, too.

Secretary MCDONALD. Well, I want to spend some time with you on the planned Road for Veterans Day, because one of the steps we are going to take is to reorganize the Department.

Senator TESTER. OK.

Secretary MCDONALD. We have nine different geographic maps for this Department. We have 14 Web sites that all require a different user name and password. The veteran does not want that. The veteran wants one geographic map, one Web site, and that simplification, I think, will flatten the hierarchy that you described and provide for information coming up and down a lot more quickly.

Senator TESTER. Thank you for your work.

Chairman SANDERS. Thank you, Senator Tester.

Senator Heller.

Senator HELLER. Thank you, Mr. Chairman, and Secretary, thank you for visiting Reno.

Secretary MCDONALD. Reno and Las Vegas.

Senator HELLER. And Las Vegas. On behalf of myself and the Governor—

Secretary MCDONALD. Yes.

Senator HELLER [continuing]. Perhaps minus the Tesla locating in the State of Nevada. It was a terrific opportunity for him to discuss with you, as myself, the concerns that we both share about Nevada's veterans. So, thank you again.

Secretary MCDONALD. You are welcome. And may I say that working with the State governments is critically important for our success.

Senator HELLER. Well, you are proving that. Thank you for doing so. I want to talk about the Reno or the Nevada VARO just for a couple of minutes. As you are probably aware, in the Inspector General's report, they did a VA two-year claims initiative and were able to recognize that about 32 percent of those claims reviewed were inaccurate.

Unfortunately, for the State of Nevada, the IG report that they did in June focusing on Reno VARO, found that 51 percent of the claims reviewed were inaccurate. That being the case, have you had an opportunity to review these reports from the IG?

Secretary MCDONALD. I have, but I also have to say that I have asked the IG to give me all of the reports over the last 5 years and to give me a triage version of those reports because I want to go back and look at all of the reports that have been issued and not acted upon.

Senator HELLER. Yeah.

Secretary MCDONALD. Now, I do know the situation in Reno, having been there. We have new leadership on the ground. We are making some progress, but we are not to where we need to be and the new leadership knows that.

Senator HELLER. Let us talk about that leadership for just a moment. As you know, I called for management changes in the Reno VARO. Do we have a permanent director in that VARO at this point? Or what is the timeline for getting that?

Secretary MCDONALD. We have an acting director right now, but we are in the process of, obviously, identifying the permanent director.

Senator HELLER. You also mentioned in that—

Secretary MCDONALD. And we will partner with you on that.

Senator HELLER. OK. You also mentioned that there perhaps is a need for four additional employees in that particular office. What is the status of that?

Secretary MCDONALD. I have to check the hiring status, but we do need more employees in the Veterans Benefits Administration and we need them in that office. There is nothing holding us back from hiring them. We do need more employees in Veterans Benefits Administration.

Right now we have, as you know, in that office and elsewhere around the country, we have all of our employees working mandatory overtime. We are stopping mandatory overtime October 1 because it is not sustainable. But, in order to be able to sustain our progress going forward and continuing to drive this backlog down, we have got to hire more people.

There was some money in the bill that was recently passed that was taken out of the bill. I think it was \$400 million. We are going to need some of that money back and we are going to cost-save to

try to find money to be able to hire those employees and continue to work that backlog down.

Senator HELLER. I am sure you tend to agree with me that overtime is not an answer, you know, long term. Short term perhaps we could make some headway, but long term overtime pay and over-working some of these employees probably is not the answer. I think there really is a structural overall change that needs to happen in some of these VAROs and I will repeat it, but at 345 days for benefits and medical claims processing, it is just unacceptable at this point.

We would certainly hope that additional employees, obviously, would be one of the answers. Whatever the resources are necessary. As you know, I talked to the management in Reno to try to find out what they need, and they told us additional resources were not necessary. Please let me know if there is anything I can do to help, because it is just absolutely unacceptable; and I also think change needs to occur.

I know you have not been in your position real long, but do you have a direction that you really want to go for these wholesale changes that are going to be necessary to reduce these backlogs?

Secretary MCDONALD. We have made progress. The claim backlog is down by 56 percent. I think Deputy Secretary Gibson has said, and I agree with him, that the changes made in the Veterans Benefits Administration over the last couple of years have just been astounding. But you are right. We have done it by brute force and what we need to do now is re-engineer the process and get the resources we need to do it on a sustainable basis and drive down the backlog to zero by 2015, which is our commitment.

Senator HELLER. Well, if there is anything that I can do to help and support—we have initiatives here. Senator Casey and I are working on those. We would certainly like to offer our services in any way that we can.

I want to change directions real quickly and that is on women veterans. As you know, there are nearly 2.3 million women veterans that have served in the military and that number, as you also know, is continuing to grow.

Since you have been Secretary, have you reviewed the care and services for these women veterans to make sure that it is adequate?

Secretary MCDONALD. I have and we have work to do. In fact, every stop I go to, whether it is Phoenix, Memphis, Las Vegas, and I go into the medical center, one of the things that strikes me is how we built facilities years ago for male veterans because there were no female veterans. I also check in to see, do we have medical practitioners in OB-GYN and other areas. I look in the prosthetics labs to see, are we used to making prosthetics?

We were just talking with Gary of the Disabled American Veterans and they have done a study now on what it means to make a prosthetic for a female who is pregnant. These are things that we have never had to deal with before, but now with 11 or 12 percent of the veteran population being female, and as you have indicated, continuing to increase in absolute numbers, these are things we have got to get after.

Senator HELLER. I think it may take some legislation to expand this care and I am eager to help your Administration move forward on these initiatives. I know something needs to be done and I look forward to assisting.

Secretary MCDONALD. We would love to partner with you on that.

Senator HELLER. Mr. Chairman, thank you.

Chairman SANDERS. Thank you very much, Senator Heller.

Senator Murray.

Senator MURRAY. Thank you very much. Before I ask my questions, I just want to say to Senator Heller, thank you for asking that question. There is a lot of work left to do in terms of privacy, in terms of doctors that know how to care for women. But we also know that one of the barriers for women to get care is child care, because if you do not have a place to leave your kids that is safe, you do not show up; particularly for mental health this is a serious issue. I would love to work with you on that as well.

Mr. Secretary, thank you, again, for being here. I want to start with talking about the fact that the IG found several cases in which veterans face delays in care or substantial care and subsequently took their own lives. VA's newest wait time data still shows it takes far too long to get into care, but the IG's findings also said that just simply meeting the wait time metric is not enough. Veterans also need to be assigned to a regular provider, they need care coordinated across the hospital and between specialists, and to get the type of care they need when they need it.

We have been working on this problem for a long time now, and I wanted to ask you today, why do you think the VA continues to struggle with providing appropriate mental health care?

Secretary MCDONALD. Senator Murray, I think mental health care is a problem in the United States and I think it is a problem in the VA. One of the things that excites me about this job is that many of the things we see at the VA is we are kind of the pathfinder for the country, whether it is, for example, the use of the bar code in a hospital to make sure somebody gets good care.

I think one of the things we have to do is to increase the number of students studying mental health in school. When I was at Duke University Medical School, I met with 17 residents who graduated from the medical school all working with the VA. Only one was a psychiatrist. So, I asked the question, why are young people not going into psychiatry and mental health? Because it is an area that we are learning a lot more about today than we knew in the past.

My father-in-law, who was a prisoner of war in World War II, he was a B-24 tail gunner. He was shot down over Germany—over Austria. He walked across Germany. I am sure he had Post Traumatic Stress, but we did not know what to call it.

Senator MURRAY. Right.

Secretary MCDONALD. He never wanted to talk about it until he joined a VA group of POWs who felt comfortable talking about it. And what they told me was, the biggest issue is that insurance reimbursements for mental health are far below the cost. Somehow we have got to get a handle on what is going on in this area and find ways to encourage people to go to school in mental health.

In all of my recruiting speeches so far, I have talked about the importance of mental health and I am trying to encourage young people to get into the discipline. I really think it is a national problem, but VA is on the cutting edge of it.

Senator MURRAY. Well, continue work on that because that, to me, is a serious issue. You are right. It is a country issue, but our veterans are at the front of this line—

Secretary McDONALD. Absolutely.

Senator MURRAY [continuing]. And we have got to make sure we have got the providers, but we also have the understanding across the VA and across the culture of the VA to really watch for this.

In your testimony, you talked about improving the Department's leadership training and breaking down some of the VA's bureaucracy as a way of enhancing accountability. That needs to happen at all levels, at all levels, and I liked your little chart where the veterans are at the top. But there are a lot of people between you and them.

Secretary McDONALD. That is why I gave out my cell phone number.

Senator MURRAY. Well, we need to look at everything from training new clinic managers to oversight and effective intervention by medical centers and network leaders. How do you make sure that these changes happen at all of those levels across the VA? It is a huge system.

Secretary McDONALD. It is a huge system. It starts by getting out and going to these different sites and meeting the people and understanding, are we providing the right leadership? Do we have the right strategic choices? Do we have the right systems? Are we, you know, doing things that repeatedly will lead to a good result? And do we have the right culture?

For example, I was at a site. I was actually in Reno and a young person was talking to me in a town hall about ways we can improve our computer system. And one of the senior managers stepped in front to try to stop the conversation, and I had to ask that senior manager to move out of the way. It just was not appropriate.

I was in Philadelphia last week. This was a site that had a training program on town halls that used Oscar the Grouch in there. I had to talk to those employees about, no matter what the intent, perception is what is important and the perception of Oscar the Grouch on a presentation is not going to be acceptable.

We simply have to dive into the culture and dig and figure out what is going on that is wrong and then set the example to do it right. I tell everyone to call me Bob. I was Bob before I became Secretary, I might be Bob after I am done being Secretary. That is not trite. That is done because we need to flatten the hierarchy. We need people to be like a family, to call each other by their first names, to feel comfortable turning in problems.

We need to reward people who turn in problems, not chastise them or not ostracize them. So, these are some of the things we are doing. It is hard work, but it is underway.

Senator MURRAY. OK. And really quickly, you said you have committed the VA to acquiring and fielding a modern scheduling sys-

tem. Can you tell me when you think that will be done and the training for employees to use that?

Secretary MCDONALD. Right now, we are doing some quick fixes on the established system. Those quick fixes are coming out periodically over the next few months. To really change the whole system and bring in a new one is going to take some time. But we would like it to be done in 2015.

Senator MURRAY. 2015. And that includes the training for everybody?

Secretary MCDONALD. Yes, of course. In fact, when you put in a new system, we want to commission it, we want to verify people know how to use it before they sit down and are qualified to use.

Senator MURRAY. Thank you very much.

Chairman SANDERS. Thank you, Senator Murray.

Senator Moran.

Senator MORAN. Mr. Chairman, thank you. Mr. Secretary, I do not think I will call you Bob in this setting, but, Mr. Secretary, thank you very much for your presence as I said earlier. I have a series perhaps of convoluted questions all related to the same topic. First of all, I would like to offer my assistance, as I have done with previous Secretaries.

You have testified, the Chairman of this Committee has great interest in trying to help the VA have the necessary professionals to meet the needs of veterans. I have asked the previous VA Secretary how can I help. What do you need? What tools do you not have to help solve this problem? With no response. Again, if there are changes in the law, programs that are necessary to encourage loan forgiveness, whatever the story is that would help you attract professionals, I would like to be of assistance. I would like to be an ally.

Here is my scenario of a couple of stories. Lee Mahin is a Smith Center veteran. I mentioned him in my opening remarks. He had the good fortune of the VA calling him to tell him that he no longer needed to drive 4 hours to Omaha, NE, from Smith Center, KS, to have a colonoscopy. That is the piece of good news. So, that suggests to me that there is change afoot. Thank you.

Down the road about an hour in Plainville, KS, Larry McIntyre tells me that last week he drove 3 hours to Wichita to get a cortisone shot in his shoulder. He goes to Wichita several times a week for other minor procedures. There is a CBOC within 25 miles of Plainville, but the CBOC does not have the professional capability, as I understand it, of providing cortisone shots.

What does exist is a hometown hospital, Rooks County Medical Center, Plainville, KS, that could provide a cortisone shot that is in the same town where Mr. McIntyre lives, and certainly less than the 3½-hour drive to Wichita. So, on the one hand, we have had some success. On the other, there still remains these issues that we are trying to get at within the VA, but also in implementation to the Care Act.

First of all, in implementation to the Care Act, when 40 miles is the determining factor as to whether or not you can access health care, how are you going to treat what that CBOC is capable of doing in determining whether or not that veteran lives within



40 miles of a facility? Is it a facility or is it a facility that can perform the service that the veteran needs?

Secretary MCDONALD. That is a really excellent question and I am glad you brought it up, because one of the technical changes that we are working with the Committee on is to give the Secretary the authority to interpret that the way it should be interpreted. In other words, let us look at it through the lens of the veteran. Does it make sense for that veteran to get a cortisone shot closer to home? What makes sense?

And one of the things we are asking is to give the Secretary that flexibility in the technical changes to the Care Bill.

Senator MORAN. You do not believe you have that authority to make that determination now?

Secretary MCDONALD. No, sir, but I think just by simply putting in a phrase, it would be very simply handled, and we have been working that with the staff.

Senator MORAN. Does there seem to be any impediment toward accomplishing that?

Secretary MCDONALD. No, sir.

Senator MORAN. OK. Then let me go back to ARCH. In the interim before the Care Act is implemented, which my guess is November being the best scenario, you have set aside \$25 million for outside of the VA care. That, I assume, funding expires at the end of the fiscal year, September 30, now 3 weeks away. ARCH is in existence and the Care Act gives you the authority to do two things with ARCH. One is to extend the contracts, extend the program, and the second is to expand the program beyond the geography that is currently served by an ARCH program.

Do you have any questions about your ability to extend the program, ARCH, and do you have any questions about your ability to expand the program?

Secretary MCDONALD. One of the technical changes that we are asking for in the bill that pertains to ARCH is the ability to just extend the contracts that we already have which will allow us to accelerate the expansion of ARCH.

Senator MORAN. So, the language in the Care Act is insufficient to allow you to extend the contracts?

Secretary MCDONALD. It just needs a modest modification.

Senator MORAN. But when do those contracts expire?

Secretary MCDONALD. Well, it is not—I do not think it is the expiration as much as it is just the assumption that we can use them moving forward so we can move more quickly rather than going through an entire rebidding process for new contracts.

Senator MORAN. ARCH is not going to go out of business—

Secretary MCDONALD. No.

Senator MORAN [continuing]. Those pilot programs before you get a technical change? The contract will continue?

Secretary MCDONALD. I think—let me check on this to make sure. It is extended for 6 months, but what we are trying to do is extend the expansion as quickly as we can, and the way to do that is this technical change.

Senator MORAN. So, you do not need an expansion. You do not need technical language to expand for 6 months. You need something to—

Secretary MCDONALD. To extend for 6 months, no.

Senator MORAN. And your expansion authority?

Secretary MCDONALD. We are OK on that, but I think, again, the technical change we are seeking would allow us to accelerate the expansion.

Senator MORAN. Mr. Chairman, with your indulgence, I would only say that I was surprised, as an author of this legislation, that the pilot programs were so narrow to begin with, very small geographic areas. My expectation was the VA would choose five sites that are Statewide or VISN-wide. We expected the entire VISN to be the pilot program, not a matter of a county or two.

Do you have an opinion? Do you have thoughts about your willingness to expand ARCH to a larger Statewide or VISN geographic area?

Secretary MCDONALD. Well, again, consistent with Deputy Secretary Gibson said, we need to look at this again from the standpoint of the veteran, and if it is good for the veteran, then we should expand it. I think that is what he said. We will expand it. We are looking forward to working with you on that.

Senator MORAN. If you can get us the analysis of the ARCH program done by the VA, which we have asked for a long time (at least months), we would like to see what the report says about how the Department of Veterans Affairs analyzed the program. I assume it would say good things.

Secretary MCDONALD. I would assume so, too, about providing care.

[Adequate responses were not received within the Committee's timeframe for publication.]

Senator MORAN. Thank you.

Chairman SANDERS. All right. Although long, I think it has been a productive hearing.

Secretary MCDONALD. Mr. Chairman, may I say one thing?

Chairman SANDERS. Sure.

Secretary MCDONALD. First of all, I want to clarify one comment I made. I recall I said that the funding for VBA was roughly \$400 million. That was part of our original \$17.6 billion request. It did not end up getting passed. So, that is why we brought that up, because we want to continue to drive down the claims.

Second, I was trying to say earlier that leasing becomes very important. Leasing is a strategy that we are using to move our footprint out, provide greater access and care, and right now we have an issue that we are trying to resolve with the General Services Administration, the GSA, where they rescinded our blanket delegation of authority in July for lease contracts.

Now, every one of our leased contracts needs an individual delegation from the GSA, and those that exceed \$2.85 million, which many of them do—59 percent of the 27 do—need to go through a relatively laborious process. So, we are working with GSA to resolve this. But while we do that, we believe there is a need and a case to be made for an independent 20-year medical lease authority for VA to carry out its mission and to continue to provide these points of access. I just wanted to make sure that I got that right.

Chairman SANDERS. Sure. This has been a long and ongoing problem, so we look forward to working with you.

Secretary McDONALD. Thank you.  
[Posthearing questions to Hon. Robert McDonald follows:]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO  
HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

DELAYS IN CARE

*Question 1.* While no deaths were attributed to delays in care, the Department of Veterans Affairs (VA) Office of Inspector General's (IG) August 26, 2014, report, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, found more than 3,500 veterans were on unofficial lists waiting for appointments, many of them for years, and were unable to obtain the care and services they deserve, in a timely manner. What steps has VA taken to ensure it eliminates the use of unofficial waiting lists?

Response. VA has reviewed 88,000 fiscal year 2014 employee performance plans. Upon review, 13,000 plans were modified to remove scheduling and wait time metrics or goals. In accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), these factors have been removed from inclusion in employee performance evaluations and when calculating whether to pay performance awards. VA will continue to review and modify employee performance plans for future years.

VA revised Human Resources handbook 5021 to include provisions related to penalties for employees who falsify data regarding access to care or quality measures. The policy has been updated to list, "Willfully submitting or directing others to submit false data concerning wait times for health care or quality measures related to health care," as an offense related to falsification. The explicit inclusion of the terminology "wait times" and "quality measures" will reinforce the expectation of the Department that no employee shall manipulate or falsify data regarding wait times or quality measures.

*Question 2.* For those veterans who were offered the option to see a health care provider in their community, as part of VA's Accelerating Access to Care Initiative, how many veterans opted to wait for VA health care?

Response. Since the beginning of the VA's Accelerating Access to Care Initiative, local facilities have been contacting those Veterans who have an appointment scheduled 60 or more days into the future. As of September 17, 2014, about one-third (104,474) of those Veterans contacted decided to keep their scheduled VA appointment.

*Question 3.* Are the mobile medical units being used at the Phoenix VA Health Care System (PVAHCS) being staffed by PVAHCS staff or augmented staff? How will information on the care veterans receive through the mobile medical units be shared with their PVAHCS health care teams to ensure continuity of care?

Response. The Medical Mobile Units (MMU) were staffed by VA's Disaster Emergency Management Personnel System and the Phoenix VA Health Care System (PVAHCS) staff simultaneously. Two clinics were set up in the MMUs and the third MMU was used as an administrative area. The first clinic was an Unassigned Patient Aligned Care Team (PACT) Walk-in Clinic. This clinic was designed for new patients who were not yet assigned a primary care provider (PCP). For example, a Veteran who was seen in the Emergency Room, but did not have a PCP established could be seen in the unassigned PACT clinic until they were assigned to a PACT team. Additionally, traveling Veterans who did not need to be assigned to a PCP in Phoenix could be seen by the Unassigned PACT Team. The creation of the Unassigned Walk-in Clinic created a central clinic for this method of care to occur.

The second MMU was established to leverage tele-health support from other VA facilities in the event those tele-health staff resources were to become available.

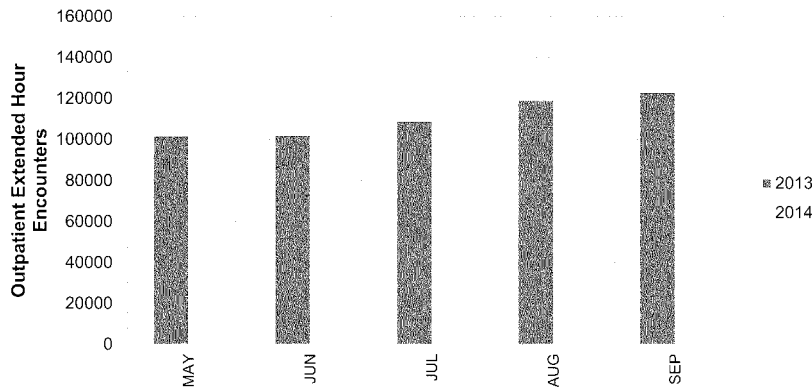
The third MMU was used as an administrative area; the facility was able to move administrative staff from the current Primary Care clinics, which freed up additional clinical space. As a result, enough space was created in the Turquoise Clinic to house up to five additional PACTs. This decision was made for the convenience of patients and to minimize exposure to heat for Veterans attempting to locate the MMUs.

The information captured during care delivered in the MMUs was captured through VA's Electronic Medical Record known as the Computerized Patient Record System (CPRS). The MMUs had full functionality with VA's CPRS and patient interactions were recorded in the same manner as any patient-provider interaction. The MMUs were utilized at PVAHCS from June 11th through August 8, 2014, at which time they were returned to their home sites.

*Question 4.* As part of the Accelerated Access to Care Initiative, VA has extended clinic hours to expand capacity. How many veterans have used these extended hours? Please discuss whether extended clinic hours for patient care are sustainable or part of a long-term access solution.

*Response.* The number of Veteran encounters during extended hours for Mental Health, Primary and Specialty Care has increased since May 2014. The Outpatient Extended Hour Encounters between May to September 2014 totaled 629,925 as compared to 553,433 during May to September 2013 (see attached chart below). The data demonstrates a 14 percent increase in the volume of extended hour encounters used by Veterans during the same timeframe (May to September) between 2014 and 2013.

#### **Mental Health, Primary and Specialty Care Outpatient Extended Hour Encounters Fiscal Year Monthly Comparison**

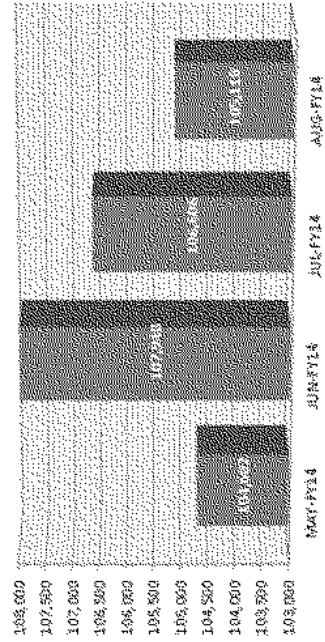


Extended clinic hours can, and must be, part of VHA's long term access solution to meet the preferences of Veterans. To provide personalized, patient-driven care, VHA must be accessible at times that are convenient for Veterans. Shifting tours of duty will help alleviate the space limitations facing a number of facilities. In addition to current staff who have altered their schedules, new staff who are hired will need to embrace working extended hours and in non-traditional tours. This additional flexibility can help with recruiting and retaining needed staff. However, in order to be fully sustainable, this cultural shift may require modification of VA's policies regarding physician tours of duty and leave.

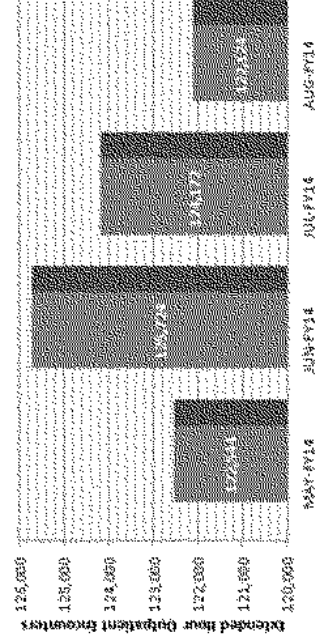
Extended Hour Completed Encounters in Primary Care, Mental Health and Specialty Care only

	MAY-FY14	JUN-FY14	JUL-FY14	AUG-FY14	Total
Extended Hour Encounters	127,544	125,734	124,172	122,134	499,584
Extended Hour Uniques	104,862	107,349	106,906	105,119	424,236

Extended Hour Uniques



Extended Hour Encounters



# Extended Hour Uniques

# Extended Hour Encounters

## DATA MANIPULATION

*Question 5.* The Committee requests information on the steps VA is taking to ensure the access data being reported bi-monthly, as a response to its Access Audit, is accurate.

*Response.* As a result of the System-wide Access Audit, VA has renewed its focus on ensuring the integrity of the data used throughout the system. Actions have been implemented to strengthen the process and improve the integrity of VA's access data at each step of the process: data input, data aggregation, data reporting, data distribution, and publication. To ensure the integrity of the access data in the input stage, VA recently launched an automated access and scheduling audit tool designed to monitor and flag any potential data integrity issues. This tool is programmed with a preset algorithm, designed by scheduling subject matter experts that will score scheduling practices at each facility and clinic and highlight those clinics that require additional follow-up. This tool is available for use by each medical center and Veterans Integrated Service Network (VISN) leadership team. This tool is also being routinely monitored in VHA Central Office by a national monitoring group and the VHA senior leadership team. Once the data are input into the system, the data from each Veterans Health Information Systems and Technology Architecture (VistA) system are transmitted to Austin Information Technology Center and aggregated into national files containing appointment and Electronic Wait List (EWL) records. These national files are used by the VHA Support Services Center for calculation and reporting of wait times. The date stamps in each appointment and EWL record are used to calculate the wait time in days. After the wait time and EWL data are prepared for public release, each number is independently verified against the VHA Support Services Center, to ensure accuracy. All data that pertain to Veteran access to care, including non-VA care, are verified by a team independent of the data production process prior to distribution and publication.

## ACCOUNTABILITY

*Question 6.* The Committee requests the following information on the Administrative Investigation Board that was established to determine whether administrative action should be taken against management officials at the Phoenix VA Health Care System as a result of the IG's final Phoenix report:

- A list of the individuals who serve on the board;
- Information on the Board's mission—specifically, are they only reviewing information gathered by the IG or are they conducting their own investigation; and
- A list of VA personnel being considered for administrative action by the Board.
- A list of VA personnel who have been put on administrative leave or removed from their positions as a result of the IG's final report on Phoenix.

*Response.* The board members consisted of a director, human resources consultants and counsels, none of whom were from the Phoenix VAMC or from VISN 18. The AIB has reviewed the OIG report and will review the underlying witness testimony and other evidence before traveling to Phoenix to begin its investigation. To the extent that OIG has already found facts or gathered evidence sufficient to support discipline, the AIB will not repeat that work, but will focus on establishing individual leader culpability and other issues not fully resolved by OIG. The AIB will also review leader culpability for whistleblower retaliation, which was not within the scope of OIG's review. The AIB will look at culpability, if any, on the part of the PVAHCS Chief of Staff, Darren Deering, MD; Associate Director, Lance Robinson; and Chief of Health Administration, Brad Curry. The latter two individuals were put on administrative leave, as was Director Sharon Helman. Ms. Helman was removed from employment effective November 24, 2014.

*Question 7.* The Committee requests VA's plan to hold local VA medical center leadership accountable for misconduct, negligence, and failure to address serious access problems identified that may be identified during the more than 100 ongoing investigations at VA facilities by the IG, Department of Justice, Office of Special Counsel. To include a list of VA personnel that have been fired, transferred, or subject to administrative action as a result of the finds of such investigations.

*Response.* VA takes the allegations and findings of misconduct seriously and is moving quickly to address the situation. Since allegations of delayed care and employee misconduct surfaced, VA has been conducting internal reviews to evaluate appointment scheduling procedures and patient care in Phoenix and nationwide. VA has initiated the process for removing senior leaders at the PVAHCS, and VA has directed an independent site team to assess scheduling and administrative practices at PVAHCS. This team began its work in April, and VA is taking action on multiple recommendations from the team's findings. VA recognizes there is a leadership and

integrity problem among some of the leaders of our health care facilities, which can and will be fixed. Breaches of integrity are indefensible and VA will use all authorities at its disposal to enforce accountability among senior leaders.

As of December 1, 2014, OIG has completed its reviews of scheduling and wait list practices at 23 sites. At seven sites, no significant misconduct was found. At three sites—Phoenix, Cheyenne, and Fort Collins—serious misconduct was found. Six disciplinary actions have been completed at Cheyenne and Fort Collins (which are both under the same leadership team) and one at Phoenix (see response to question 6 above). Additional actions may be taken at Phoenix following VA's administrative investigation there (see response to question 6). VA is reviewing the evidence OIG collected at the fourteen other sites where OIG is done, and will determine based on that evidence whether further investigation and/or accountability actions are warranted.

The Office of Accountability Review commenced an accountability audit that is taking place at facilities that are not under current investigation by the Inspector General (IG) and DOJ, or have been cleared by those entities. VA wants to be as proactive as possible, while respecting the need of the IG and DOJ to conclude their own investigations. The purpose of the accountability audit is to determine what senior leaders at each facility did to ensure the integrity of their wait time data and that front-line schedulers were aware of the rules and were following them. In situations where leadership misconduct, negligence, or other leadership failures appear to have occurred, the Office of Accountability Review will investigate to obtain evidence to support appropriate personnel actions against culpable leaders.

#### EMERGENCY ROOM USED AS PRIMARY CARE

*Question 8.* The IG's final report on Phoenix identified numerous veterans that were forced to visit the Emergency Room because they were unable to obtain a primary care appointment. The Committee requests VA's plan to address its system-wide shortage of primary health care providers.

*Response.* As the Nation's largest integrated health care delivery system, VHA's workforce challenges mirror those of the health care industry as a whole.

As physician shortages exist throughout the private sector, medical schools are growing to address these shortages. In order to carry out the primary patient care mission of VHA and to assist in providing an adequate supply of health personnel to the Nation, VA is authorized by Title 38 Section 7302 to provide clinical education and training programs for developing health professionals. VA conducts the largest education and training effort for health professionals in the United States. In fiscal year (FY) 2013, 40,420 physician residents and fellows in graduate medical education programs rotated to a VA clinical facility for education and training.

VA employs an aggressive, multi-faceted strategy to recruit and hire physicians. Executive and clinical leaders at 150 medical centers assess physician staffing needs. Physician shortages or deficits at specific locations are addressed by increased marketing and recruitment efforts on a case-by-case basis. In addition to actively recruiting primary care physicians, increasing and further incorporating nurse practitioners and physician assistants with specialized training and experience in primary care into care teams will increase Veterans access to care. Marketing is also targeted to academic affiliates, professional health care associations, the Department of Defense, the Department of Health and Human Services, and Office of Personnel Management.

VHA's National Recruitment Program (NRP) provides an in-house team of skilled professional recruiters employing private sector best practices to the agency's most critical clinical and executive positions. NRP has increased its targeted recruitment efforts for mission critical clinical vacancies that directly impact and, once filled, will improve access to care. These specialties include primary care, mental health, and critical medical subspecialties. The national recruiters, all of whom are Veterans, work directly with VISN Directors, Medical Center Directors, and clinical leadership in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs. Since its founding in April 2009, VHA's NRP efforts resulted in filling 1,327 mission-critical vacant positions (as of September 23, 2014), which increased access to care in rural communities and contributed to Title 38 Veteran hiring goals. In FY 2014, as of September 23, 2014, the recruiters have placed 561 health care providers:

- 91.80 percent are physicians
- 32.97 percent are primary care physicians
- 24.95 percent will go to rural/highly rural facilities
- 15.68 percent are Veterans

- 16 of these Veteran hires will fill clinical and executive leadership roles at VA hospitals

The national recruiters are attending conferences to showcase clinical practice opportunities to potential candidates. These include American College of Physicians, American Psychiatric Association, and American Psychological Association. The team will also attend additional conferences through the end of 2014, targeting specialties such as Anesthesia, Gastroenterology, Family Medicine, Emergency Medicine, and Pharmacy.

VHA, in partnership with the Office of Academic Affiliations, pioneered the agency's first-ever recruitment outreach program targeting health professions trainees. The "Take a Closer Look" Initiative provides VHA with a standardized outreach strategy to recruit health professions trainees from VHA affiliate programs for employment upon completion of training. Throughout their programs, residents and fellows receive information on careers at VHA, as well as guidance on contacting and facilitating employment with a National Recruiter.

In addition to actively recruiting primary care physicians, increasing and further incorporating nurse practitioners and physician assistants with specialized training and experience in primary care into care teams will increase Veterans access to care. Additionally, VA continues to recruit for a variety of administrative, technical, and professional occupations to ensure the right mix of staff are available to provide safe, quality care to Veterans.

VHA has a number of education and loan repayment programs, which include providing education/tuition assistance, education debt reduction and loan repayment programs, to recruit and retain Title 38 medical professionals. VHA utilizes the Education Debt Reduction Program (EDRP) for candidates in hard-to-recruit or retain Title 38 occupations who would otherwise decline or leave VHA. Employees or their lender(s) receive loan reimbursements for up to five years as long as the employee remains employed by VHA in the position that was approved for EDRP, thereby serving as a significant retention incentive. Public Law 113-146, The Veterans Access, Choice, and Accountability Act of 2014 (VACAA), increased the EDRP loan reimbursement cap from \$60,000 to \$120,000. This cap can be waived for specific critical clinical specialty positions, including mental health specialties such as psychiatrists, psychologists, and mental health nurses. There is ample capacity in the program to reach clinical providers in hard to recruit and retain positions for mental health, primary care, and specialty care positions around the country. In addition, VHA is in the process of implementing direct loan repayment to the lender.

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and VA's National Education for Employees Program (VANEEP) are policy-derived programs which originated from the legislative authority of EISP. EISP awards cover tuition and related expenses such as registration, fees, and books. NNEI is limited to funding Registered Nurses (RN) pursuing associate, baccalaureate, and advanced nursing degrees. VANEEP provides replacement salary dollars to VA facilities for scholarship participants to accelerate their degree completion by attending school full-time. Participants incur a 1 to 3-year service obligation following completion of their program.

#### TIMELY ACCESS TO CARE

*Question 9.* Due to the backlog of new patient Primary Care appointments discovered the IG's final report on Phoenix, 544 appointments as of March 31, 2014, PVAHCS now monitors all new veterans to ensure timely access to care. The Committee requests:

- Information on the monitoring process that the Phoenix VA is using, and
- A list of VA employees, and a description of their positions, responsible for the monitoring process.

Response. PVAHCS, through its Health Administration Service (HAS) monitors and reports data from the EWL and the New Enrollee Appointment Request (NEAR) on a daily basis. Medical Support Assistants under the supervision of their respective sections monitor the list daily and contact the patient. The process for monitoring the EWL is administered in the Primary Care Call Center. The NEAR is reviewed daily by the Eligibility and Enrollment department. Both teams pull the names from the EWL and the NEAR and contact the Veterans to offer them an appointment. The teams make three attempts to contact the Veteran and then send a certified letter. The teams obtain the EWL and NEAR from reports in VA's mainframe architecture also known as VistA.



Personnel involved in the monitoring process include supervisors, patient service assistants and medical support specialists. The results of these reports are reported daily to the Medical Center Director, Executive Leadership and all Service Line Chiefs at Morning Report.

#### STAFFING MODEL

*Question 10.* In 2012, the IG found only 2 of 33 VA health care specialties had staffing standards. Has VA developed staffing models for each health care specialty? If so, please provide the Committee with a copy of each staffing model. If not, please provide the Committee VA's plan to develop a staffing model for each health care specialty.

*Response.* Attached is the Report on the Specialty Physician Productivity & Staffing Operational Plan and Status Report. VA concurred with the OIG recommendation to develop productivity and staffing models for all physician specialties by the end of FY 2015. The current status of the recommendations resulting from the OIG report is that all physician specialties, except for Anesthesia and Emergency Medicine, have productivity and staffing standards in place. Productivity and Staffing Models for Anesthesia and Emergency Medicine have been developed and will be fully implemented in FY 2015.

## Report of VHA Specialty Physician Productivity & Staffing

### Operational Plan & Report EOFY14 Update

## Report of VHA Specialty Physician Productivity &amp; Staffing

## Operational Plan &amp; Report EOFY14 Update

*Overview:*

The idealized Staffing Model considers the productivity of the provider, the performance (quality and access) and the needs of the population served. Physician staffing could be defined as adequate when the provider productivity falls within an acceptable range, with ready patient access to the delivery of high quality care/outcomes. When performance goals are not met, facilities need to determine whether this imbalance is related to inadequate: provider productivity, systems to support high productivity such as support staff and capital infrastructure, and/or the supply of the providers for the Veteran population served.

*Background:*

Since 2008, VHA has maintained a comprehensive database (Physician Productivity Proclarity Cube) of the physician workforce that provides information about the staffing levels for each Medical Center and calculates the productivity of our physician workforce utilizing a standard health care measure of relative value units (RVUs) per physician clinical FTE. RVUs consider the time and the intensity of the medical services delivered and has been utilized by Medicare since the early 1990's.

These data are developed and maintained by the VHA Office of Productivity, Efficiency & Staffing (OPES) established in FY 2007 to develop effective management tools, systems, and studies to inform leadership on how best to optimize clinical productivity and support policy on the creation of efficiency and staffing standards that promote the goals of clinical excellence, access, and the provision of safe, efficient, effective, and compassionate care.

In December 2012 an Office of the Inspector General (OIG) Audit, "Physician Staffing Levels for Specialty Care Services," recommended that the Veterans Health Administration (VHA): (1) establish productivity standards for at least five specialty care services by the end of FY 2013 and approve a plan that ensures all specialty care services have productivity standards within three years; and (2) provide medical facility directors with more specific guidance on how to develop staffing plans and ensure that medical facility management review them at least annually to confirm optimal efficiency.

The current status of the recommendations resulting from this report is that 91 percent of all specialties have productivity and staffing standards in place and the remaining specialties will be completed by September 30, 2014 –1 year ahead of the OIG recommended timeframes for implementation.

In 2013, VHA provided a status update to the OIG on the implementation of OIG recommendations. As a result of that briefing, the OIG closed out all recommendations (See Appendix 4 OIG Closure Memo). VHA briefed the OIG on the development of practice management tools and they were pleased with the progress VHA had achieved. VHA continues to brief the OIG on progress and enhancements to specialty physician practice management tools inclusive of the most recent briefing held on June 12, 2014.

In March 2013, the House Veterans Affairs Committee held hearings: "Meeting Patient Care Needs: Measuring the Value of VA Physician Staffing Standards" in which VHA testified on the progress in implementing productivity standards. Subsequent to this, in May 2014, VHA met with all of the physicians on the House Veterans Affairs Committee and briefed them on the details of the progress, data, and tools that have been developed.

## Report of VHA Specialty Physician Productivity &amp; Staffing

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*Staffing & Productivity Measurement:*

VHA has a physician workforce of more than 18,000 FTE representing over 30 sub-specialties. The largest proportion of VHA's physician workforce is composed of Internal Medicine (largely primary care) and Mental Health (psychiatrists), representing nearly half of the physician workforce. The majority of VHA's physicians are salaried, with approximately 10 percent of the physician workforce under a contractual type arrangement. RVU productivity measurement is the most widely utilized system for measuring specialist physician's productivity. VHA measures physician productivity:

$$\text{Productivity} = \text{wRVU} \div \text{Direct Clinical FTE}$$

**Clinical Work** = wRVUs consider the time and intensity of the professional service(s) delivered and are a common metric used throughout health care.

Example:

CPT 99203 Routine New Office Visit = 1.42 wRVUs

CPT 44392 Colonoscopy & Polypectomy = 3.81 wRVUs

**Direct Clinical FTE** = worked FTE removing leave, research, education and administration and is derived from actual labor mapping of the physician workforce from VHA PAID data.

VHA has established a system for collecting, analyzing, and reporting RVU productivity data for all medical specialties. In 2007 VHA established an Office of Productivity, Efficiency, and Staffing (OPES) and in 2008 began reporting physician productivity using RVUs. VA has provided specialty physician productivity data utilizing RVUs on the VA Intranet (Physician Productivity Cube) to VHA managers since 2008. The productivity data utilized by the OIG was derived from this VHA Physician Productivity report.

In June 2012, VHA established a Specialty Physician Productivity & Staffing Task Force to recommend and establish productivity standards. The Specialty Physician Productivity & Staffing Task Force developed and executed an Operational Plan (Appendix 1) that has resulted in the implementation of productivity standards in 91 percent of VHA specialties as of July 2014 and is on target to deliver productivity standards for all specialties by the end of FY 14 – one year ahead of the timelines of the original Operational Plan as well as the OIG recommendation of establishing productivity standards for all specialties by the end of FY 15.

*Implementing Productivity Standards:*

Primary Care, the largest component of VA's physician workforce (34 percent), has been employing a panel model for standardizing productivity and staffing in PC since 2004. Mental Health, the 2<sup>nd</sup> largest component of VA's physician workforce (14 percent) has developed a productivity model that was implemented in June 2013. As of July 2014, 91 percent of all specialties have productivity and staffing standards in place and the remaining specialties will be completed by September 30, 2014. (See Table 1 for Productivity Standards Implemented)

To implement these productivity standards and guidelines, the following steps were completed:

- a. Each facility was requested to review and ensure the following about the productivity source data:
  1. Person class designations within the specialties are correct;
  2. Labor mapping of physicians in the specialties is consistent with standardized business rules; and
  3. Review the amount of workload that is identified as resident only workload. Guidance was provided to assist in the review of person class designations, labor mapping, and resident only workload.



- b. Each facility reviewed the Specialty Productivity – Access Report & Quadrant tool (SPARQ) to evaluate specialty productivity, access, staffing, and efficiency. Algorithms were provided to guide the interpretation and utilization of the Specialty Practice Management Tools (see examples of guidance in Appendix 2, 3). The purpose of these algorithms is to assist facility leaders in the management of specialty care resources and ensure appropriate staffing for specialty care services across all VHA sites.
- c. Practices that fall below the 25<sup>th</sup> percentile productivity or above the 75<sup>th</sup> percentile for a specific specialty and medical center complexity group underwent a review to address data inputs. If a specialty practice productivity level was found to be more than one standard deviation below the mean for its specialty and medical center complexity group, facility clinical leaders were requested to work with the specialty to develop a remediation plan. The remediation plan was forwarded through the Medical Center Director to the VISN for review and concurrence. The SPARQ Tool was reviewed for all specialties to assist local leaders in a review of specialty care resources and to ensure that specialty physician staffing plans address productivity and access. This review should be conducted at least annually.

The Office of Productivity, Efficiency, and Staffing (OPES), the four pilot VISNs (VISNs 7, 12, 19, and 22) and the Task Force held national teleconferences to ensure local clinical leaders were fully prepared for VHA-wide implementation. To ensure VHA met the quarterly goals, each VISN Director was asked to upload a signed version of the attestation memorandum template for the specialties selected by quarter of implementation to the OPES Specialty Practice Management SharePoint site. VHA has on file attestation memoranda indicating that all VISNs have reviewed and implemented productivity standards.

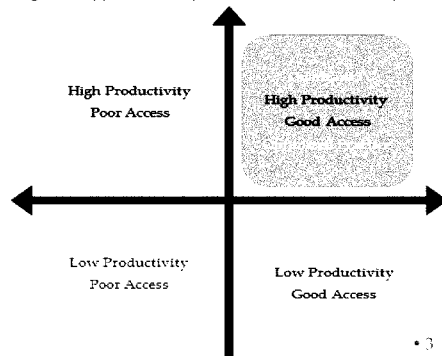
**Table 2: Productivity Standards**, provides the detailed productivity standards for each specialty by Medical Center Complexity Group where applicable that have been implemented as of July, 2014. The remaining specialties: Pathology, Emergency Medicine, Geriatrics, and Anesthesiology are on schedule to be implemented in Qtr. 4 of FY 14.

*Specialty Productivity – Access Report Quadrant tool (SPARQ)*

Productivity data coupled with access measures provides a framework for determining specialty physician staffing. A web-based tool was developed that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians. This integrated approach, coupled with measures of the practice environment and the amount of specialty non-VA

community care (FEE- Basis care), was proposed to help VA medical center leaders make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs.

A critical component of the implementation of the productivity standards was the development and deployment of the Specialty Productivity – Access Report Quadrant tool (SPARQ). The SPARQ tool provides comprehensive Specialty Practice Management information for local managers and an algorithm for the effective management of VHA's specialty physician practices. The tool is designed to drive



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performance improvement in Veteran access to specialty care. The key elements of the tool uses an importance-performance framework and plots each VHA specialty practice into one of four quadrants based on their productivity and access performance. Practices with high productivity and good access to care for Veterans are identified as optimized. Practices that have high productivity and poor access are identified as potentially needing resources. Practices with low productivity and poor access are identified as inefficient. Lastly, practices with low productivity and good access are identified as potential practices that have been over-resourced. SPARQ provides information to inform business strategies including measures of Specialty-specific Fee Care expenditures (care purchased in the community) and VA Reliance or Market Share. The tool also includes measures of value that include compensation per RVU to assist in 'make or buy' decisions. The tool expands into measures of the care team bringing in the physician extender workforce (Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists), support staff, and workload (RVUs). The tool also includes measures of projected workload from the Enrollee Health Projection Model so that workforce planning in out years is included. (See SPARQ Tool Exhibit A, B, C & D.)

*Evaluating Capacity:*

Using the framework and data that VHA has put in place to measure physician productivity and staffing we have now used these data to assess capacity. The key elements of capacity include: (1) the numbers of clinical providers (physicians and physician extenders) and (2) the specialty-specific productivity expectations (acceptable/achievable levels of productivity) for each of those healthcare providers. The product of the two represents capacity. VHA can increase the number of providers, increase productivity, or increase both to increase capacity. Achieving desired levels of productivity for healthcare providers requires (1) an efficient clinical environment (adequate numbers of exam rooms per provider and efficient clinic space, scheduling support, IT support (automatic appointment reminders for patients to minimize no-shows, etc.), Operating Room (OR) availability for surgeons, etc.); and (2) an optimal number and mix of clinic support staff per provider to ensure these providers can practice to the full extent of their license/capability. We have simulated productivity expectations (moving low performers to the standard) and calculated the appropriate support staff ratios to assist providers to become more productive or maintain productivity as well as to assist potentially overburdened practices with the necessary physician staffing augmentation. These data were used in the assessment of VHA's actions to address the access crisis. Additionally, these data have been leveraged to assess VHA sites at significant risk --inefficient specialty practices (low productivity, poor access) and OPES staff are actively engaging with these sites to assist with process improvement.

*External Benchmarks:*

VHA productivity levels in general, compared to external benchmarks such as the Medical Group Management Association (MGMA), are lower than that of the private/academic sector. While productivity is noted to be lower, (See Table 3 VHA Productivity vs. MGMA) it is important to recognize that measures of annual compensation for many VHA specialists are lower than that of the benchmarks (See Table 4: Total Compensation VHA vs. MGMA). Furthermore compensation per RVU for VHA compared to MGMA is observed to be more in line with the external benchmarks. (See Table 5: Compensation per RVU VHA vs. MGMA) support staff to VHA physicians are generally half that of the private/academic sector.

VHA is committed to providing high value care to Veterans and demonstrating this to our stakeholders. VHA does consider external benchmarks. When considering external benchmarks it is important to note that VHA has a social mission that might not necessarily be considered in the external benchmarks. For example, payers (Medicare and private insurance) may not recognize important aspects of a Veteran's treatment plan such as telephone encounters or an extended visit involving the family so as to assist in the Veterans recovery. We consider this a critical component of our work. Because the RVU system, based on payment for

## Report of VHA Specialty Physician Productivity &amp; Staffing

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healthcare services, might not recognize these important social components of health care delivery, we benchmark internally to drive system improvement while maintaining our important social mission.

*Next Steps:*

VHA has delivered on productivity and staffing standards for all VHA physicians except for the specialties of Anesthesiology and Emergency Medicine which will be fully implemented in FY15. VHA should re-visit productivity standards, as appropriate, with the expectation to improve value to Veterans and stakeholders. VHA should continue to refine specialty practice management business strategies to maximize efficiency and healthcare value in the delivery of healthcare services, and ensure ready access to medical care for Veterans.

OPES has already developed additional web-based practice management tools to provide local managers with information on: (1) capacity; (2) support staffing; and (3) physician staffing.

- (1) **Capacity:** To estimate capacity in specialty care, it was assumed that VAMCs with a specialty productivity level below the MCG mean could be brought up to the mean productivity level (since that level of productivity is attainable for about half of VHA's specialty practices). The methodology employed in the web-based tool identifies sites with below average productivity and estimates the additional specialty-specific workload in RVUs that could be provided if productivity is increased to VHA MCG mean levels for a specific specialty. That projected increase in RVUs can be equated with additional potential specialty capacity. And given that physician productivity depends not only on the effort of the individual physician but also the practice setting (clinic support staff and clinic environment/space), this tool also assesses clinic support staff for each specialty.
- (2) **Support Staffing:** To estimate clinic support staffing needs, it was assumed that practices with support staff ratios below specialty- and MCG-specific mean levels could be brought up to the mean. VHA utilized internal benchmarks because VHA ratios may not be directly comparable to private sector benchmarks (MGMA) for a number of procedure-based specialties. Although MD FTE can be mapped to outpatient care, this mapping does not distinguish time mapped to specialty outpatient clinics vs. procedure areas (i.e., cath/EP lab for cardiology, reading echocardiograms or ECGs for cardiology, endoscopy for gastroenterology, bronchoscopy for pulmonary, outpatient dialysis for nephrology, EEG lab and sleep lab for neurology, or the operating room for surgeons). VHA's clinic support staff ratios measure only the staff in the specialty outpatient clinic (not procedure areas). The support staff ratio represents the total outpatient support staff FTE mapped to that specialty clinic divided by the total MD FTE mapped to outpatient care (including time and FTE mapped to these procedure areas). As a result, lower staff ratios are expected for gastroenterology, cardiology, pulmonary, nephrology, neurology, and the surgical specialties due to the fact that these specialties spend more outpatient clinical time away from the clinic, so their clinical adjusted FTE overestimates the amount of time in outpatient specialty clinic, and therefore results in an underestimate of the ratio.
- (3) **Physician Staffing:** To estimate physician staff needs, it was assumed that all practices with a specialty- and MCG-specific productivity level >75<sup>th</sup> percentile were staffed up to a level that would bring the practice back to the 75<sup>th</sup> percentile. This approach was applied to all practices with high productivity (Quadrants 1 and 2). This approach could have been selectively applied to only those Quadrant 2 practices with poor access. However, the reasons for including all high-productivity sites, regardless of access, are because of: (1) concerns re the accuracy of the access measure, therefore inaccuracy in discriminating a true Quadrant 1 from a true Quadrant 2 practice; and (2) any site operating at the very high end of productivity (even with good access), has very little margin or reserve

## Report of VHA Specialty Physician Productivity &amp; Staffing

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in terms of a sudden change in FTE levels (retirement, illness,) and could easily slip into Quadrant 2. This approach provides a margin for all high productivity sites. In effect, it sets a productivity standard at the VHA specialty- and MCG-specific 75<sup>th</sup> percentile.

VHA is currently integrating SPARQ and the recent work estimating potential capacity, support staffing requirements, and physician staffing requirements, the Enrollee Health Care Projection Model (projecting future workload in wRVUs by facility and specialty), performance metrics, program planning, and budget formulation and execution (VERA). The purpose is to align program development, performance metrics, productivity, staffing, and capacity, and financing. As part of these efforts, OPES has created a web-based tool [Site Overview Report](#) that allows a composite facility-level view (aggregated data across all specialties) including: predominant quadrant designation (quadrant where most specialties are located); EWL data (aggregated across all specialties for a facility); % of specialties with support staff ratios below the mean; FEE costs; potential physician capacity data (total physician RVUs for all specialties, projected RVUs that could be produced if all specialties could achieve productivity levels for each specialty that are at the mean or greater, and potential increase in capacity); physician staff data (current total MD FTE, additional MD FTE needed to address high-productivity specialties above the 75<sup>th</sup> percentile, and the percent increase in physician staffing required); and support staff data (total support staff on board, additional support staff needed to bring all specialties up to at least the mean level, and percent increase in support staff necessary). Data (including annual projections of potential capacity, estimates of physician staffing needs, and estimates of support staffing needs) is available for the years FY12 to FY14.

## Report of VLA Specialty Physician Productivity &amp; Staffing

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Table 1: Productivity Implementation Time Line (updated EOFY14):

Specialty Productivity Standards Time Line			
Group	Group % of Total FTE FY13	Cumulative Total	Status as EOFY 14
1			Complete Internal Medicine
1			Complete Preventive Medicine
1			Complete Psychiatry
1			Complete Psychology
1			Complete Radiology
	59%	59%	Complete
2			Complete Dermatology
2			Complete Gastroenterology
2			Complete Neurology
2			Complete Ophthalmology
2			Complete Orthopaedic Surgery
2			Complete Urology
	9%	67%	Complete
3			Complete Allergy and Immunology
3			Complete Endocrinology
3			Complete Hematology-Oncology
3			Complete Obstetrics & Gynecology
3			Complete Optometry
3			Complete Otolaryngology
3			Complete Plastic Surgery
3			Complete Podiatry
3			Complete Rheumatology
	10%	77%	Complete
4			Complete Chiropractic
4			Complete Infectious Disease
4			Complete Nephrology
4			Complete Neurological Surgery
4			Complete Pain Medicine
4			Complete Thoracic Surgery
4			Complete Vascular Surgery
	4%	81%	Complete
5			Complete Cardiology
5			Complete Critical Care / Pulmonary
5			Complete Physical Medicine & Rehab
5			Complete Surgery
	10%	91%	Complete
6			Interim FY15 Implement Anesthesiology
6			Interim FY15 Implement Emergency Medicine
6			Complete Pathology
6			Complete Geriatric Medicine
	9%	100%	Complete

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## Report of VHA Specialty Physician Productivity &amp; Staffing

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Table 2: Productivity Standards (updated EOFY14): Specialty Productivity Report

<b>Annual Review Quadrant Report &amp; Practice Management Report</b>						
Productivity Standards Target: Mean or otherwise noted						
<b>Specialty</b>	<b>1a-High Complexity</b>	<b>1b-High Complexity</b>	<b>1c-High Complexity</b>	<b>2 -Medium Complexity</b>	<b>3 -Low Complexity</b>	<b>Notes</b>
Allergy and Immunology	2,476	2,476	2,476	2,476	2,476	
Anesthesiology						FY15 ASA Unit Implementation
Cardiology	6,081	5,401	5,162	3,811	3,739	
Chiropracty	2,787	2,745	2,343	2,300	2,841	
Critical Care / Pulmonary Disease	4,968	3,760	3,640	3,192	3,326	
Dermatology	7,935	9,194	6,321	4,886	4,397	
Emergency Medicine						FY15 EMS Implementation
Endocrinology	3,086	2,795	2,685	2,616	2,399	
Gastroenterology	6,596	7,975	6,359	5,115	4,592	
Geriatric Medicine	2,430	2,326	2,285	2,432	1,831	
Hematology-Oncology	4,100	3,239	2,969	2,602	2,205	
Infectious Disease	2,674	2,406	2,511	3,128	2,771	
Internal Medicine	2,894	2,786	2,812	2,672	2,492	Primary Care Panel Size
Nephrology	6,542	3,397	3,469	2,752	2,652	
Neurological Surgery	4,055	4,055	4,055	4,055	4,055	
Neurology	2,965	3,103	3,266	2,692	2,693	
Obstetrics & Gynecology	2,508	2,508	2,508	2,508	2,508	
Ophthalmology	6,543	7,006	6,433	5,422	4,044	
Optometry	4,077	3,598	4,073	4,365	4,368	
Orthopaedic Surgery	4,759	4,165	4,572	4,344	3,809	
Otolaryngology	4,453	4,982	3,882	3,751	4,310	
Pain Medicine	3,235	2,473	2,507	1,891	3,226	
Pathology	3,897	4,949	4,173	3,263	2,352	
Physical Medicine & Rehabilitation	2,770	3,179	2,714	2,236	1,988	
Plastic Surgery	3,703	3,703	3,703	3,703	3,703	
Podiatry	4,028	5,037	4,031	3,073	3,332	
Psychiatry	2,574	2,574	2,574	2,574	2,574	Outpatient Median VHA Directive 1161
Psychology	1,926	1,926	1,926	1,926	1,926	Outpatient Median VHA Directive 1161
Radiology	5,000	5,000	5,000	5,000	5,000	
Rheumatology	3,454	3,619	2,403	2,996	3,764	
Surgery	4,030	3,800	4,035	3,410	3,634	
Thoracic Surgery	4,764	3,992	3,338	2,149		
Urology	4,957	5,189	4,501	3,495	3,472	
Vascular Surgery	5,118	5,118	5,118	5,118	5,118	

Note: Data Represent Baseline Productivity Standards Implemented. Adjustments and recalibration will be undertaken as necessary.

## Report of VHA Specialty Physician Productivity &amp; Staffing

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Table 3: VHA Productivity vs. MGMA

VHA Specialty	# VHA Facilities	VHA Productivity Mean	VHA Mean	MGMA Academic Practice Mean	MGMA Private Practice Mean	VHA Median	MGMA-Academic Practice Median	MGMA-Private Practice Median
Allergy and Immunology	44	2,985	2,821	4,029	4,630	2,552	3,896	4,277
Cardiology Combined (Includes EP, Interventional)	120	5,727	5,354	*	*	4,920	*	*
Cardiovascular Disease	119	5,470	5,215	5,992	7,114	4,919	5,923	6,528
Chiropracty	37	2,953	3,124	*	*	2,663	*	*
Clinical Cardiac Electrophysiology	25	6,593	6,998	10,840	11,871	6,739	10,306	10,921
Clinical Pharmacology	2	2,267	1,746	*	*	1,746	*	*
Critical Care / Pulmonary Disease	115	4,273	4,470	6,187	8,170	3,766	6,224	7,233
Dermatology	88	6,732	7,630	7,928	8,543	6,137	6,842	7,840
Emergency Medicine	100	3,909	3,851	7,761	6,203	3,479	7,458	6,266
Endocrinology	96	2,956	3,322	4,035	5,031	2,955	3,877	4,695
Gastroenterology	104	6,413	6,825	8,031	8,837	6,013	7,377	8,492
Geriatric Medicine	109	2,539	2,838	3,667	3,856	2,324	3,371	3,562
Hematology-Oncology	108	3,677	3,606	5,237	5,285	3,262	4,893	4,726
Infectious Disease	94	2,383	2,663	3,004	5,187	2,259	2,821	4,758
Internal Medicine	140	3,049	2,977	4,635	5,049	3,009	4,695	4,795
Interventional Cardiology	52	6,699	6,493	8,088	10,015	5,796	7,694	9,406
Medical Genetics	2	2,377	5,466	1,904	*	5,466	1,676	*
Nephrology	99	5,242	5,264	5,676	6,653	3,342	5,251	6,168
Neurological Surgery	53	4,841	4,498	10,341	10,030	4,442	9,085	9,548
Neurology	123	3,354	3,525	3,698	5,290	3,275	3,393	4,862
Obstetrics & Gynecology	71	2,994	2,977	8,105	7,068	2,809	7,648	6,714
Ophthalmology	107	6,436	6,691	6,811	8,911	6,213	6,700	8,573
Optometry	130	4,245	4,376	*	*	4,124	*	*
Orthopaedic Surgery	121	4,573	4,796	9,683	8,700	4,367	8,853	7,981
Otolaryngology	92	4,707	4,753	8,481	7,434	4,399	7,849	7,118
Pain Medicine	44	3,232	3,495	3,222	7,428	3,055	3,335	6,761
Pathology	111	4,243	4,621	6,903	7,629	3,857	6,711	7,341
Physical Medicine & Rehabilitation	116	3,069	2,904	5,435	5,161	2,813	5,339	4,683
Plastic Surgery	66	4,104	4,066	8,889	6,720	3,844	7,926	6,410
Podiatry	128	3,759	3,889	5,724	4,725	3,686	6,076	4,406
Preventive Medicine	35	1,549	1,962	*	*	1,158	*	*
Psychiatry	140	2,873	2,842	2,727	3,821	2,735	2,588	3,539
Psychology	140	1,807	1,777	2,090	*	1,753	*	*
Radiology	125	5,652	5,680	8,215	8,998	5,486	7,605	8,763
Rheumatology	92	3,062	3,325	4,269	5,069	3,063	3,929	4,825
Surgery	125	4,173	4,011	7,579	7,118	4,017	7,571	6,812
Thoracic Surgery	64	4,740	4,411	10,523	8,371	4,022	8,631	8,280
Urology	114	4,817	4,906	8,909	8,059	4,445	8,476	7,533
Vascular Surgery	81	6,005	5,623	10,147	8,662	5,085	9,389	8,805

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## Report of VHA Specialty Physician Productivity &amp; Staffing

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**Table 4: Total Compensation VHA vs. MGMA**

VHA Specialty	#VHA Facilities	Total Compensation			
		VHA Average Physician Salary	VHA Adjusted Avg. Salary (%Clinical)	MGMA Academic Practice Mean	MGMA Private Practice Mean
Allergy and Immunology	44	\$200,118	\$144,547	\$178,323	\$331,410
Cardiology Combined (Includes EP, Interventional)	120	\$273,118	\$186,026	*	*
Cardiovascular Disease	119	\$273,118	\$183,161	\$259,837	\$473,548
Chiropracty	37	\$104,744	\$96,583	*	\$129,300
Clinical Cardiac Electrophysiology	25	\$273,118	\$214,416	\$354,237	\$572,820
Clinical Pharmacology	2	*	*	*	*
Critical Care / Pulmonary Disease	115	\$233,167	\$107,652	\$234,177	\$391,984
Dermatology	88	\$265,472	\$213,091	\$291,868	\$475,596
Emergency Medicine	100	\$225,379	\$201,532	\$253,033	\$308,215
Endocrinology	96	\$202,355	\$111,269	\$172,745	\$240,993
Gastroenterology	104	\$271,655	\$200,662	\$278,784	\$529,172
Geriatric Medicine	109	\$199,757	\$85,883	\$173,611	\$196,207
Hematology-Oncology	108	\$229,440	\$150,443	\$239,879	\$465,089
Infectious Disease	94	\$199,531	\$79,620	\$170,227	\$250,575
Internal Medicine	140	\$194,020	\$143,265	\$194,491	\$236,392
Interventional Cardiology	52	\$273,118	\$190,711	\$376,774	\$559,567
Medical Genetics	2	*	*	\$163,565	\$137,841
Nephrology	99	\$215,377	\$111,931	\$196,872	\$321,783
Neurological Surgery	53	\$357,453	\$285,610	\$550,078	\$775,968
Neurology	123	\$203,228	\$130,560	\$192,381	\$281,616
Obstetrics & Gynecology	71	\$231,903	\$215,029	\$250,659	\$323,776
Ophthalmology	107	\$253,739	\$230,203	\$245,078	\$388,521
Optometry	130	\$125,745	\$118,181	\$130,435	\$149,738
Orthopaedic Surgery	121	\$322,811	\$294,029	\$443,204	\$569,202
Otolaryngology	92	\$273,633	\$239,958	\$347,140	\$425,493
Pain Medicine	44	*	*	\$325,086	\$529,347
Pathology	111	\$223,691	\$174,809	\$232,594	\$425,817
Physical Medicine & Rehabilitation	116	\$217,415	\$137,063	\$217,477	\$288,885
Plastic Surgery	66	\$291,155	\$262,702	\$447,371	\$472,433
Podiatry	128	\$138,296	\$128,769	\$194,600	\$220,933
Preventive Medicine	35	\$188,021	\$148,998	*	*
Psychiatry	140	\$204,675	\$147,745	\$174,467	\$214,327
Psychology	140	\$104,310	\$88,227	\$108,363	\$97,682
Radiology	125	\$309,838	\$265,491	\$346,520	\$477,989
Rheumatology	92	\$198,227	\$119,815	\$180,171	\$277,361
Surgery	125	\$284,639	\$230,860	\$322,810	\$386,894
Thoracic Surgery	64	\$329,155	\$264,187	\$484,792	\$469,442
Urology	114	\$281,393	\$251,332	\$346,023	\$435,633
Vascular Surgery	81	\$307,736	\$244,956	\$396,199	\$483,653

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## Report of VHA Specialty Physician Productivity &amp; Staffing

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**Table 5: Compensation per RVU VHA vs. MGMA**

VHA Specialty	Compensation to Work RVU Ratio (calculated)				Compensation to Work RVU Ratio (MGMA Survey Tables)	
	VHA Mean	VHA Adjusted Mean (Clinical)	MGMA Academic Practice Mean	MGMA Private Practice Mean	MGMA Table 45.1 Academic Practice Mean	MGMA Table 22.1 Private Practice Mean
Allergy and Immunology	\$70.94	\$51.24	\$44.26	\$71.57	\$62.20	\$72.05
Cardiology Combined (Includes EP, Interventional)	\$51.01	\$34.74	*	*	*	*
Cardiovascular Disease	\$52.37	\$35.12	\$43.36	\$66.56	\$57.82	\$75.55
Chiropractic	\$33.53	\$30.92	*	*	*	*
Clinical Cardiac Electrophysiology	\$39.03	\$30.64	\$32.68	\$48.26	\$52.04	\$52.47
Clinical Pharmacology	*	*	*	*	*	*
Critical Care / Pulmonary Disease	\$52.16	\$24.08	\$37.85	\$47.98	\$57.23	\$53.66
Dermatology	\$34.79	\$27.93	\$36.82	\$55.67	\$87.57	\$58.24
Emergency Medicine	\$58.53	\$52.34	\$32.61	\$49.69	\$45.06	\$56.02
Endocrinology	\$60.91	\$33.49	\$42.81	\$47.90	\$63.56	\$53.49
Gastroenterology	\$39.81	\$29.40	\$34.71	\$59.88	\$55.85	\$63.49
Geriatric Medicine	\$70.40	\$30.27	\$47.34	\$50.88	\$114.38	\$57.72
Hematology-Oncology	\$63.63	\$41.72	\$45.81	\$88.00	\$64.97	\$98.36
Infectious Disease	\$74.92	\$29.90	\$56.67	\$48.31	\$73.20	\$51.23
Internal Medicine	\$65.18	\$48.13	\$41.96	\$46.82	\$70.64	\$49.70
Interventional Cardiology	\$42.06	\$29.37	\$46.59	\$55.88	\$60.63	\$63.24
Medical Genetics	*	*	\$85.89	*	*	*
Nephrology	\$40.92	\$21.26	\$34.69	\$48.37	\$67.68	\$56.24
Neurological Surgery	\$79.47	\$63.50	\$53.19	\$77.37	\$84.54	\$84.08
Neurology	\$57.65	\$37.03	\$52.02	\$53.23	\$95.66	\$56.24
Obstetrics & Gynecology	\$77.90	\$72.23	\$30.93	\$45.81	\$47.01	\$49.07
Ophthalmology	\$37.92	\$34.41	\$35.98	\$43.60	\$46.45	\$44.02
Optometry	\$28.74	\$27.01	*	*	*	\$34.37
Orthopaedic Surgery	\$67.30	\$61.30	\$45.77	\$65.42	\$62.08	\$69.89
Otolaryngology	\$57.56	\$50.48	\$40.93	\$57.23	\$61.78	\$59.34
Pain Medicine	*	*	\$100.91	\$71.26	\$196.15	\$87.98
Pathology	\$48.41	\$37.83	\$33.69	\$55.82	\$402.67	\$71.85
Physical Medicine & Rehabilitation	\$74.88	\$47.20	\$40.02	\$55.98	\$49.78	\$61.38
Plastic Surgery	\$71.61	\$64.61	\$50.33	\$70.30	\$65.63	\$82.78
Podiatry	\$35.56	\$33.11	\$34.00	\$46.76	\$40.85	\$46.34
Preventive Medicine	\$95.82	\$75.93	*	*	*	*
Psychiatry	\$72.03	\$51.99	\$63.97	\$56.09	\$390.50	\$64.27
Psychology	\$58.68	\$49.64	\$51.85	*	*	\$40.53
Radiology	\$54.55	\$46.74	\$42.18	\$53.12	\$59.05	\$56.44
Rheumatology	\$59.62	\$36.03	\$42.20	\$54.71	\$51.27	\$56.66
Surgery	\$70.96	\$57.55	\$42.59	\$54.35	\$85.79	\$58.50
Thoracic Surgery	\$74.63	\$59.90	\$46.07	\$56.08	\$81.45	\$74.85
Urology	\$57.35	\$51.23	\$38.84	\$54.05	\$55.79	\$54.66
Vascular Surgery	\$54.73	\$43.56	\$39.05	\$55.83	\$46.97	\$61.70

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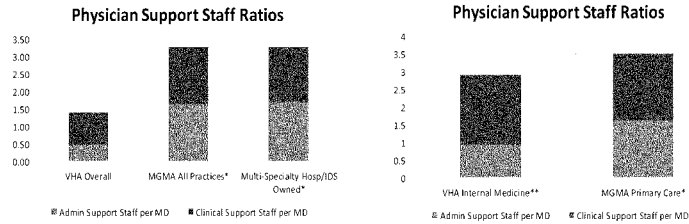
Report of VHA Specialty Physician Productivity & Staffing



**Table 6: VHA Support Staff Ratios vs. MGMA**

	VHA Overall	MGMA All Practices*	VHA Internal Medicine*	MGMA Primary Care*	Multi-Specialty Hosp/IDS Owned**
Admin Support Staff per MD	0.48	1.64	0.95	1.64	1.71
Clinical Support Staff per MD	0.92	1.64	1.96	1.88	1.56
Total Support Staff per MD	1.40	3.35	2.91	3.52	3.27

\*Source: MGMA Cost and Production Report 2010 based on 2009 Data  
 \*\*Largely Primary Care



Sources:

Physician Productivity VA Provider Productivity FY 2012 = Work RVUs (RVUSumFiltered) ÷ Direct Clinical FTE (Adjusted MD FTE(C))

PAID Cube for VHA Average Salary (includes Base Salary, Lump Sum, Bonus & Incentives)

MGMA Academic Survey 2013: 2012 Data

MGMA Physician Compensation and Production Survey 2012: 2011 Data for Private Practice Data

Notes about Specialty MGMA Benchmark Data:

- Critical Care/Pulmonary Disease = Pulmonary Medicine: Gen & Critical Care
- Pathology = Pathology Anatomical and Clinical
- Radiology = Radiology: Diagnostic -Noninvasive
- MGMA Academic Practice=Standardized Work RVUs (NPP Excluded) to 100% Billable Cycle
- MGMA Private Practice=Physician Work RVUs for Private Practice Physicians (CMS RBRVS Method) (NPP Excluded) Standardized Work RVUs (NPP Excluded) to 100% Billable Clinical Activity = Physician Work RVU X 100 / Percent of Billable Clinical Activity , excluding Nonphysician Providers

2013 Academic Survey Report Based on 2012 Data. Copyright © 2013. All Rights Reserved. Medical Group Management Association.  
 2012 Report Based on 2011 Data. Copyright © 2012. All Rights Reserved. MGMA-ACMPE

Notes on VHA Data:

VHA Adjusted Avg. Salary is adjusted for % Clinical effort using the physician productivity cube %Adjusted MD FTE(C) (also excludes inpatient % effort for Medicine and Mental Health Specialties).

Report of VHA Specialty Physician Productivity & Staffing



Exhibit A: SPARQ Tool Specialty Quadrant



Specialty Productivity - Access Report and Quadrant Tool

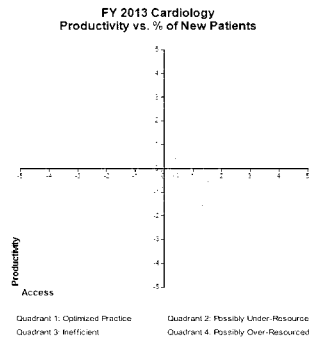
ATTENTION: Please note data is only as current as each data source. See 'Last Updated' list.

Facility Quadrant | Facility Measure Detail | Facility Measure Detail by Specialty

Data Definitions | SPC Charts | VSSC Help Desk

FY 2013 Cardiology Specialty Quadrant: 1a-High Complexity Facilities  
Z-Score Calculated using MCG Averages and Standard Deviation

Facility	3-Yr Growth Specialty Patients	% New Patients	Productivity	New Patients (Z-Score)	Productivity (Z-Score)
(V01) (623) VA Boston HCS, MA	6%	57.37%	4,569	0.71	(0.70)
(V01) (689) VA Connecticut HCS, CT	7%	61.08%	6,856	0.95	0.42
(V03) (630) New York Harbor HCS, NY	-21%	81.34%	2,949	2.22	(1.51)
(V04) (646) Pittsburgh, PA	5%	70.31%	4,699	1.52	(0.66)
(V06) (558) Durham, NC	-2%	49.72%	7,058	0.23	0.52
(V06) (682) Richmond, VA	6%	45.97%	4,521	0.00	(0.73)
(V07) (508) Atlanta, GA	-11%	52.83%	6,975	0.43	0.48
(V07) (521) Birmingham, AL	-1%	43.14%	8,982	(0.18)	1.47
(V08) (518) Bay Pines, FL	0%	35.57%	5,214	(0.85)	(0.24)
(V08) (573) Gainesville, FL	4%	46.32%	4,349	0.02	(0.81)
(V08) (672) San Juan, PR	-1%	53.45%	5,775	0.47	(0.11)
(V08) (873) Tampa, FL	-5%	28.01%	9,062	(1.13)	1.51
(V09) (614) Memphis, TN	-4%	20.72%	9,234	(1.59)	1.50
(V09) (626) Middle Tennessee HCS, TN	6%	33.55%	6,136	(0.78)	0.67
(V10) (541) Cleveland, OH	9%	66.54%	6,114	1.29	0.66
(V11) (583) Indianapolis, IN	9%	40.03%	10,523	(0.37)	2.24
(V12) (576) Miness. IL	19%	44.42%	5,495	(0.10)	(0.25)
(V12) (695) Milwaukee, WI	5%	43.3%	5,227	(0.17)	(0.68)
(V15) (657) St. Louis, MO	-6%	36.64%	7,448	(0.59)	0.72
(V15) (580) Houston, TX	14%	27.88%	7,074	(1.14)	0.53
(V17) (549) Dallas, TX	3%	24.43%	7,957	(1.35)	0.97
(V17) (671) San Antonio, TX	23%	36.48%	4,143	(0.80)	(0.92)
(V18) (501) New Mexico HCS	-8%	52.16%	5,292	0.39	(0.35)
(V18) (678) Southern Arizona HCS	-1%	30.76%	11,299	(0.96)	2.62
(V19) (554) Denver, CO	5%	44.44%	7,490	(0.10)	0.74
(V20) (648) Portland, OR	6%	44.19%	6,595	(0.11)	0.29
(V20) (663) VA Puget Sound, WA	-2%	66.55%	7,096	1.42	0.54
(V21) (640) Palo Alto, CA	-3%	66.83%	3,073	1.31	(1.45)
(V21) (662) San Francisco, CA	5%	51.29%	4,078	0.33	(0.95)
(V22) (664) San Diego, CA	-1%	83.4%	5,622	2.35	(0.19)
(V22) (691) Greater Los Angeles HCS	7%	46.24%	6,814	0.05	0.40
(V23) (616) Minneapolis, MN	4%	67.55%	5,078	1.35	(0.45)



Report of VHA Specialty Physician Productivity & Staffing

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Exhibit B: SPARQ Tool Facility Quadrant



Specialty Productivity - Access Report and Quadrant Tool

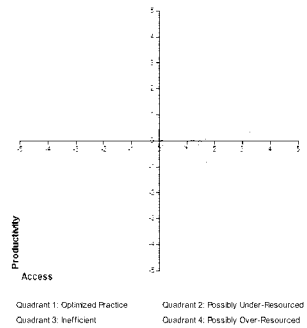
ATTENTION: Please note date is only as current as each data source. See 'Last Updated' list.

Specialty Quadrant    Facility Measure Detail    Facility Measure Detail by Specialty    Data Definitions    SPC Charts    VSSC Help Desk

FY 2014 (V01) (689) VA Connecticut HCS, CT Facility Quadrant  
 Z-Score: Calculated using MCG Averages and Standard Deviation

Specialty	% New Patients	Productivity	New Patients (Z-Score)	Productivity (Z-Score)
Allergy and Immunology	32.91%	955	0.21	(0.99)
Cardiology	47.54%	4,204	0.09	(0.26)
Chiropractic	45.64%	1,880	0.69	(0.18)
Critical Care / Pulmonary Disease	41.45%	3,019	0.03	0.18
Dermatology	75.13%	5,491	1.66	0.25
Endocrinology	43.64%	2,291	0.30	0.24
Gastroenterology	68.88%	4,789	3.41	0.72
Hematology/Oncology	43.97%	3,401	(0.65)	(0.11)
Infectious Disease	71.7%	1,813	0.88	0.10
Internal Medicine	54.16%	1,865	1.19	0.59
Nephrology	53.19%	8,392	0.93	(0.10)
Neurological Surgery	58.54%	3,176	1.46	0.31
Neurology	24.88%	2,243	(0.41)	0.30
Obstetrics & Gynecology	45.28%	2,077	(0.01)	0.31
Ophthalmology	70.52%	5,855	2.23	0.45
Optomety	85.32%	2,995	3.25	(0.54)
Orthopaedic Surgery	30.07%	2,417	(0.60)	(0.27)
Otolaryngology	67.08%	3,084	1.87	(0.56)
Pain Medicine	25.18%	1,504	(0.43)	(0.40)
Physical Medicine & Rehabilitation	60.66%	1,553	0.65	1.30
Plastic Surgery	43.54%	50	0.58	(0.80)
Podiatry	50.75%	4,095	0.58	(1.52)
Psychiatry	82.97%	1,769	1.62	2.12
Psychology	82.97%	922	1.62	1.18
Rheumatology	53.26%	4,507	0.54	(0.77)
Surgery	32.64%	3,443	(0.61)	(0.50)
Thoracic Surgery	39.46%	4,315	(0.77)	1.13
Urology	53.0%	2,475	1.13	(0.40)
Vascular Surgery	43.53%	3,238	0.12	

FY 2014 (V01) (689) VA Connecticut HCS, CT  
 Productivity vs. New Patient Access



Report of VHA Specialty Physician Productivity & Staffing

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Exhibit C: SPARQ Tool Facility Measure Detail (updated EOFY14)



Specialty Productivity - Access Report and Quadrant Tool

ATTENTION: Please note data is only as current as each data source. See 'Last Updated' list.

Specialty Quadrant Facility Quadrant Facility Measure Detail by Specialty Data Definitions

FY 2014 Cardiology Facility Detail: (Sample Medical Center)

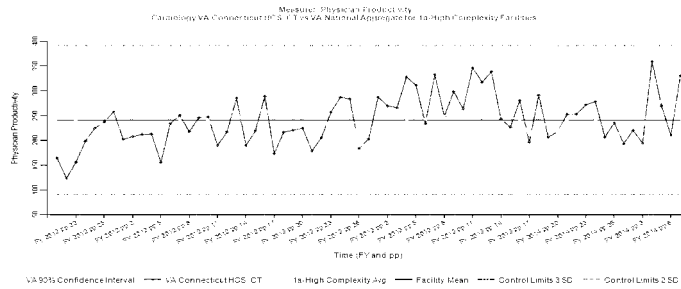
Category	Measure	Facility Value	Facility Peer Group Mean (MCG)
Trend Data	3 yr % Change in Core Facility Uniques	2.25 %	4.88 %
	FY13-FY18 Projected RVU Growth (Enrollee HealthCare Projection Model)	9.44 %	17.76 %
Workforce Supply	% MD FTE (C)	81 %	76 %
	Total Bedday FTEE	6.37	1.12
	Physician Clinical FTEE	4.87	6.76
Workforce per Population	Physician Clinical FTEE per 10K Specialty Patients	4.06	5.47
	Physician Clinical FTEE per 100K Core Facility Uniques	8.25	8.87
Procedure Suite Based Workforce	Cardiac Cath Admin Support Staff per 10000 RVUs	1.47	1.80
	Cardiac Cath Clinical Support Staff per 10000 RVUs	3.93	4.15
	Cardiac Cath Total Support Staff per 10000 RVUs	5.40	5.95
Office Based Clinic Support Staff	Total Support Direct FTEE Per Physician Clinical FTEE	1.03	0.77
APP Workforce	APP Workforce per Physician Clinical FTEE	0.59	0.34
	APP Workforce per 10K Specialty Patients	2.40	1.87
	APP Workforce per 100K Core Facility Uniques	4.89	3.04
Productivity Measure	Productivity Measure	6.831	6.708
Teaching Mission	Resident Workforce	8.0	7.0
Access/Demand	New Patient % Wait Between 0 and 30 Days	84.4 %	77.3 %
	All Patient % Wait Between 0 and 30 Days	97.5 %	96.0 %
	Established Patient % Wait Between 0 and 30 Days	88.5 %	97.7 %
	Avg Days to 3rd Next Available Appointment	31.04	28.89
	EWL Total Patients Waiting		4
Practice Management	E&M New to Established Encounters	0.30	0.46
	Physician E&M New to Established Encounters	0.34	0.50
	APP E&M New to Established Encounters (No PPC on Encounter)	0.25	0.35
	Cancelled by Clinic Prior to Appointment Rate	14.8 %	10.1 %
	Missed Opportunity Rate	15.2 %	12.2 %
Specialty Workload	FY18 Projected Total RVUs (Enrollee HealthCare Projection Model)	32,540	40,184
	Total RVUs (VA Paid, Non-VA, Residents)	30,552	39,021
	Annual % Change in Total RVUs	3%	11%
	VA Paid RVUs (% of Total)	28,458 (93.15%)	82,34%
	Non-VA Paid (Fee & Other) RVUs (% of Total)	2,025 (6.63%)	6.08%
	Resident Only RVUs (% of Total)	69 (0.23%)	1.58%
	Total APP RVUs (No PCP on Encounter)	11,212	2,671
	Total RVUs (PPC (Paid & Non VA Paid), Residents, APP)	41,784	41,693
	Average Outpatient VA Encounters per Day (Physician & APP no PCP)	51.59	40.12
Physician Compensation (Not geographically adj.)	Facility Average Total Compensation	\$266,756	\$269,864
	Total Compensation per RVU	\$39	\$40
	Facility Average Clinical Compensation (% Clinical)	\$198,369	\$172,499
	Clinical Compensation per RVU (% Clinical)	\$29	\$26
Procedure-Based Fee Care	Total Disbursed Amount	\$247,831	\$410,685
VA Reliance	Outpatient Medicine	31 %	43 %
	Inpatient Medicine	12 %	28 %



Report of VHA Specialty Physician Productivity & Staffing



**Exhibit D: Statistical Process Control Charts:**



**Appendix 1: Operational Plan for Productivity & Staffing Standards Implementation.**

**Overview:**

An Office of the Inspector General (OIG) Audit, "Physician Staffing Levels for Specialty Care Services," from December, 2012, recommended that the Veterans Health Administration (VHA): (1) establish productivity standards for at least five specialty care services by the end of FY 2013 and approve a plan that ensures all specialty care services have productivity standards within three years; and (2) provide medical facility directors with more specific guidance on how to develop staffing plans and ensure that medical facility management review them at least annually to confirm optimal efficiency.

VHA concurred with these recommendations and agreed to establish productivity standards for five specialties in FY 2013 and the remaining specialties by the EOFY 2015. To this end, the Specialty Physician Productivity & Staffing Task Force (Task Force) that VHA established in June 2012 has begun to leverage the extensive work VA has already completed in building the necessary data sources to measure specialty physician productivity and staffing on an ongoing and systematic way. This operational plan outlines the steps VHA will take to address the OIG recommendations within the required timeframes.

**Background:**

VA has already established productivity standards for more than half (54%) its physicians, has been analyzing and reporting RVU productivity data for all specialists since 2008, and has committed to establishing productivity standards for five specialties by the end of this year. The Task Force has concentrated on establishing Relative Value Unit (RVU)-based productivity standards for seven additional specialties representing an additional 15% of VA's physician workforce, so that by the end of FY13, more than two-thirds of physicians in VA will have productivity standards.

Primary Care, the largest component of VA's physician workforce (34%), has been employing a panel model for standardizing productivity and staffing in PC since 2004. Mental Health, the 2<sup>nd</sup> largest component of VA's physician workforce (14%) has developed a productivity model that will be implemented this year. Radiology,

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the 3<sup>rd</sup> largest component of VA's physician workforce (6%) has employed an RVU-based productivity model that has set a productivity standard of 5,000 RVUs/FTE since 2008.

VA has already established a system for collecting, analyzing, and reporting RVU productivity data for all medical specialties. In 2007 VA established an Office of Productivity, Efficiency, and Staffing (OPES) and in 2008 began reporting physician productivity using RVUs. VA has provided specialty physician productivity data utilizing RVUs on the VA Intranet (Physician Productivity Cube) to VA managers since 2008. The productivity data utilized by the OIG was derived from this VA Physician Productivity report.

In June 2012, VA established a Task Force to recommend and establish productivity standards in 5 specialties by the end of FY13 and develop a plan to ensure that all specialties have productivity standards by the end of FY15. To link productivity measurement to staffing standards, the Task Force developed a web-based tool that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians. This integrated approach, coupled with measures of quality and the amount of specialty non-VA community care (FEE- Basis care), was proposed to help VA medical center leaders make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs. Productivity data coupled with access measures provides a framework for determining specialty physician staffing. This model was prototyped for the seven specialties of Cardiology, Gastroenterology, Dermatology, Neurology, Orthopedics, Urology, and Ophthalmology.

The primary data source that will be used to assess Specialty Physician Productivity and Staffing in VHA will be the Physician Productivity Cube (PPC). The PPC is a critical component to VHA's ability to systematically assess Specialty Physician Productivity & Staffing within VHA and, as such, will continue to be refined and improved upon. The Task Force has and will continue to validate and make recommendations for improvement in this key data source, as well as develop additional tools for local leadership to improve their specialty practices with the ultimate goal of providing high quality, efficient specialty care to our Veteran patients.

Through the use of Veterans Integrated Service Network (VISN) pilots, extensive stakeholder input will be obtained and considered. VISN pilots (VISN 7, 12, 19, and 22) have been targeted to ensure an appropriate spectrum of U.S. regions (South and East, Midwest, and West as well as a mix of rural and urban) and practice settings (Medical Center Complexity Group (MCG) Levels) is included, as well as to ensure a core group of VISNs to assist in the diffusion of core competencies in specialty practice management knowledge. The VISN pilots will simulate implementation of productivity standards (25<sup>th</sup> percentile and mean by specialty and MCG) and, through this, identify business rule gaps and any potential unintended consequences to the efficient delivery of specialty care services to our Veterans. Based on this feedback we will then move forward with the necessary modifications to foundational business rules and deploy productivity and staffing standards for five specialties to be completed by EOFY13.

Through the foundational work of the Task Force and the VISN Pilots, rapid implementation of the remaining specialties is expected to ensue. A focus on 'hospital based' specialties, e.g., Anesthesiology, Laboratory and Pathology and Emergency Medicine where alternatives to RVU-based productivity based models, will be developed through individual working groups.

#### **Operational Plan for Establishing Physician Productivity Standards:**

The following summary of VHA's operational plan details the actions planned and in process to accomplish implementation of productivity standards for Specialty Physicians:

**Stage I:** Four VISN Pilots (VISNs 7, 12, 19, and 22) review and refine preliminary RVU-based productivity standards and specialty management tools for seven specialties for VHA-wide implementation. **Target date for completion: July, 2013**

- Office of Productivity, Efficiency and Staffing (OPES) establish preliminary productivity standards (25<sup>th</sup> percentile and mean for Medical Center Complexity Group (MCG) Level) for the Specialties of: Cardiology, Gastroenterology, Neurology, Dermatology, Ophthalmology, Urology and Orthopedics in VISN Pilots.  
**Target date for completion: April, 2013.** Status: Completed for all seven specialties and all MCG levels.
- OPES develop and refine specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for Medical Center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs.  
**Target date for completion: April, 2013.** Status: Quadrant tool developed for all seven specialties.
- OPES develop methodology for capturing professional services associated with inpatient care for medical specialties.  
**Target date for completion: April, 2013.** Status: Methodology developed and workload estimated for all medical specialties.
- OPES provide preliminary productivity standards for the seven specialties for all VISN Pilot sites and identify outliers falling below 25<sup>th</sup> percentile and mean.  
**Target date for completion: April, 2013.** Status: Completed.
- VISN Pilots simulate productivity standard implementation and review factors associated with productivity outliers such as inconsistent application of foundational business rules (person class designation, labor deployment, and professional workload capture) and modify business rules accordingly. See Appendix A.  
**Target date for completion: April, 2013.** Status: Completed.
- VISN Pilots review OPES methodology for capturing professional services associated with inpatient care for accuracy and inclusion in productivity assessment.  
**Target date for completion: July, 2013.** Status: Completed and decision made to treat inpatient workload separately by backing out Bedday FTE.
- VISN Pilots review other factors contributing to productivity including practice setting, support staff, specialty demand, contract and FEE Basis care, and coding accuracy.  
**Target date for completion: July, 2013.** Status: Completed—contributing factors included in Practice Management Report.
- VISN Pilots review and refine specialty management tools (Quadrant Report) and algorithms for assessing specialty physician staffing.  
**Target date for completion: July, 2013.** Status: Completed.
- Communicate and establish core competencies within Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports).  
**Target date for completion: July, 2013.** Status: Completed. DUSHOM issued memo to VISN and Facility Directors on July 26, 2013 and six national calls were conducted for OPES and Task Force leaders to communicate directly to VISN CMOs and QMOs, COSSs, QMs, Service and Section Chiefs, AOs, and DSS leaders.

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**Stage II:** Establish productivity standards for five of the seven specialties across VHA. **Target date for completion: October, 2013.**

- Modify and finalize the preliminary productivity standards for at least five of the seven specialties.  
**Target date for completion: July, 2013.** Status: Completed for six specialties.
- VISN Pilots communicate and establish core competencies across all VISNs on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports).  
**Target date for completion: August, 2013.** Status: Completed. The decision was made to centralize the communication and establishment of core competencies. In August, six national calls were conducted for OPES and Task Force leaders to communicate directly to VISN CMOs and QMOs, COSs, QMs, Service and Section Chiefs, AOs, and DSS leaders.
- All VISNs communicate and establish core competencies across all Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports).  
**Target date for completion: September, 2013.** Status: Completed. The decision was made to centralize the communication and establishment of core competencies. In August, six national calls were conducted for OPES and Task Force leaders to communicate directly to VISN CMOs and QMOs, COSs, QMs, Service and Section Chiefs, AOs, and DSS leaders.
- Health Information Management Service (HIMS) and Compliance and Business Integrity establish procedures to ensure accurate coding for the five specialties.  
**Target date for completion: October, 2013.** Status: In process. Processes being developed to monitor distribution of E&M codes.
- Incorporate specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports into specialty physician staffing assessments for five specialties.  
Status: Completed for six specialties.
- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in these five specialties.  
**Target date for completion: October, 2013.** Status: In process.

**Stage III A:** Establish productivity standards and staffing plans for the three hospital-based specialties: Anesthesiology, Laboratory & Pathology Medicine and Emergency Medicine that require core staffing levels.  
**Target date for completion: October, 2015.** Status: Target date advanced to October 2014.

- Establish VA sub-groups to address the three hospital-based specialties: Anesthesiology, Laboratory & Pathology Medicine and Emergency Medicine that require core staffing levels.  
**Target date for completion: October, 2013.** Status: Completed. Sub-Groups established.
- Establish preliminary productivity standards and staffing plans for these three hospital-based specialties.  
**Target date for completion: October, 2014.** Status: In process
- VISNs evaluate and refine preliminary productivity standards and staffing plans and communicate and establish core competencies across all VISNs on effective specialty practice management for these three hospital-based specialties.  
**Target date for completion: January, 2015.** Status: In process
- Modify and finalize the preliminary productivity standards and staffing plans for these three hospital-based specialties.  
**Target date for completion: July, 2015.** Status: In process
- Establish and implement productivity standards for these three hospital-based specialties.  
**Target date for completion: October, 2015.** Status: In process
- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in these three specialties.  
**Target date for completion: October, 2015.** Status: in process

**Stage III B:** Implement RVU-based Productivity Standards for the 22 remaining specialties (Table 1).  
**Target date for completion: Half the remaining specialties (second-tier) implemented by October, 2014; and half the remaining specialties (third-tier) implemented by October 2015.**

- Prioritize and identify second-tier of specialties.  
**Target date for completion: October, 2013.** Status: Completed. OPES has already established 25<sup>th</sup>/75<sup>th</sup> percentile, mean, and mean – 1SD productivity levels for all specialties and has built in functionality for Quadrant tool and Practice Management Reports that includes all specialties. Decision has been made to proceed with all remaining specialties after October 2013 phasing in 6-8 specialties per quarter.
- OPES establish preliminary productivity standards (25<sup>th</sup> and mean for Medical Center Complexity Group (MCG) Level) for the 11 second-tier specialties.  
**Target date for completion: October, 2013.** Status: Completed for all specialties.
- OPES provide preliminary productivity standards for the 11 second-tier specialties for all VISNs and identify outliers falling below 25<sup>th</sup> percentile and mean.  
**Target date for completion: October, 2013.** Status: Completed for all specialties.
- OPES refine specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for Medical Center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs to encompass 11 second-tier specialties.  
**Target date for completion: December, 2013.** Status: Completed. OPES has already incorporated feedback and has developed an improved Phase II Quadrant Report.
- VISNs simulate productivity standard implementation and review factors associated with productivity outliers such as inconsistent application of foundational business rules (person class designation, labor deployment, and professional workload capture) and modify business rules accordingly.  
**Target date for completion: January, 2014.** Status: Completed. Developed Statistical Process Control Charts to identify out of line situations.
- All VISNs evaluate and refine preliminary productivity standards and communicate and establish core competencies across all Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports) for the 11 second-tier specialties.  
**Target date for completion:** Status: Completed. Training provided. On-Demand VEHU Sessions available.
- Modify and finalize the preliminary productivity standards and staffing algorithms for the 11 second-tier specialties.  
**Target date for completion: July, 2014.** Status: Completed.
- Establish and implement productivity standards for the 11 second-tier specialties.  
**Target date for completion: October, 2014.** Status: Completed
- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in the 11 second-tier specialties.  
**Target date for completion: October, 2014.** Status: In process.
- HIMMS and Compliance and Business Integrity establish procedures to ensure accurate coding for the 11 second-tier specialties implementing RVU-based productivity standards.  
**Target date for completion: October, 2014.** Status: In process
- Incorporate specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports into specialty physician staffing assessments for the 11 second-tier specialties.  
**Target date for completion: October, 2014.** Status: Completed
- OPES establish preliminary productivity standards (25<sup>th</sup> percentile and mean for Medical Center Complexity Group (MCG) Level) for the 11 third-tier specialties  
**Target date for completion: October, 2014.** Status: Completed
- OPES provide preliminary productivity standards for the 11 third-tier specialties for all VISNs and identify outliers falling below 25<sup>th</sup> percentile and mean.

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- Target date for completion: October, 2014. Status: Completed**

  - OPES refine specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for Medical Center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs to encompass 11 third-tier specialties.  
**Target date for completion: December, 2014. Status: Completed**
  - VISNs simulate productivity standard implementation and review factors associated with productivity outliers such as inconsistent application of foundational business rules (person class designation, labor deployment, and professional workload capture) and modify business rules accordingly.  
**Target date for completion: January, 2015. Status: Completed**
  - All VISNs evaluate and refine preliminary productivity standards and communicate and establish core competencies across all Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports) for the 11 third-tier specialties.  
**Target date for completion: March, 2015. Status: Completed**
  - Modify and finalize the preliminary productivity standards and staffing algorithms for the 11 third-tier specialties.  
**Target date for completion: July, 2015. Status: Completed**
  - Establish and implement productivity standards for the 11 third-tier specialties.  
**Target date for completion: October, 2015. Status: Completed**
  - Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in the 11 third-tier specialties.  
**Target date for completion: October, 2015. Status: In process**
  - HIMs and Compliance and Business Integrity establish procedures to ensure accurate coding for the 11 third-tier specialties implementing RVU-based productivity standards.  
**Target date for completion: October, 2015. Status: In process**
  - Incorporate specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports into specialty physician staffing assessments for the 11 third-tier specialties.  
**Target date for completion: October, 2015. Status: Completed**

**Appendix 2: Step 1 Algorithm: Review and Address Critical Elements used to Calculate Productivity (Person Class, Labor Mapping, and Resident Only instructions).**

Step 1: Review and Address Critical Elements used to Calculate Productivity

**A. Medical Specialties of Dermatology, Gastroenterology, and Neurology**

1. Review Productivity Measure for each Medical Specialty (Dermatology, Gastroenterology, and Neurology) and compare your level of productivity to the productivity standard thresholds [25<sup>th</sup> percentile for your MCG (1a-c, 2, 3) for a particular Medical Specialty].



05. Attachment 5 -  
FY12 Productivity Ou

2. Review the accuracy of the data elements that contribute to the calculation of the productivity measure to ensure accuracy and comparability to other sites of similar complexity. These data elements include: (a) Person Class designations for Medical Specialists; (b) DSS Labor Mapping for Medical Specialists; and (c) Resident Only workload.
  - a. **Person Class:** Each attending physician is assigned to a single Person Class, or practicing specialty. For more information, please see the [VHA Person Class Taxonomy Directive 2012-003](#). Physicians cannot have more than one Person Class, so the physician should be assigned to a Person Class that reflects that specialty where they are performing the majority of their clinical work. The Person Classes for Dermatology, Gastroenterology, and Neurology are provided below:
    - **Dermatology**
      - Dermatology Clinical and Laboratory Dermatological Immunology (V180501)
      - Dermatology (V180500)
      - Dermatology Dermatological Surgery (V180502)
      - Dermatology MOHS-Micrographic Surgery (V180504)
      - Dermatology Pediatric Dermatology (V180505)
      - Dermatology Dermatopathology (V180503)
      - Pathology Dermatopathology (V182407)
    - **Gastroenterology**
      - Internal Medicine Gastroenterology (V181009)
      - Internal Medicine Hepatology (V181013)
      - Pediatrics Pediatric Gastroenterology (V182512)
    - **Neurology**
      - Psychiatry and Neurology Clinical Neurophysiology (V182904)
      - Psychiatry and Neurology Neurodevelopmental Disabilities (V182907)
      - Psychiatry and Neurology Neurology (V182908)
      - Psychiatry and Neurology Sports Medicine (V182912)
      - Neurology; Vascular Neurology (V182913)
      - Pediatrics Developmental - Behavioral Pediatrics (V182503)
      - Pediatrics Neurodevelopmental Disabilities (V182506)
      - Psychiatry and Neurology Neurology with Special Qualifications in Child Neurology (V182909)

Productivity for a specialty medical service is determined by the ratio of specialty service RVUs (CMS RVUs not DSS RVUs) generated by VA Paid Attendings divided by the adjusted clinical MD FTE of VA Paid Attendings. An accurate and full accounting of specialty service RVUs requires an accurate accounting of all specialty physicians (correct association with Person

## Report of VHA Specialty Physician Productivity &amp; Staffing

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Class). If a physician's Person Class assignment is incorrect, all their workload (RVUs) and their clinical FTE will not be included in the correct specialty and lead to errors in the calculation of specialty service productivity. It is critical that each specialty, review the list of physicians associated with that Person Class to ensure the list of physicians for a particular specialty is correct (ensure that no attending specialty physicians are missing and that no physicians on the list belong to other specialties). This list should include all VA Paid physicians, onsite contract/FEE physicians, and WOC physicians who provided any clinical care during the current fiscal year (since October 1, 2012). If an attending physician has left after October 1, 2012, that physician's name will still appear on the list. If there are any errors, please work with local staff to make needed corrections to the Person Class designations.

- b. **DSS Labor Mapping:** As was already noted, productivity is determined by the ratio of specialty service RVUs generated by VA Paid Attendings divided by the adjusted clinical MD FTE of VA Paid Attendings. Adjusted clinical MD FTE is the amount of time (portion of a physician's FTE) associated with all clinical activity less the amount of clinical time associated with inpatient attending activity (Bedday). This adjusted clinical FTE includes time spent in outpatient clinics, procedure areas (e.g., GI Endoscopy), and inpatient consults. It excludes time spent as general ward attending.

The adjusted clinical MD FTE is derived from DSS Labor Mapping. DSS maps the percent of a physician's time to performing administrative duties, didactic medical education, research, clinical activities, and bedday or inpatient activities (a subset of clinical activities). Multiplying the percent of effort by the total FTE results in the estimates of FTE for each area of effort.

- Clinical MD FTE = Total MD FTE – Administrative MD FTE - Education MD FTE - Research MD FTE
- Adjusted clinical MD FTE = Total MD FTE – Administrative MD FTE - Education MD FTE - Research MD FTE - Bedday MD FTE

Business rules have been established to ensure consistent application of DSS Labor Mapping of a physician's time. Sites should review labor mapping for all VA Paid Attending specialty physicians in Gastroenterology, Dermatology, and Neurology and ensure that mapping is consistent with the business rules for estimating the percent of time mapped to Administration, Research, Education, and Bedday. Adjusted clinical MD FTE is calculated by subtracting these components from the total VA Paid Attending MD FTE for each specialty.

- c. **Resident Only Workload:** Only workload that can be traced back to an attending physician is included in the calculation of productivity; therefore, the attending physician should be identified as the primary provider on the encounter. For more information on data capture, please see the [VHA Patient Care Data Capture Directive 2009-002](#). If a resident is assigned as the primary provider and no attending physician is identified, this workload is not included in the specialty service workload. Approximately 4% of all physician workload is classified as "Resident Only." However, this percentage varies by specialty and by facility. It is critical for sites to address this missing workload since it adversely impacts a specialty's productivity measure.



**Appendix 3: Step 2 Algorithm: Integrating Productivity, Access, and Staffing.**

## Step 2: Algorithm for Integrating Productivity, Access, and Staffing

**Medicine and Surgical Specialties:**

1. Review the [Specialty Productivity Access - Report and Quadrant tool \(SPARQ\)](#) of productivity and access (looking at different access measures) for each Specialty and note the quadrant where a specialty service is found. The Quadrant Display is available for the 2 most complete FY time periods to provide a comparison of productivity and access over time.

- a. **Quadrant 1** (Productivity and Access above the mean) represents optimal practice. It is critical that the access measures accurately reflect access to care.

First review and ensure accuracy of access measures. If access measures are not reflecting true access (access is much worse than reported in the Quadrant Display) proceed to 1.b. If access measures are accurate, click on the tab at the bottom of the page of the Quadrant Display to review detailed facility-level practice management data for the specialty to ensure performance can continue to be sustained given the historic growth in total specialty RVUs and FEE care, the historic and projected growth in unique veterans seeking care, and VA reliance (and Medicare reliance) for specialty care.

- b. **Quadrant 2** (Productivity above the mean; Access below the mean) may indicate that the specialty service is under-resourced and/or the demand/utilization for specialty services is not appropriately managed.

First review and ensure accuracy of access measures. If access measures are not reflecting true access (access is much better than reported in the Quadrant Display) proceed to 1.a. If access measures are accurate a complete assessment will require a review of detailed practice management data including: (i) specialty MD staffing and % clinical time of MD FTE; (ii) direct clinical support staffing levels; (iii) APP staffing; (iv) use of specialty FEE care; (v) 1-yr and 3-yr growth in total uniques and specialty uniques; (vi) total RVUs generated by year for the entire specialty practice (in-house VA Paid physicians, FEE and contract physicians, WOC physicians, and other licensed providers); (vii) physician salary costs/RVU; and (viii) ratio of new to established specialty patients to determine if additional resources are required and/or strategies to better manage clinical demand are required.

Evidence of inadequate resources could include low specialty MD staffing with high % clinical time compared to peers, low physician salary costs/RVU, low direct clinical support staffing, low APP staffing, low (or recently declining) levels of FEE care, or high OR utilization rates (for applicable surgical specialties). Clinical resources could be enhanced by increasing % clinical time of MD FTE, adding additional specialty MD FTE, adding clinical support staff, adding APPs, expanding OR capacity, or increasing FEE care.

Evidence of excessive demand/utilization of clinical services could include high levels of specialty utilization compared to peers, low ratios of new to established patients, and disproportionate growth of specialty uniques compared to total uniques. Strategies to manage clinical demand could include utilization review of specialty care, service agreements with PC, and discharging of specialty patients back to PC.

The intensity of these management strategies will need to be adjusted based upon the degree to which measures of productivity for specialty physicians and specialty clinic access fall above and below accepted VA targets respectively, the historic growth in total specialty RVUs and FEE care, the historic and projected growth in unique veterans seeking care, and VA reliance (and Medicare reliance) for specialty care.

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- c. **Quadrant 3** (Productivity and Access below the mean) may indicate that the specialty service is inefficient.

First review and ensure accuracy of access measures. If access measures are not reflecting true access (access is much better than reported in the Quadrant Display) proceed to 1.d. If access measures are accurate a complete assessment will require a review of detailed practice management data including: (i) specialty MD staffing and % clinical time of MD FTE; (ii) direct clinical support staffing levels; (iii) APP staffing; (iv) use of specialty FEE care; (v) 1-yr and 3-yr growth in total uniques and specialty uniques; (vi) total RVUs generated by year for the entire specialty practice (in-house VA Paid physicians, FEE and contract physicians, WOC physicians, and other licensed providers); (vii) physician salary costs/RVU; and (viii) ratio of new to established specialty patients to determine if in-house clinical resources are inefficiently utilized and/or clinical services are inefficiently operated.

Evidence of inefficient utilization of in-house clinical resources could include high MD staffing with inadequate support staff (limiting MD productivity) or high FEE costs. If a specialty has high FEE costs, that FEE care could be shifted to in-house, cutting FEE costs and increasing specialty service productivity. Depending on MD staff, support staff, and APP staff levels, strategies might require the shifting of MD responsibilities to cover other medical center priorities including relieving the administrative burdens (realignment of Hospital committees, etc.) for other high productivity specialties and/or considering additional support staff or APPs to improve MD productivity.

If active agreements are in place for physicians to provide coverage/work for sister VA's please consider and investigate, via the Physician Productivity Cube (PPC), that the specialty practice workload and workforce (measures of productivity) are correctly aligned.

Evidence that clinical services are inefficiently operated could include high no-show rates and high clinic cancelation rates. Strategies to improve clinical efficiency could include reducing no-show rates or clinic cancelation rates if these rates are excessive.

The intensity of these management strategies will need to be adjusted based upon the degree to which measures of productivity for specialty physicians and specialty clinic access fall below accepted VA targets, the historic growth in total specialty RVUs and FEE care, the historic and projected growth in unique veterans seeking care, and VA reliance (and Medicare reliance) for specialty care.

- d. **Quadrant 4** (Productivity below the mean; and Access above the mean) may indicate that the specialty service is over-resourced and/or the demand/utilization for in-house specialty services is constrained.

First review and ensure accuracy of access measures. If access measures are not reflecting true access (access is much worse than reported in the Quadrant Display) proceed to 1.c. If access measures are accurate a complete assessment will require a review of detailed practice management data including: (i) specialty MD staffing and % clinical time of MD FTE; (ii) direct clinical support staffing levels; (iii) APP staffing; (iv) use of specialty FEE care; (v) 1-yr and 3-yr growth in total uniques and specialty uniques; (vi) total RVUs generated by year for the entire specialty practice (in-house VA Paid physicians, FEE and contract physicians, WOC physicians, and other licensed providers); (vii) physician salary costs/RVU; and (viii) ratio of new to established specialty patients to determine if resources are excessive and/or the in-house demand for clinical services is constrained.

Evidence that resources might be excessive could include high MD staffing compared with peer medical centers and high physician salary costs/RVU and could be managed by attrition as well as through the shifting of MD responsibilities to cover other medical center priorities including relieving the administrative burdens (realignment of Hospital committees, etc.) for other higher productivity specialties.



If active agreements are in place for physicians to provide coverage/work for sister VA's please consider and investigate, via the Physician Productivity Cube (PPC), that the specialty practice workload and workforce (measures of productivity) are correctly aligned.

Evidence that in-house specialty care might be constrained could include high specialty FEE care, low VA reliance (high Medicare reliance), or underutilization of specialty services compared with peers. If a specialty has high FEE costs, that FEE care could be shifted to in-house, cutting FEE costs and increasing specialty service productivity. Utilization review of specialty services would be necessary to evaluate the appropriateness of specialty care utilization.

2. The intensity of these management strategies will need to be adjusted based upon the degree to which measures of productivity for specialty physicians and specialty clinic access fall below and above accepted VA targets respectively, the historic growth in total specialty RVUs and FEE care, the historic and projected growth in unique veterans seeking care, and VA reliance (and Medicare reliance) for specialty care.

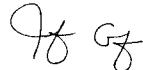
**Appendix 4 OIG Closed Report—Audit of VHA's Physician Staffing Levels for Specialty Care Services  
(Report No. 11-01827-36, Issued December 27, 2012)**

## Memorandum

### Department of Veterans Affairs

Date: December 13, 2013  
From: Director, Operations Division, Office of Management & Administration (53B)  
To: Director, Management Review Service (10AR)  
CC: Director, Kansas City Office of Audits and Evaluations (52KC)  
Subj: Closed Report—Audit of VHA's Physician Staffing Levels for Specialty Care  
Services (Report No. 11-01827-36, Issued December 27, 2012)

The subject report is closed based upon your latest status update. No additional reporting is required.



JENNIFER GELDHOF

**Attachments:**

Table 1: Productivity Implementation Time Line:

Table 2: Productivity Standards:

Table 3: VHA Productivity vs. MGMA:

Table 4: Total Compensation VHA vs. MGMA

Table 5: Compensation per RVU VHA vs. MGMA

Table 6: VHA Support Staff Ratios vs. MGMA

Exhibit A: SPARQ Tool Specialty Quadrant

Exhibit B: SPARQ Tool Facility Quadrant

Exhibit C: SPARQ Tool Facility Measure Detail

Exhibit D: Statistical Process Control Charts

Appendix 1: Operational Plan for Productivity & Staffing Standards Implementation.

Appendix 2: Step 1 Algorithm: Review and Address Critical Elements used to Calculate Productivity (Person Class, Labor Mapping, and Resident Only instructions).

Appendix 3: Step 2 Algorithm: Integrating Productivity, Access, and Staffing

Appendix 4: OIG Closure: Audit of VHA's Physician Staffing Levels for Specialty Care Services (Report No. 11-01827-36, Issued December 27, 2012)

There are staffing standards for SCI/D (VHA Directive 2008–085, Spinal Cord Injury Staffing and Beds: [https://www1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=1816](https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1816)). This directive will be updated after an SCI/D nurse staffing pilot is completed.

## OFFICE OF THE MEDICAL INSPECTOR

*Question 11.* When does VA expect to complete the Office of Special Council's Section 2302(c) Certification Program?

Response. VA registered for the Office of Special Counsel (OSC) 2302(c) Certification Program on July 11, 2014. The Certification Program ensures that VA meets its statutory obligation to inform its employees about the rights and remedies available to them under the Whistleblower Protection Act, the Whistleblower Protection Enhancement Act, and related civil service laws. VA received OSC certification on October 3, 2014.

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 RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 12.* In response to a question from Chairman Sanders, the Secretary indicated that then-Acting Secretary Gibson proposed the Department of Veterans Affairs (VA) would need 28,000 additional staff to meet the current demands of VA.

a. Please provide the Committee with a detailed breakdown of the number and type of providers (separated by specialty), the number and general schedule level of Title 5 positions, and the number of and position titles of any Title 38-hybrids. Response. Please see the attached spreadsheet with the breakouts of the 28,000 number from the August 27, 2014 pull of VA's WebHR data. WebHR is a new Web application VHA is now using to track vacancies nationally; it was first deployed in June 2014. The 28,000 number is shown by occupation type, in separate groupings for Title 38, Title 38 Hybrid, and Title 5. This 28,000 represents funded but vacant positions, based on the snapshot in time of WebHR data.

<b>Title 38</b>	<b>TOTAL</b>
Physicians	4024
Nurses	9068
Physician Assistants	433
Dentists	197
Chiropractors	8
Nurse Anesthetists	60
Optometrists	143
Podiatrists	91
<b>Title 38 Hybrid</b>	
Psychologists	874
Speech Pathologists & Audiologists	185
Social Workers	1888
LPN/Practical Nurses	1895
General Health Science	548
Nursing Assistants	1909
Medical Supply Aides/Technicians	471
Dietitians/Nutritionists	250
Occupational Therapists	173
Physical Therapists	267
Kinesiotherapists	26
Rehabilitation Therapy Assistants	127
Health Aids/Technicians	1268
Medical Technologists	599
Diagnostic Radiologic Technologists	500
Therapeutic Radiologic Technologists	31
Medical Instrument Technicians	387
Respiratory Therapists	86
Pharmacists	969
Pharmacy Technicians	389
Orthotists/Prosthetists	54
Dental Assistants	132
Dental Hygienists	49
<b>Title 5</b>	
Recreation/Creative Arts Therapists	107
Nuclear Medicine Aids	2
Medical Technicians	351
Pathology Technicians	48
Health Systems Specialists	319
Dental Laboratory Aids/Technicians	35
Industrial Hygienists	38

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		V/ISN #s																					
		1	2	3	4	5	6	7	8	9	10	11	12	15	16	17	18	19	20	21	22	23	
<b>Title 38</b>																							
Physicians	190	59	47	156	73	323	331	294	246	118	136	169	182	287	164	205	170	240	148	282	204		
Nurses	285	134	183	276	88	574	640	850	496	228	157	374	521	738	357	623	393	517	569	743	322		
Physician Assistants	17	3	2	31	11	68	25	20	18	19	2	14	24	33	23	22	21	20	10	30	20		
Dentists	4	1	19	11	1	4	23	14	7	6	8	17	4	21	6	5	4	13	15	11	3		
Chiropractors	0	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	1	0	1	0	1		
Nurse Anesthetists	4	0	0	3	1	5	2	2	0	2	1	10	2	1	0	4	7	2	3	9	2		
Optometrists	2	1	9	6	0	8	9	11	9	11	6	2	5	11	5	11	1	9	3	20	4		
Podiatrists	6	4	7	5	2	3	4	6	4	8	2	3	4	5	4	6	4	3	3	7	1		
<b>Title 38 Hybrid</b>																							
Psychologists	34	16	15	34	21	94	61	54	69	41	19	27	30	66	37	17	38	52	61	55	33		
Speech Pathologists & Audiologists	7	1	2	10	12	15	12	15	7	3	3	5	4	10	9	12	9	11	17	18	3		
Social Workers	51	23	29	72	27	198	116	156	104	44	47	64	58	148	55	112	97	102	148	184	54		
LPN/Practical Nurses	68	35	12	76	18	113	210	134	89	70	37	40	81	144	82	131	113	127	117	126	72		
General Health Science	49	18	11	18	7	50	30	36	22	9	18	11	17	51	28	9	11	6	79	51	17		
Nursing Assistants	96	21	36	53	38	121	141	146	116	52	45	75	73	174	74	128	85	77	115	186	57		
Medical Supply Aides/Technicians	16	6	2	14	7	18	64	42	40	4	11	21	16	49	24	14	20	32	23	26	22		
Dietitians/Nutritionists	7	1	3	12	4	29	22	18	18	8	6	11	10	23	4	12	5	14	19	13	11		
Occupational Therapists	4	6	5	9	4	23	13	9	8	5	1	5	5	16	6	8	4	18	7	11	6		
Physical Therapists	12	3	4	5	8	15	22	12	8	8	8	12	15	17	8	16	9	29	18	25	13		
Kinesiotherapists	0	0	0	0	0	8	5	0	2	0	0	2	0	4	0	0	0	0	1	2	0		
Rehabilitation Therapy Assistants	6	2	2	0	2	20	11	8	3	8	1	10	5	3	9	7	6	7	3	12	2		
Health Aids/Technicians	57	12	47	62	26	57	70	153	83	22	26	104	51	78	44	44	58	72	61	110	31		
Medical Technologists	21	9	18	20	15	80	44	88	25	6	7	27	13	63	27	12	12	37	21	39	15		
Diagnostic Radiologic Technologists	32	5	8	13	5	36	34	30	23	14	5	17	25	27	20	28	23	29	51	64	11		
Therapeutic Radiologic Technologists	0	0	0	0	1	2	0	2	2	2	2	4	0	3	8	0	0	1	0	6	0		
Medical Instrument Technicians	16	2	3	13	4	22	37	44	23	8	10	21	18	34	16	5	14	20	36	38	3		
Respiratory Therapists	0	1	1	2	0	12	3	5	2	1	2	0	1	3	11	4	9	2	15	12	0		
Pharmacists	43	19	23	36	17	67	66	115	32	23	12	54	36	49	34	47	36	50	68	86	56		
Pharmacy Technicians	20	8	8	12	4	29	38	24	17	14	2	15	28	19	29	14	11	27	18	35	17		
Orthotists/Prosthetists	8	2	0	0	0	7	3	5	1	0	2	1	4	8	4	4	1	3	2	7	1		
Dental Assistants	2	0	4	5	3	8	14	10	12	5	1	6	5	7	2	7	3	10	9	11	0		
Dental Hygienists	0	0	0	1	2	0	2	3	1	3	0	3	1	6	3	3	2	8	3	3	4		

	VISN #s																						
	1	2	3	4	5	6	7	8	9	10	11	12	15	16	17	18	19	20	21	22	23		
<b>Title 5</b>																							
Recreation/Creative Arts Therapists	1	2	7	6	3	11	9	5	8	2	1	6	9	2	6	5	5	6	9	3	1		
Nuclear Medicine Aids	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0		
Medical Technicians	13	0	4	4	0	40	14	51	4	10	6	5	16	44	15	4	10	10	18	82	5		
Pathology Technicians	4	1	1	0	3	4	2	5	7	1	1	1	2	1	2	2	2	1	2	3	3		
Health Systems Specialists	36	5	4	10	16	30	21	21	11	12	5	6	12	20	17	15	10	14	29	17	8		
Dental Laboratory Aids/Technicians	0	0	0	0	3	1	3	2	1	0	2	2	1	5	10	0	0	0	3	1	1		
Industrial Hygienists	4	0	0	2	1	2	0	7	4	0	0	2	0	4	1	0	2	0	4	1	4		



b. For any positions that would not be assigned to the Veterans Health Administration (VHA), please identify the number of positions and office, agency, or administration to which the position would be assigned.

Response. None of the positions would be assigned outside VHA.

c. For any medical personnel included in the 28,000, please provide the Committee with a detailed staffing analysis VA used to determine the number of providers needed for each type of provider (please separate out by specialty) and which VA Medical Center (VAMC) those providers would be located.

Response. The 28,000 represents the number of vacancies captured in WebHR as of August 27, 2014, for clinical positions. WebHR is a Web application VHA is using to track vacancies nationally and was first deployed in June 2014. The functionality for collecting vacancies in this application is relatively new. Transactions against the management of positions occur daily as the system captures new and completed recruitment actions in real time. The 28,000 number was not based on a detailed staffing analysis.

d. Please identify which positions are intended to be located in VA Central Office (VACO) or the "Field;" for VACO positions, please identify which Administration or Staff office (VHA, the Veterans Benefit Administration, the National Cemeteries Administration, the headquarters of the Office of Public and Intergovernmental Affairs, the headquarters of the Office of Information Technology, etc.). For VHA Field positions, please identify whether the personnel are to be assigned to the Veterans Integrated Service Network or VAMC.

Response. None of the positions identified in these data sets are intended to be located at VA Central Office or VHA Central Office; they are all field positions assigned to medical facilities.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO  
HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 13.* Mr. Secretary, we have talked a lot about hiring people for VA. That is important in Alaska as well. I have told you about how important it is to me that we leverage Federal resources wherever they come as we provide care to Veterans. We are doing some great work in Alaska. A model really increasing coordination and collaboration.

a. That said, as you are hiring all of these people, where are you going to put them? Do you lease, do you build?

Response. We are proud of our staff and facilities in Alaska, and the quality of services provided there. The Alaska Department of Veterans Affairs (VA) Healthcare System currently has capacity within the seven Alaska VA facilities, throughout the state, to accommodate all current employees, as well as currently recruited positions.

VA has several capital and non-capital tools at its disposal to address evolving space needs to provide care. Leasing is a flexible vehicle that allows VA to provide care to Veterans at the right place at the right time with less lead time than construction. In addition, VA can execute capital renovation projects at existing owned or leased space to increase capacity within the existing footprint. VA can also use telehealth and other modalities for newly hired staff to engage with veterans despite limited space.

b. Do you have the flexibilities you need in law and authority to get the space that you need? For example how would VA partner with IHS facilities?

Response. We already have collaborative relationships in place with Indian Health Service. In addition, the Alaska VA Healthcare System has agreements with 26 Alaska Native Tribal Healthcare Organizations, which provide rural health care access for eligible Alaska Native and American Indian (AN/AI) and non-AN/AI Veterans in approximately 150 rural Alaskan communities. Under these agreements, VA reimburses Alaska Native Tribal Healthcare Organizations for direct care services they provide to eligible AN/AI and non-AN/AI Veterans throughout Alaska. The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) affords us the flexibilities to expand our own internal resources, as well as interagency relationships, to help ensure Veterans have access to quality, affordable health care. Also under Choice Act, VA has identified about 400 projects to renovate, repair, or replace much of our aging health care infrastructure, and expand at some sites, at a cost of \$1.3 billion. The Choice Act will fund these projects during fiscal year (FY) 2015 and FY 2016.

*Question 14.* Mr. Secretary, as you know with Veterans Access Choice and Accountability Act passed, it brought in some needed resources, such as hiring more clinical staff, this is good. However, in remote and rural areas like Alaska, we have

had problems with recruiting and retention, specifically for primary care doctors. The Mat-Su Valley is an example, we are fortunate to have a native clinic across the road that is taking up to 400 veterans a day.

a. What are the plans for VA to hire and keep clinical staff in rural areas?

Response. One of the strategic objectives of the Office of Rural Health (ORH) is to develop innovative methods to identify, recruit and retain health care professionals and requisite expertise in rural and highly rural communities. ORH has made significant investments in strengthening the rural VA provider workforce and is continuously seeking to understand the current and future rural workforce needs, as well as all of the potential opportunities to expand and improve our current efforts. ORH investments are aimed at both mitigating common factors that contribute to providers leaving rural practice, as well as providing experiences that may attract providers to rural practice. The goal is that these investments into rural workforce programs will retain rural providers thereby impacting subsequent periods without physician care. In FY 2013 and 2014, ORH invested more than \$15 million to support rural provider education and training initiatives. The targeted efforts by ORH are intended to supplement the existing workforce strategies implemented nationally, regionally, and locally by the Veterans Health Administration (VHA).

*Question 15.* Alaska's Licensed Professional Counselors have proudly served our military and veterans community in their time of need after 13 years of war. However, these professionals have recently been told their experience and credentials will not suffice to continue treating our veterans' mental health needs. In recent letters to the TRICARE and the Army I pressed them to reconsider new accreditation policies that unintentionally omitted Alaskan counselors.

Will you commit to reviewing the LPC accreditation issue in my state? Highly qualified counselors are excluded from filling many of these highly difficult to fill positions, and the veterans are the one who suffer.

Response. The VA qualification standard for Licensed Professional Mental Health Counselors includes the basic requirement of a master's degree in mental health counseling, or a related field, from a program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP). This was developed by a group of highly qualified Subject Matter Experts (SME), leadership within VHA's Mental Health Services, and VA's Office of Human Resources Management. The qualification standard is based on the health care industry standards for the profession and licensure and/or certification requirements. Additionally, the standard was developed to assure the provision of the highest quality of care to our Nation's Veterans. The SMEs reviewed documentation on current industry standards and practices and included consideration of all state requirements, including the licensing requirements for the State of Alaska. It is important to note, the qualification standards for each core mental health profession require that an individual in that discipline have graduated from a program that is accredited by an approved accrediting body that accredits training programs in that discipline. This rule applies to all VA core mental health disciplines (Psychology, Psychiatry, Social Work, Nursing, Licensed Professional Mental Health Counseling, and Marriage and Family Therapy).

*Question 16.* It was recently shared with me that scheduling vendors are providing commercialized off-the-shelf scheduling software system that can significantly solve most of the scheduling challenges facing the Veterans Administration within the budget parameters.

a. What are you and the department doing to ensure that systems like these, from non-traditional government vendors, are considered in addressing the scheduling software program across the entire VA?

Response. VA will procure a commercial-off-the-shelf (COTS) replacement for its medical appointment scheduling system from the private sector. The Department is seeking a COTS scheduling system to provide a resource management-based solution. VA chose a full- and open-competitive acquisition strategy to benefit from the innovative marketplace.

In addition, VA has worked closely with industry to ensure requirements are clearly understood. VA conducted an "Industry Day" to brief industry representatives on VA's scheduling system needs. As a result, VA received and responded to over 100 questions from industry. After the successful Industry Day, VA met one-on-one with interested vendors, during which the VA achieved a better understanding of the marketplace, different vendor approaches, and associated risks. VA also issued a draft of its request for proposal (RFP) in order to solicit industry feedback to improve the language before release of the full RFP.

b. What are the most important criteria you are looking for in the selection of a national scheduling software solution?"

Response. In its meetings with industry and in the documents VA has made publicly available, the following key criteria have been emphasized:

- Proactive resource management-based scheduling that schedules staff, facilities, equipment
- Transparency to balance supply with demand
  - Provide single, consolidated view of resource availability (e.g. one calendar for a clinician)
  - Provide single, consolidated list of appointment requests (e.g. single view of the patient)
  - Improved transparency through richer data for reporting
- Consistent implementation and visibility of business rules to support scheduling policies and directives
  - c. “What is your timeline for consideration and award of a contract for a national scheduling software solution?”

Response. VA is planning to issue a RFP for the medical appointment scheduling system under a full and open competition in the first quarter of FY 2015. Offerors will have 45 days to respond from the day of issuance. The solicitation may require a two-part demonstration of capabilities: a written proposal and a technical demonstration to scheduling staff. VA expects to award the contract within the second quarter of FY 2015.

*Question 17.* I do have a bill for loan repayment of Psychiatrists and other incentives to recruit mental health providers to the VA. I understand recruiting and retaining Psychiatrists is a top need for VA.

Would a loan repayment help with this recruitment? (Right now it’s the discretion of the VISN on whom and how many get the loans) As you may know I have a bill to do this.

Response. Yes. VA believes loan repayment would help with recruitment and retention of Psychiatrists. The passage of recent legislation would assist VA with the recruitment and retention efforts.

Specifically, the passage of Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014, increased the maximum Education Debt Reduction Program (EDRP) loan amount from \$60,000 to \$120,000. In addition, the Secretary has the ability to waive the cap for specific critical clinical specialty positions, including the top physician specialties of primary care, psychiatry, gastroenterology, orthopedic surgery, emergency medicine, and cardiology; nurse specialties of head nurse, staff nurse, nurse practitioner, mental health and substance abuse, inpatient community living centers, and certified registered nurse anesthetist. Furthermore, Section 408 of the VA Expiring Authorities Act of 2014 allows VA to directly pay the lenders for qualified loans. Therefore, the authority to provide a higher level of loan repayment for psychiatrists is already in place through the existing EDRP program.

*Question 18.* VA has suspended all VHA senior executive performance awards for fiscal year 2014 and increased accountability for senior leaders.

Do you expect to bring back these awards in 2015? If not, what is the plan to attract and retain superior executive leadership in the future.

Response. While it is the Secretary’s prerogative to pay or withhold performance awards, no final decision has been made for FY 2015 at this time. Since Senior Executive performance awards are based on organizational results, as well as individual performance, it would not be appropriate to predict final decisions one year in advance. Regarding the Secretary’s decision to approve no performance awards for FY 2014 in VHA, the Secretary had significant performance indicators to determine FY 2014 organizational results could not be accurately validated based on performance.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE HIRONO TO  
HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 19.* What was the rationale behind the then-Deputy Under Secretary for Health for Operations Management waiving the requirement to certify compliance of VA’s scheduling directive in May 2013 and does VA plan to reinstate that requirement?

Response. At the time the requirement was waived, there was concern that it was hard to reach full compliance with the scheduling directive and also hard to maintain it. By a Medical Center Director certifying in writing that they were in compliance, this puts them at risk if a subsequent external audit or review found weaknesses. Directors felt it was a no-win situation. The decision was made at a time when the environment was characterized by performance measure and certification

fatigue. There are plans to reinstate the requirement in the new scheduling directive, but this time it will be accompanied by significantly better training of clinic managers and better tools to monitor performance.

*Question 20.* How will the policy actions taken and to be taken by VA be communicated to the Veteran and Veteran Service organizations? Do you plan any changes to the policy as a result of this nationwide review and how do you plan to communicate it to veterans and to different generations of veterans?

Response. There are a number of important changes related to improving access to health care that will be communicated to Veterans. The changes are driven by policy decisions and by the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), which established the Veterans Choice Program. With respect to the Choice Program, the Department of Veterans Affairs (VA) will communicate information regarding eligibility and Program operations directly to Veterans through the mail, a new call center, press releases, and communications on VA's main Web site, and communications on VA medical facility Web sites. VA also anticipates Veterans Service Organization briefings and town hall meetings at VA facilities to educate Veterans about any changes that may impact them.

*Question 21.* In your testimony, you state "where willful misconduct or management negligence is documented, appropriate personnel actions will be taken." At nearly 5 months after the allegations at Phoenix surfaced, what appropriate personnel actions have been taken and with the newly enacted authorities to dismiss certain personnel, how will you exercise it to meet your commitment to address misconduct at the VA?

Response. VACAA facilitates and promotes sustainable accountability. For instance, the Act allows VA to resolve Senior Executive Service (SES) removal actions more quickly than before. VA has used the expedited SES removal authority in VACAA to remove the Phoenix Director and other SES-level VA leaders. Now that the criminal investigations at the Phoenix VAMC have concluded, VA is moving to close out its administrative investigations of non-SES leaders there and expects to issue final decisions in all Phoenix leadership cases after the administrative investigations are concluded.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 22.* Secretary McDonald, in the Veterans Access, Choice and Accountability Act of 2014 (hereinafter "the Choice Act"), that Congress recently passed, there were provisions that significantly expanded your ability to remove senior VA employees for poor performance or misconduct. On August 26, 2014, the VA OIG published a report that addressed the scheduling problem at the Phoenix VA as well as other issues. In the report, it clearly states that executives in the Phoenix VA were well aware that subordinate staffs were manipulating wait times. I am also aware that a number of my colleagues here in the Senate have expressed frustration that the former director of the Phoenix VA Health Care system is still on paid administrative leave. I understand your desire to ensure that all VA employees receive due process and I appreciate that. However, I believe that in order for you to make real reforms within the VA, there must be a change in the institutional culture and to do so, I believe you have to hold people accountable. I would like to know, what do you consider a "fireable offense," and how do you plan to implement this new authority that you have?

Response. The Department is firmly committed to instituting a culture of sustainable accountability. As we confront our challenges in VA, it is also essential we empower employees to speak up when they see wrongdoing, and protect them from unlawful retaliation. On June 4, 2014, VA announced new procedures to ensure that we fully consider disciplinary action against managers and supervisors who commit discrimination and retaliation against employees. VA will hold those who violate this precept accountable. This is a Department-wide responsibility. On August 22, 2014, the Secretary called for every VA employee to reaffirm his or her commitment to the VA values—integrity, commitment, advocacy, respect, and excellence (I CARE). Further, all employees were reminded, in addition to demonstration of VA I CARE values, failure to adhere to ethical, legal, and/or professional standards of conduct may be considered as factors when evaluating performance.

There is not a simple definition of a "fireable offense." A decision to terminate an individual is informed by several factors including, but not limited to, (1) the seriousness of the offense; (2) whether the offense was malicious or done for personal gain; (3) whether alternative sanctions would work; and (4) whether or not the employee is otherwise salvageable. Typically, if an employee otherwise has a clean dis-

ciplinary record, such an employee would have to commit an egregious act of misconduct in order to be removed on his/her first offense. Serious offenses often involve breaches of institutional values.

Regarding the new authorities provided in the Choice Act, VA has developed a new policy codifying the process by which the Secretary will determine when a Senior Executive Service (SES) employee's performance or misconduct warrants removal or transfer to a non-SES position.

- The new policy will give the employee five business days to review and reply to the evidence and charges supporting the removal.

- VA's policy requires that a removal or transfer for misconduct or poor performance be supported by substantial evidence. The Merit Systems Protection Board will review any appeals against the higher standard of a preponderance of the evidence.

The lengthier historic process will still apply to all disciplinary actions taken against SES employees other than removal or transfer to a GS position.

*Question 23.* Is the fact that senior officials at the Phoenix VA were placed on paid administrative leave prior to Congress passing the Choice Act prohibiting you from using the provisions contained in the Choice Act to remove them?

Response. It should be noted that the Choice Act provisions apply only to Senior Executives, not to non-Senior Executive Service leaders. The Medical Center Director is the only Senior Executive among the Phoenix VAMC leadership team. The fact that a Senior Executive was placed on paid administrative leave prior to enactment of the Choice Act should not preclude a removal action being taken under that authority.

*Question 24.* The use of unofficial waiting lists was a prevalent practice at the Phoenix VA and has proven to be a systemic problem across the VA. What are you doing to ensure that this sort of problem does not happen again?

Response. The use of an unofficial wait list is not an acceptable practice. To ensure this problem is corrected, the Veterans Health Administration (VHA) provided immediate remedial training to 9,000 key staff from all networks in July and August 2014. This training reinforces the appropriate policies and processes associated with scheduling patients. Likewise, VHA is designing a clinic manager training program which is scheduled to begin in early 2015 that will include training on appropriate use of the Electronic Wait List (EWL). To ensure the integrity of the access data in the input stage, VA recently launched an automated access and scheduling audit tool designed to monitor and flag any potential data integrity issues. This tool is programmed with a preset algorithm, designed by scheduling subject matter experts that will score scheduling practices at each facility and clinic and highlight those clinics that require additional follow-up. This tool is available for use by each medical center and Veterans Integrated Service Network (VISN) leadership team. This tool is also being routinely monitored in VHA Central Office by a national monitoring group and the VHA senior leadership team.

Additionally, VA has eliminated the unrealistic 14-day access measure from all employees on the Executive Career Field Performance Plan, Title 5 Performance Appraisal Program, and the Title 38 Proficiency Rating System. This action will eliminate incentives to engage in inappropriate scheduling practices or behaviors. To reinforce these measures, Medical Center and VISN Directors are conducting in-person visits to all of their assigned facilities. These in-person site inspections include observing daily scheduling processes and interacting with scheduling staff to ensure all scheduling practices are appropriate and allowing front line staff to provide unfiltered feedback directly to the facility's and VISN's senior leadership team.

*Question 25.* Within the Phoenix VA, a number of medical areas where identified as being deficient. Mental health and psychotherapy where specifically mentioned. What has been done to correct this problem and ensure continuity of care and increased access to providers?

Response. As stated in the OIG report, Mental Health leadership had been addressing these issues at the time of the OIG visit in April–May 2014. The new Chief of Psychiatry successfully recruited 13 additional mental health-prescribing clinicians to the facility within a seven-month period. He has also begun reorganizing the service. The influx in new psychiatrists has provided an ability to assign patients to a mental health provider and an availability of new and established patient appointments.

As of early June 2014, Psychology leadership reported 11 vacancies for which 9 candidates had been selected and were pending offer acceptance, credentialing, privileging, and/or on-boarding. As of November 2014, Psychology has eight remaining vacancies; seven of these were new positions added in October 2014 (i.e., only one of the positions from June 2014 remains unfilled). Of the remaining eight vacancies, four have been selected and are in the onboarding process, and four have not

been selected yet. Phoenix VA Health Care System (PVAHCS) has leveraged non-VA care via the TriWest/Patient-Centered Community Care contract to obtain psychotherapy for patients who cannot be seen within 30 days.

In addition to the increased staff, PVAHCS has concurred with the four recommendations related to this issue which are listed in the OIG Final Report and has developed action plans which are available for review in Appendix K of the final report.

*Question 26.* The OIG report recommended that the VA Secretary direct the Veterans Health Administration to establish a process that requires facility directors to notify, through their chain of command, the Under Secretary of Health when their facility cannot meet access or quality of care standards. The report indicated that VHA has already implemented this recommendation. Since this process has already been implemented, has the VHA had to notify the Under Secretary of any facilities that cannot meet access or quality of care standards? If so, what facilities have made such a notification and for what reason?

Response. Issues related to access no longer solely depend on local leadership raising the concern up through a chain of command. VHA has increased its transparency by making data (described below) available and easily accessible to the public and the entire organization. Transparency of data facilitates timely, honest, and open discussion throughout the organization, among leadership peers, among employees, and among Veterans.

Twice monthly, VHA publishes data on access to care on a public Web site (<http://www.va.gov/health/access-audit.asp>). Leadership at all levels use the same data to determine trends, foretell access shortfalls, and address underlying issues that impede Veterans' access. These data include: the number of appointments scheduled at each facility; the number of requested appointments that are on each facility's EWL; the number of newly enrolled patients who have not yet been scheduled by facility; and average wait times for mental health, primary care, and specialty care at each facility, for both new and established patients.

Additionally, VHA publishes a scorecard model for internal quality of care benchmarking. The Strategic Analytics for Improvement and Learning (SAIL) Value Model assesses 25 quality measures in areas such as mortality, complications, and customer satisfaction, as well as overall efficiency. SAIL benchmark tables can be found at <http://www.hospitalcompare.va.gov/docs/SAILData.pdf>

*Question 27.* Since 2005, the IG has published 20 reports focused on patient wait times and access to care issues. However, VHA has yet to effectively address the issues associated with patient wait times, inappropriate scheduling practices, and access to care. The IG has, in total, received approximately 225 allegations regarding Phoenix VA and roughly 445 allegations regarding similar issues related to wait times at other VA facilities. It appears that this problem has been going on for 9 years now and VA has continually failed to correct it. What is your plan to effectively resolve this problem once and for all?

Response. Over the past 9 years, VA has considered and acted upon each of the IG's reports and implemented changes as recommended. However, it was not until the System-wide Access Audit, conducted in May 2014, that VHA came to truly understand the full extent of the problem. In retrospect, both the findings contained in the OIG reports, and the remedial actions taken by VHA to address those findings, only had limited impact on what we now know was a much larger systemic issue. VA has taken immediate steps to address portions of what are believed to be the underlying systemic issues.

In addition to those immediate actions, Secretary McDonald has set a course to reshape the organization and reset the culture throughout the Department. This effort will refocus the organization on the Veterans.

Aided by the thoughtful audits of the OIG, VA will continue to improve its access and availability to services for our Nation's Veterans. Through continuing program evaluations VA will, over time, ensure Veterans are receiving the care they have earned when, where and in the manner they desire.

*Question 28.* I am pleased to see that VA is aggressively recruiting new health care professionals in order to meet the needs of our veterans. However, I remain concerned that VA is not utilizing existing health care professionals in an efficient manner. Physicians in the private sector consistently have higher caseloads than VA physicians and more efficiently utilize nurses and physician assistants. Simply put, a veteran does not need to see a doctor for every health care need; nurses and physician assistants have the training and expertise to address many health issues which allows physicians to focus on more serious and complex matters. What is the VA doing to ensure that all the health care professionals employed by VA are being utilized to the maximum extent practicable?

Response. VHA overhauled the primary care model in 2010 to emphasize team-based care, called Patient Aligned Care Teams (PACT), focusing on a teamlet (which includes a provider, registered nurse, medical assistant (typically licensed practical nurse or health technician) and clerical associate (typically a scheduling assistant)). In addition, most PACT's also have a clinical pharmacist, social worker, dietitian, and/or behavioral therapist available to provide assistance. This focus on team-based care allows, among other things, a distribution of workload among the whole team to "share the care." This emphasis has been associated with increased utilization of telephone care and secure messaging as non-provider team members play important roles in patient care. VA is expanding primary care capacity by adding new PACTs, focusing on team-based care, and utilizing all staff in a manner that optimizes their capabilities.

*Question 29.* Secretary McDonald, a number of the senior positions within VA are being filled by personnel in an "acting" status. Mr. Griffin for example is the Acting Inspector General. Is this problematic? Do you foresee this creating problems in implementing the Choice Act?

Response. VA follows a formal process for placing an individual into an "Acting" role. Typically there is a request with justification provided for why a position must be filled in this manner and why this is the most appropriate person to fill this role. There is a defined time limit prescribed and finally there are a number of senior level personnel who will review and eventually approve this request.

The point of appointing "Acting" individuals into any given position is to ensure continuity of on-going day-to-day operations. The designation of individuals as "Acting" is needed to ensure someone is performing the duties and overseeing the activities of the organization or operational unit that is temporarily lacking permanent leadership. The length of time an individual is designated as "Acting" varies, and often cannot be predicted. For example, a person may be designated as "Acting" in a leadership position while recruitment is ongoing, the incumbent may be temporarily absent while on a rotational assignment in response to critical Departmental needs in an alternate location or position; on a developmental assignment, experiencing long-term medical issues, or similar issue. Ensuring leadership is in place to see to the day-to-day activities of an organization or operational unit supports rather than harms the Department's ability to implement the Choice Act.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR ON BEHALF OF HON. JEFF FLAKE TO HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 30.* During your confirmation hearing on July 22, 2014, you stated that you intended to travel the Nation to meet with veterans and staff at various VA facilities across the country.

a. Have there been any significant takeaways from these visits?

Response. The Secretary continues to travel to various Department of Veterans Affairs' (VA) facilities to meet with Veterans, the VA workforce (including whistleblowers), and other stakeholder groups including local leadership from Veterans Service Organizations, our Union partners, Congressional members and staff, and media. As he has publicly stated at each visit, we must regain the trust of Veterans and other stakeholders, improve service delivery, and set the course for longer term excellence and reform. He has also asked employees to reaffirm their commitment to VA's mission and core values (I CARE: Integrity, Commitment, Advocacy, Respect, and Excellence).

At each visit, the Secretary has found that the overwhelming majority of the VA workforce is dedicated to serving Veterans, and cares deeply about the VA mission. He has made it clear that each member of the workforce is critical to identifying barriers and improving service delivery, and that he welcomes all constructive input, including that of whistleblowers, who seek to improve service to Veterans.

The Secretary has also found the Town Halls with Veterans and other stakeholders extremely valuable in restoring trust and communication. He originally directed all VA health care and benefits facilities to hold a Town Hall event by the end of September 2014 to improve communication with, and hear directly from, Veterans nationwide. Congressional and state representatives, as well as other stakeholders from these areas were invited to attend. He has since directed these Town Halls be held quarterly.

Finally, the Secretary has also met with local VA leadership during each site visit. Many have identified local barriers and other challenges to improving service. The issues raised at these meetings, together with others, are being both assessed and addressed as quickly as possible. VA is aggressively implementing its Accelerated

Access to Care Initiative and the provisions of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act). The Secretary also initiated a national effort to recruit medical professionals into VA to address staffing shortages.

b. Do you believe that the recommendations provided by OIG go far enough in addressing some of the systemic issues plaguing the VA?

Response. VA greatly appreciates and supports the Office of Inspector General's (OIG) extensive ongoing efforts to identify systemic barriers to the access and high-quality care that the Nation's Veterans have earned and deserve. OIG continues to review wait time and scheduling issues at a large number of Veterans Health Administration (VHA) facilities, and the Department will fully consider their recommendations.

In addition to the OIG's recommendations, the Department will receive input from other reviews such as those required by Choice Act. The Department has also conducted various internal reviews.

This collection of insights has, and will continue to provide, VA with important feedback as it addresses systemic issues related to access and care shortfalls. VA is committed to restoring the trust of Veterans and other stakeholders, and to improving access to high-quality care. Comprehensive action is underway.

*Question 31.* This OIG report lists 24 recommendations aimed at improving the quality of care for veterans. The VA has since concurred with all of these recommendations and vowed to implement them. However, as cited in this report and elsewhere, OIG notified the Veterans Health Administration (VHA) in 2012 that staff at PVAHCS was not complying with VHA scheduling policies.

a. Although the VA has known for some time about inappropriate scheduling practices at facilities across the country, the problem has yet to be remedied. Are you confident that the VA will successfully implement the reforms outlined by OIG?

Response. VA has concurred with all recommendations and is working hard to implement the reforms outlined by OIG. VA will make every attempt to fully and successfully implement all reforms outlined by OIG. At the same time it is important to understand that scheduling appointments requires human interactions that can be subject to error. Even with the best reforms VA cannot guarantee that all instances of appointment scheduling will be error-free.

b. Are there any reforms that you believe are necessary but were omitted by the OIG report?

Response. OIG did a thorough job of making recommendations. In the course of following the recommendations, VA will make every attempt to write clear and comprehensive policy, design effective training, and implement oversight that complies with OIG recommendations.

*Question 32.* As you know, the Veterans Access, Choice, and Accountability Act of 2014 was recently passed by Congress and signed into law by the president. Among other things, the purpose of this legislation is to provide the VA with increased latitude to remove agency employees when necessary.

a. Do you believe that this legislation provides the VA with adequate authority to remove underperforming employees?

Response. VA notes this law only applies to Senior Executive Service employees, which constitute less than 1 percent of VA's workforce. One of the goals of the Senior Executive Service is to ensure accountability for efficient and effective government. This is achieved by holding senior executives accountable for their individual and organizational performance through an effective and rigorous performance appraisal program, as well as taking immediate steps to address performance or conduct issues. This legislation provides that authority. While VA previously had authorities to take action to hold employees and executives accountable for performance or misconduct, the amendments will strengthen or enhance those authorities.

b. Will the added hiring and firing flexibility enable the VA to significantly improve the quality of care that it delivers to veterans?

Response. Removing Senior Executives who are not performing as expected by the Secretary will ultimately be a benefit to Veterans and the delivery of care. Added hiring flexibilities will allow the VA to have the necessary staffing required to improve the quality of care delivered to Veterans.



RESPONSE TO ADDITIONAL POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

FUNDING TO HIRE ADDITIONAL VA HEALTH CARE PROVIDERS

I participated in a VA Town Hall Meeting in Newington, Connecticut, along with William Streitberger, the Director the Hartford VA Regional Office, and Gerald F. Culliton, the Director of the VA Connecticut Healthcare System. This Town Hall offered Connecticut veterans, family members and constituents the opportunity to provide the VA with feedback and recommendations on local operations and programs.

During the Town Hall, we heard from K. Robert Lewis, a Veterans' Service Officer from the Veterans of Foreign Wars. He shared with the audience his understanding that many veterans with the VFW have received outstanding service from Connecticut VA facilities, but that the lack of providers remains a pervasive challenge that has hindered our veterans' access to care. I know that the Veterans Access to Care Act authorized \$5 billion to enable the VA to hire additional health care providers and clinical staff as well as provide enhanced incentives to attract more health care professionals to the VA.

*Question 33.* Secretary McDonald, how will you implement this funding to demonstrate your continued commitment to hiring new physicians, nurses and staff to address these challenges? What, if anything, is the impediment to hiring mental health professionals and how can we ensure that our veterans receive the mental health assistance they require?

a. How will you implement this funding to demonstrate your continued commitment to hiring new physicians, nurses and staff to address these challenges?

Response. The Office of Finance will distribute the available funding per the implementation plan associated with individual medical center staffing needs.

b. What, if anything, is the impediment to hiring mental health professionals and how can we ensure that our veterans receive the mental health assistance they require?

Response. In order to provide Veterans with the services they need and desire to aid in recovery from mental health issues, the Department of Veterans Affairs (VA) must have access to the appropriate number of mental health professionals who can deliver their services to sites where the Veterans want to receive their care. A significant challenge in meeting the needs of Veterans is the rapid growth rate in demands for mental health services. Between 2005 and 2013, the number of Veterans who received mental health care from VA grew by 63 percent, over three times the rate of increase seen in the overall number of VA users (Figure 1). As a consequence, the proportion of Veterans receiving mental health services has increased from 19 percent in 2005 to 26 percent in 2013. The growth in the number of mental health encounters or treatment visits has been even more dramatic; mental health encounters have increased from 10.5 million in 2005 to 18.0 million in 2013—a 71-percent increase.

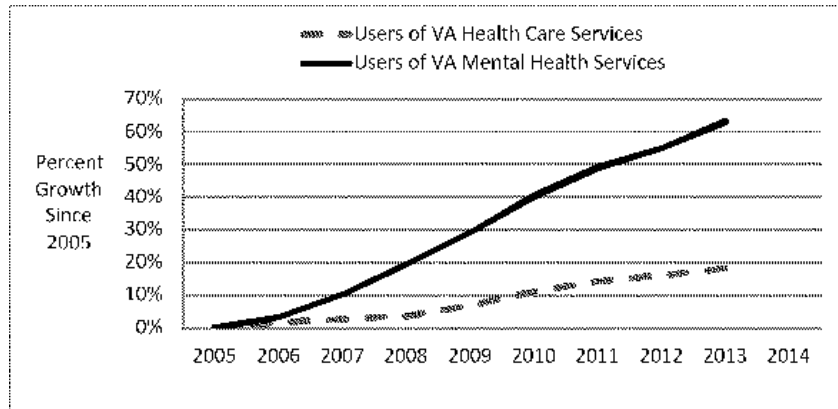


Figure 1. Percent growth since 2005 in numbers of Veterans using VA mental health services and VA health care services overall.

The recent rapid growth in the number of Veterans seeking mental health treatment in VA has posed challenges in the area of staffing. In Figure 2, the growth in numbers of Veterans using mental health services is depicted by the solid line, which shows an increase from 897,643 in 2005 to 1,464,700 in 2013. (The number of patients is expressed in terms of hundreds in order to show staff and patient numbers on the same graph. For example, 10,000 on the vertical axis represents 1,000,000 patients.) Current projections for future growth show a somewhat slower rate than has been experienced over the past decade.

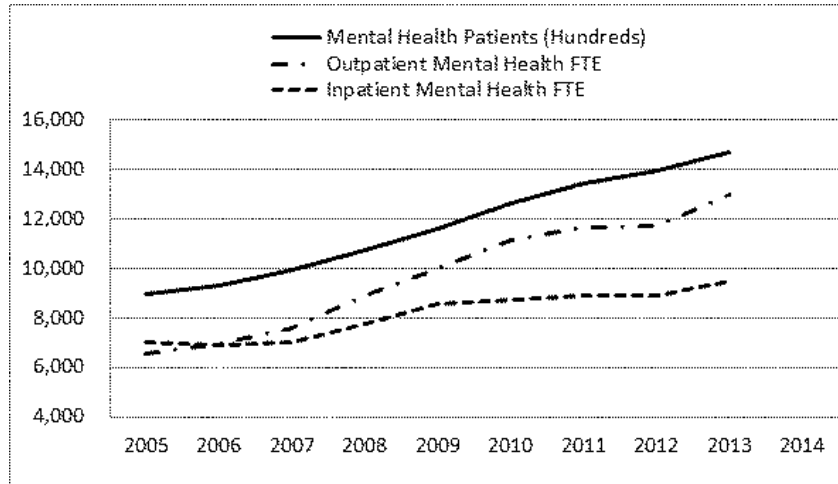


Figure 2. Growth in annual numbers of patients using mental health services and in outpatient and inpatient full-time equivalent staffing levels since 2005.

This graph also shows the growth in numbers of mental health clinical staff, measured in terms of the full-time equivalent (FTE) staff providing outpatient and inpatient treatment. Consistent with the increased reliance on outpatient care, the inpatient mental health staff FTEs began to level off after 2009. The hiring of outpatient mental health clinical staff grew somewhat faster than mental health patient numbers through 2010 and then began leveling off. A 2012 hiring initiative resulted in gains in both inpatient and outpatient staff FTEs.

Thus, VA has been addressing the need to hire and retain new mental health staff to meet new demand for some time. The recent hiring initiative allowed mental health staffing growth to keep up with growth in demand. With expected ongoing increases in demand, VA will need to keep hiring. However, a focus on the overall ratio of mental health staff to Veterans for the entire system does not fully identify or address a different and critical issue for VA. Unfortunately, the areas with lower availability of mental health professionals often coincide with sites where VA is faced with the challenge of meeting high and/or growing Veteran demand. VA is working on a variety of mechanisms to meet that hiring challenge including: (1) use of recruitment and retention incentives; (2) use of loan repayments; (3) creation of a mechanism for higher, overall salaries for VA psychiatrists; and (4) consideration of other approaches to recruit and retain necessary staff. VA is also working to expand targeted use of tele-mental health services.

While VA has been effective, overall, in hiring on a nationwide basis, putting those resources to maximum use also depends on having appropriate space in which professionals can work. While VA is increasing use of mental health services delivered into the Veteran's home, use of extended hour clinics (so that available space can be more fully used), and use of non-VA care to decrease the impact of restricted space, the need for rapid expansion of office and group room space at some sites remains. VA is pushing forward with space improvements to address this need.

Staff must also be appropriately trained and equipped. As staff is hired, plans are being made to meet their needs for computers and other supports for modern practice of mental health care. Already, over 6,000 providers have been trained in evidence-based psychotherapy, and VA is exploring ways to expand that training to even more clinicians.

Finally, VA is looking toward the future by engaging in projects aimed at measuring and predicting capacity for various aspects of care including mental health. VA capacity to deliver mental health care refers to the availability of resources required for timely delivery of high-quality mental health services. A work group has embarked on a plan to assess and understand the numerous facets of capacity and their impact on the delivery of mental health care in a large, complex health care system. Continued work will make prediction and management of VA mental health capacity more sophisticated in the future.

Having sufficient staff with sufficient space, equipment, and training does not guarantee that Veterans will receive all of the appropriate care they need. VA, through the Office of Mental Health Operations (OMHO), Mental Health Services and collaborating units, sets policy for care and monitors compliance with those policies. Each year, one-third of facilities are surveyed by a well-trained team of clinical experts using a semi-structured interview as well as a review of specific clinical and administrative measures that assess access, efficiency, staffing, and other important dimensions of mental health service functions. These surveys lead to strategic action plans to address any shortcomings in performance or resourcing. Progress on these plans is reviewed quarterly by OMHO staff who work in close collaboration with Veterans Integrated Service Network (VISN) and local mental health leaders. OMHO uses its three program evaluation centers to monitor important metrics, including Veteran and provider satisfaction, in a wide variety of VA Mental Health programs. The program evaluation centers have created easily accessible Web sites where individual VISNs and facilities can monitor their own performance regularly. Finally, VA has created mechanisms by which productivity of providers of various disciplines can be monitored at local and higher levels, so that facilities and VISNs can take action to optimize the amount of care that is provided by staff. Taken together, these mechanisms provide VA leadership many indications of how the VA mental health system is functioning as a whole and at local levels.

#### HIRING ADDITIONAL VETERANS

I have additionally spoken to members of my Veterans' Advisory Council of Connecticut Veterans and community leaders who have concerns regarding VA hiring practices. These constituents expressed the difficulties that many qualified Veterans encounter in applying for jobs at the VA. I am concerned that VA, which should lead the Federal Government, does not hire as many Veterans as it should.

*Question 34.* Secretary McDonald, as you move forward to hire new staff for VA facilities, what is your operational plan to hire more veterans, specifically members of the National Guard and Reserve?

*Response.* The percentage of new Veteran hires in government is at its highest since the mid-1970s. VA is helping to lead the way in Veteran hiring and now ranks second only to the Department of Defense in the number of Veterans in our workforce. As of the end of fiscal year (FY) 2014, we had a total of 113,432 Veterans on board, which accounts for 32.66 percent of our workforce.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014, we are executing an extensive recruitment plan to increase access to care through the hiring of physicians and other medical staff. This effort calls for VA to hire tens of thousands more medical professionals—an ambitious undertaking, especially considering the current nationwide shortage of certain medical professionals. Given the scope of this effort, and the often limited supply of Veteran medical professionals, VA has determined that we will focus our goal for the percentage of Veterans in our workforce to 35 percent by the end of FY 2017. This short-term goal is not only attainable and realistic; we are confident that we can find some of the best and brightest Veterans to join our workforce to achieve this hiring goal. Our Veteran Employment Services Office (VESO) will work collaboratively with our Administrations and Staff Offices to meet this hiring goal. In October, VESO participated in 30 Veteran-focused hiring events nationwide, which include several disabled Veteran-specific events and employment briefings for transitioning Servicemembers including National Guard and Reserve forces and attend Yellow Ribbon Program events. Our VESO office provides Federal employment services to all Servicemembers and Veterans. We are also actively participating in an inter-agency work group focused on increasing our women Veteran population in the Federal workforce through targeted strategies. In addition, as a part of the hiring initiative, The Secretary has traveled to several Medical Centers and Medical Schools to recruit medical professionals to join the VA.

## WEST HAVEN VA

Many Connecticut veterans who utilize the West Haven VA facilities are pleased with the quality of care they receive and hope to maintain access to that level of care, even while capacity is expanded. The West Haven medical facilities must have the funding to make necessary upgrades in infrastructure and capacity to build more facilities and ensure that it can keep pace with the needs of Veterans, especially female Veterans.

*Question 35.* Secretary McDonald, how do you plan to bring the West Haven facilities into the 21st century and will you ensure that the West Haven facility is not overlooked in capital improvements?

Response. VA Connecticut Health Care System (VACTHCS) is actively using the strategic planning process to identify and prioritizing critical infrastructure reinvestment needs of its campuses in West Haven (WH) and Newington (NEW). In support of this initiative, VISN 1 is in the process of completing a VISN-wide master plan that is intended to help facilitate better planning and utilize all capital solutions to ensure Veterans needs are met.

The plan includes both short range and long range initiatives to address the needs of the Veterans as well as the required infrastructure improvements that support the mission. Below are some of the projects and initiatives VA is currently pursuing. This list will change as new issues arise and new requirements are encountered.

In addition to the planned project work, VACTHCS continues to improve its infrastructure and space through the active construction and maintenance. Many new improvements, repairs, renovations were successfully accomplished this past year.

*Projects in process*

- Infrastructure upgrades
  - Boiler and Domestic Water improvements 689-12-052 (WH)—Replaces antiquated water pumps.
  - Replace 120,000 Gallon Oil Tank 689-14-101 (WH)—Replaces current oil tank that has corrosion issues.<sup>2</sup>
  - 010 Boiler Corrections 689-10-213 (WH)—Corrects safety deficiencies and compliance issues.
  - Replace Load Center 1A, 689-13-151 (WH)—Replacement of electrical load center which supplies the facility main electrical feed.
  - Electrical Control Systems upgrade, 689-13-155 (WH)—Upgrades to existing electrical systems.
  - Replace Load Center 2&5, 689-13-154 (WH)—Replacement of electrical load centers in poor condition.
  - Building Envelope Repairs B1 & 2, 689-12-202 (WH)—Corrects water infiltrations through windows that are in urgent need of replacement.
  - Supply Backup Power for Buildings 3, 4, 5, 27 & 34, 689-13-150 (WH)—Installation of emergency generator power feeds.
  - Building 36 Structural Corrections, 689-12-001 (WH)—Repair structural deficiencies in Bldg. 36.
  - Replace Roofs B35, 35A & 36, 689-12-120, (WH)—Replaces roofs
  - Building 27 & 34 Heating, Ventilation and Air Conditioning Corrections, 689-14-002, (WH)—Current unit has exceeded its useful life.
  - OR Heating, Ventilation, and Air Conditioning, 689-10-121 (WH)—replaces deteriorating Operating Suite HVAC components.
  - Correct Electrical Deficiencies Phase 2, Veterans Health Administration-689A4-2013-10500, (WH)—Corrects deficiencies and installs back up separation requirements.
  - (Approved and in design or pending construction) Expand Primary Care Clinic, 689-402, (NEW)—This project will add a single level addition to the northwest corner of Building 2E and renovate the first floor of Building 2C to accommodate the expansion of the Primary Care Clinic by approximately 9,691 square feet.
  - In-Patient Unit Rehabilitation, 689-12-102, (WH)—This project will completely renovate an existing outdated medical/surgery ward in building 1, 4th floor, east side.
  - Psych Emergency Department (ED) Expansion, 689-390, (WH)—Project will add an approximately 12,000 square feet addition adjacent to the existing Medical ED and renovate 1200 additional square feet.
  - Replacements of high tech/high cost equipment and upgrades to Catherization Lab, X-Ray, and Computed Tomography Scanners.

*Projects identified through the planning process for future implementation as funding allows:*

- Infrastructure upgrades
  - Electrical Deficiencies Phase 2, (WH)—Addresses deficiencies (Arc flash condition) identified in electrical study.
  - Chiller Plant (WH)—Address undersized and antiquated chilled water distribution system feeding the campus.
  - Elevator Replacements, (WH/NEW)—This project will address outdated and aging elevators systems.
  - Replace Roofs B1, 2, 11, 12, 15 & 16—NEW B6, 7 & 8
  - SPS Air Handler Replacement, (WH)—Corrects environmental conditions in the Sterile Processing Service.
  - Water Treatment System, (WH/NEW)—This project will help address the aging pipes and plumbing systems throughout VACTHCS and activate a water treatment system.
  - Correct and Upgrade Exterior, PH1 689A4-12-211, (NEW)—Corrects building envelope façade which is compromised and causing water infiltration.
  - Domestic Water and Sanitary Main Pipe Replacements, (WH)—Replaces aging pipes and corrects deficiencies.
- Patient/Safety/Environmental upgrades
  - Surgical Core (WH)—the project consolidates the operating room and other surgical and related services such as the sterile processing service and patient acute care unit.
  - Parking Garage (WH)—Design and construction for a 409 car parking garage. Project will greatly enhance access to care due to inadequate parking spaces.
  - Nursing Home—Conceptual project to address the lack of community living center beds. Project would greatly enhance access and quality of care.

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RESPONSE TO ADDITIONAL POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO HON. ROBERT A. McDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 36.* The VA IG report details the death of a number of veterans. Has VA done anything to assist and support the surviving spouses and families of veterans whose deaths were reported by the IG? More specifically, have these spouses and family members received counseling from the VA about any benefits that they may be entitled to?

Response. The Phoenix Regional Office has attempted to contact all next of kin of deceased Veterans identified in the OIG Report. The Regional Office provided benefits information to the individuals it was able to reach and answered additional benefits-related questions.

*Question 37.* At the macrolevel, does VA have a system in place to advise surviving spouses and family members of whether they qualify for benefits and to assist in filing for such benefits? Especially veterans who are in the care of the VA at the time of death? If a veteran is terminally ill and receiving end of life care from the VA, does the VA proactively provide assistance to the spouse/family of that veteran to help prepare them once their loved one passes?

Response. VBA's Pension and Fiduciary Service and regional offices' Public Contact employees work closely with the Veterans Health Administration and other stakeholders to conduct outreach for survivors and ensure they are aware of benefits they may be eligible to receive. Survivors can access information on VBA benefits by contacting VBA call center agents at 1-800-827-1000, by appearing in person at a VA regional office, or by mailing or emailing a request for information or assistance to VBA. VBA's call center agents and public contact employees are trained to provide one-on-one guidance to survivors to help them understand their benefits and assist them through the process of submitting a claim for benefits. Spouses of Veterans who are under care in one of VA's medical facilities may contact the facility's Office of Decedent Affairs, which also works closely with the family to assist with benefits and guide them through the process.

VBA has developed fact sheets detailing its benefit programs to assist Veterans and their family members. These fact sheets include survivor's benefits and application instructions, and are available at <http://www.benefits.va.gov/BENEFITS/fact-sheets.asp>. In addition, VBA has taken steps to automate the payment of certain benefits to survivors (Veteran's benefit payment for the month of death, burial allowance, and some dependency and indemnity compensation) when it receives notice

of a Veteran's death. This automation ensures that survivors receive the benefits they need as quickly as possible during the difficult time that follows a Veteran's death.

Chairman SANDERS. Mr. Secretary, Dr. Clancy, thank you very much for being with us. Thank you for the hard work that you are putting in right now and for the changes that we are seeing.

This hearing is now adjourned.

[Whereupon, at 12:35 p.m., the hearing was adjourned.]

