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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
May 15, 2014***

Chairman Sanders, Ranking Member Burr, and Members of the Committee:

Thank you for inviting DAV to testify today about “The State of VA Health Care.” As the nation’s largest veterans service organization comprised completely of wartime disabled veterans, no one has more interest or greater experience and expertise when it comes to the quality and timeliness of health care provided to veterans by the Department of Veterans Affairs (VA).

DAV is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Our 1.2 million members—all of whom were wounded, injured or made ill through their military service—rely heavily on VA for some or all of their physical and mental health care needs. We have an enormous stake in making certain that VA continues to provide high-quality health care, and that it does so in a timely manner.

Mr. Chairman, while I am pleased to be here today to share some insights about what DAV members see, hear and experience firsthand at VA’s 1,700 points of care, the circumstances that precipitated this hearing are troubling indeed. DAV remains deeply concerned about allegations of secret waiting lists, falsification of medical appointment records and the destruction of official documents that may have occurred in Phoenix, Arizona; Fort Collins, Colorado; Cheyenne, Wyoming; Austin, Texas; and potentially, other sites as well. These reports raise troubling questions about whether VA employees or management took actions that, whether by design or not, obscured the true picture of access problems at some VA facilities, whether proper procedures concerning scheduling and wait list were followed, and whether any laws were broken.

We fully support the ongoing investigation by the Inspector General and look forward to receiving and analyzing its results and conclusions. We will demand full accountability for anyone found to have violated the law or failed to responsibly follow and enforce VA’s rules and regulations, no matter who or where they are inside VA.

We also support Veterans Affairs Secretary Shinseki’s initiative to audit all VA facilities immediately to determine whether similar scheduling issues or waiting list problems may be uncovered. We expect that this audit will bring greater accuracy to assess the number of veterans waiting to receive different services at each VA facility. We strongly recommend that

VA bring in outside, third-party experts to increase the objectivity and credibility of this audit process in order to help regain the full trust of veterans and the American people. Further, it is imperative that VA release all data, information, findings and conclusions of this audit to both Congress and the public in a fully transparent manner. We stand ready to provide any assistance to VA that can help in achieving these objectives.

Mr. Chairman we also take very seriously recent news reports that raise questions about whether VA's inability to provide timely access to certain health care services may have caused or contributed to negative patient health outcomes or even deaths. Such grave questions must be aggressively pursued by VA as well as by outside experts to determine their validity. While no health care system is perfect, and medicine is far from an exact science, veterans have earned the right to expect the VA health care system to provide medical care at the highest level, equal to if not better than private sector care. Furthermore, when problems and challenges arise, as they will from time to time in all health care systems, VA must act swiftly, transparently and effectively to correct the problems and overcome the challenges. In the coming weeks, we will closely monitor how well and how quickly VA responds to these serious questions and allegations.

Unlike private providers and health care systems, VA is required by its own policy to admit and publicly report all medical errors and fully investigate all untimely deaths. VA uses the information from these investigations for self-improvement and to strengthen prevention protocols system wide. To be effective, VA must have sufficient internal monitoring and reporting systems that detect and report problems rapidly through the chain of command in order to correct them and develop prevention strategies nationwide. These recent revelations indicate that there are troubling gaps in this reporting system that need to be addressed.

Although it may be weeks or months before we have all the results of the ongoing investigations and audits, we continue to have confidence that VA, led by Secretary Shinseki, can and will correct any problems identified or uncovered. This Secretary has a track record of directly and honestly confronting problems that he has inherited or that were uncovered during his tenure, and then working with Congress and stakeholders to correct them. For example, after decades of inaction and inattention, the Secretary laid out a bold course four years ago to finally modernize the VA disability claims processing system, a transformation that has already reduced the backlog of disability compensation claims by about half in the past year. Similarly, when IT problems interrupted payments to thousands of student veterans under the new Post 9-11 GI Bill, VA leadership moved aggressively to confront and resolve the problems, building an entirely new IT system in less than 13 months. When access to mental health services became a crisis a couple of years ago, at the direction of the Secretary, VA rapidly hired an additional 1,600 mental health professionals, 952 peer counselors, 300 support personnel, and increased staffing for the Veterans Crisis Line (1-800-273-8255) by 50 percent, to break down stigma barriers and increase access.

Mr. Chairman, let me be clear, by no means have all of VA's problems been solved or challenges overcome, nor is it yet clear the full scope of the problems that may be uncovered by current investigations and audits into waiting times and alleged preventable deaths. However, based on our experience, we continue to have full confidence that the Secretary can and will

confront any such problems directly and honestly, just as he has throughout his career. For our part, we stand ready to work with him, this Committee and others in Congress to openly investigate problems, honestly discuss constructive solutions, and collaboratively work to fix them.

Moreover, let me emphasize one point on which we are resolute: the VA health care system is both indispensable and irreplaceable; there is no substitute for it. Based upon our collective knowledge and experience, we continue to believe that VA provides high-quality health care for the vast majority of veterans treated each year, and that veterans are now and will be better served in the future by a robust VA health care system than by any other model of care. The real challenge facing VA, and the root cause of the issues being reported today, have to do with access to care rather than the quality of care that is delivered.

Mr. Chairman, as I stated at the outset, DAV and our members are not just observers of the VA health care system, but active consumers of it. Our testimony reflects both current research and analysis as well as the collective experience of our professional staff, which includes over three hundred National Service and Transition Service Officers and nearly two hundred hospital coordinators covering every VA medical center. We also have thousands of Department and Chapter Service Officers and leaders who use VA and work directly with millions of veterans enrolled in the system. Our transportation network, which provides more than 770,000 rides for veterans to and from VA health care facilities each year, is another point of contact that we have with which to assess the State of VA Health Care. There are also 1.2 million DAV members across the nation who regularly receive care at VA's Community-Based Outpatient Clinics (CBOCs), medical centers and other facilities. Let me assure you that when our members see, hear or personally experience problems at VA, we hear from them at our meetings, during our conventions, in phone calls, via email and on Facebook. It is from this broad and diverse base of knowledge and expertise that we come to our conclusions.

VA today operates nearly 1,700 sites of care including 152 hospitals, almost 900 community-based and mobile outpatient clinics, 300 Vet Centers for psychological counseling and other facilities that provide vital health care and services to millions of veterans. VA provides medical services to more than 6 million veterans annually, out of almost 9 million enrolled in the VA system. For more than a decade, numerous independent auditors and analysts have concluded that the quality care provided by VA is equal to or better than similar care provided by private sector systems and at lower costs to the taxpayer. The 2013 American Customer Satisfaction Index reported that veterans themselves ranked VA hospitals among the best in the nation with equal or better ratings than private hospitals. This is not to imply that VA faces no challenges or that no problems occur within the VA system. However, it is important to put in context the quality of care delivered by VA compared to private sector alternatives.

The VA health care delivery model provides comprehensive, patient-centered and evidence-based care that leads the nation in many areas. VA's clinical research program has elevated the American standard of care and invented cutting edge devices and treatment techniques that have improved the lives of millions of veterans and non-veterans in areas such as spinal cord injury, blind rehabilitation, amputation care, advanced rehabilitation (such as polytrauma and traumatic brain injury), prosthetics, post-traumatic stress disorder, substance-use

disorder, multiple sclerosis, diabetes, Alzheimer's, Parkinson's and dementia. VA's model of care emphasizes preventive strategies that elevate the quality of life for millions of veterans while reducing health care costs overall. With its focus on preventative medicine, life-time care of veterans in a patient-centered model and the use of low-cost, bulk-procured medications, VA is able to provide high-quality care for less than the cost of Medicare and private sector providers.

It is worth noting that in addition to providing high-quality health care to veterans, VA is also the largest single provider of health professional training in the world. Each academic year, VA helps train over 100,000 students in the health professions through its academic affiliation with 152 schools of medicine and over 1,800 schools in total.

Mr. Chairman, to better understand why the VA health care system is so uniquely suited to veterans' needs today, it is useful to look at how the current system evolved. Twenty years ago, VA was still based upon the post-World War II model of care, with large hospitals located in major cities providing primarily inpatient care. At that time, VA based eligibility for services on inpatient admission status and routine care was often delivered in major medical centers at very high cost, and in often inconvenient locations and times for an increasingly suburban population. In the mid-1990s, with the approval of Congress, VA leadership developed a new paradigm that decentralized the delivery of health care and with the help of Congress reformed eligibility allowing more veterans to receive comprehensive care. As a result, hundreds of CBOCs were opened in every state over the next decade and millions of veterans living in suburban, rural and remote areas now found VA a convenient provider of high-quality care. In addition, as VA moved to a model of care that emphasized preventative services and focused on the comprehensive health care needs of veterans, both the quality and cost-efficiency of care dramatically increased. In addition, VA built a forward-looking electronic medical record system that contributed to the efficiency and safety of the system. Within a decade, VA was being hailed as the "best care anywhere" by major independent studies, publications and by author Philip Longman, who wrote a book by that name.

Today, VA has undertaken another major step forward by evolving the system to a patient-centered care model focusing on the needs of veterans, rather than VA processes. We believe that VA is on the right path forward and that the vast majority of veterans receiving medical services from VA receive high-quality care. The real challenge facing VA is providing all veterans seeking medical care with access to the VA system.

As we have testified consistently over the past decade, we continue to find that access remains a problem for too many veterans at too many VA facilities. Based on our information, not all facilities have access problems and even at those that do, it may only be related to some of the services they provide. We have heard often from VA employees and sometimes local VHA leadership that there have been shortfalls in staffing or resources that forced them to take actions limiting services sought by veterans. There is now a growing body of evidence validating our concerns.

For example, in December 2012, GAO investigated reports of long wait times for outpatient medical appointments and found that the metrics provided by VHA were "unreliable."

Furthermore, GAO found that VHA's scheduling policy and training documents were "unclear" and led to inconsistent reporting of wait times. They also found that scheduler training was inconsistent from one VA facility to the next. GAO made four recommendations that VA generally agreed with, and VA outlined an implementation with target dates of March 30 and November 1, 2013. We expect to hear from VA today if, when and how these plans were implemented, and the results from those changes.

Investigations have also been reported in the news media regarding scheduling problems and possible violations of VA policies identified by the VA Office of Medical Inspector, and the Office of Special Counsel over the past year regarding access, scheduling and waiting times. Again, we look to VA to forthrightly address those management and administrative issues with specific responses.

However, improved administrative procedures and management can only address part of VA's access challenges. The ability of VA to provide veterans timely access to medical care is primarily driven by four factors: how many medical personnel are available to provide medical care (resources), how much usable space is available to treat veterans (infrastructure), can VA leverage health care capacity in the community (purchased care), and can VA produce accurate and valid data to properly manage access issues (metrics).

Mr. Chairman, for the past decade, DAV and our partners in *The Independent Budget* (IB) have consistently testified before this Committee and others about shortfalls in VA's medical care and construction budgets. In the prior ten VA budgets, the amount of funding for medical care requested by the Administration and ultimately provided to VA by Congress was more than \$5.5 billion *less* than what was recommended by the IB. Over the past five years, the IB recommended \$3.5 billion more than VA requested or Congress approved and for next year, FY 2015, the IB has recommended just over \$2 billion more than VA requested. I would point out that you, Mr. Chairman, did call for an increase of \$1.6 billion for FY 2015 medical care funding, which we believe is fully justified, but based on available information today, it appears that your Senate colleagues will not significantly increase the Administration's inadequate request, just as the House failed to do.

Even worse, the funding shortfalls that we have consistently pointed out have been exacerbated by annual budget gimmicks that replace actual dollars to be appropriated with "projected" savings from proposed "management efficiencies" and "operational improvements." As GAO has consistently pointed out, VA's projections of such future "savings" have rarely, if ever, been documented or substantiated, leaving VA facilities short of the funding needed to provide medical care to all veterans using the system. A similar problem occurs when VA also replaces appropriated dollars in their budget requests with anticipated collections from third party insurers. When the actual amounts collected through the Medical Care Collection Fund (MCCF) fall short of the projected levels, as has been the case almost every year, VA is once again forced to make do with less than its actuarial model estimates is needed to provide care to enrolled veterans. If just these two "gimmicks" were removed from the budgets proposed by the Administration and subsequently approved by Congress, VA would have had significantly greater resources, billions more, with which to increase staffing and better address access issues that have become so prevalent now.

Mr. Chairman, in your Views and Estimates letter to the Senate Budget Committee last year you made this same point when you said, “based upon operational efficiencies identified as cost savings in previous VA budgets, I am concerned there will be a similar shortfall next fiscal year.” You went on to express concerns about the “...potential impact that failing to achieve the identified costs savings may have on VA’s provision of health care.” Unfortunately, neither the Senate nor the House heeded this advice and we find ourselves today in this dilemma.

The second challenge in access, and over the long term probably the greatest challenge that must be addressed, is providing VA sufficient resources to properly maintain, realign or expand its infrastructure. Over the past decade, the amount of funding requested by VA for major and minor construction, as well as the final amount appropriated by Congress, has been more than \$9 billion less than what the IB has estimated was needed to continue delivering timely, high-quality care. Over the past five years, that shortfall is more than \$6 billion and for next year, the VA budget request is more than \$2.5 billion less than the IB recommendation. Furthermore, the IB recommendations are primarily based upon VA’s own internal analysis of funding needed to maintain VA’s existing physical infrastructure.

According to VA’s Strategic Capital Investment Plan (SCIP), VA needs to invest between \$56 to \$69 billion in facility improvements over the next ten years; however, the Administration’s budget requests have averaged between \$1 to \$1.5 billion for major and minor construction over that time. Again, Mr. Chairman, I want to commend you for pointing out this fact in your Views and Estimates letters the past two years. You very honestly stated that the funding level proposed by the Administration for construction and maintenance has been “clearly insufficient to meet the identified needs...” Unfortunately, as with medical care funding, neither your Senate colleagues nor the House took actions to increase funding for VA’s construction and maintenance accounts, ignoring not just the IB’s recommendations, but VA’s own internal SCIP analysis.

Mr. Chairman, a little over a decade ago, VA faced a similar and serious crisis over access to VA health care, as hundreds of thousands of veterans were found waiting six months or longer just to receive primary care medical appointments. The root cause of that situation also was insufficient resources to meet the actual demand for services. Even after VA moved to close its doors to new Priority 8 veterans, the shortfall in funding soon became unmanageable. By 2005, shortly after testifying before this Committee and the House Veterans’ Affairs Committee that the Administration’s budget was sufficient, then-VA Secretary Jim Nicholson was forced to return to Congress and admit that there was a shortfall of about a billion dollars, which Congress subsequently appropriated. Only after the funding levels for medical care were increased closer to the levels recommended by the IB did the wait lists finally begin to decline. Today it appears that VA may once again be approaching that same dangerous crossroad; unless the Administration begins to request more adequate funding, and/or unless Congress starts to increase insufficient funding requests, the growing problems related to access will continue. And no amount of administrative or management changes, or replacement of VA leadership, can begin to make up for the \$15 billion shortfall identified by the IB over the past decade.

The third challenge is for VA to utilize its purchased care authority when necessary to supplement and bolster the VA health care system. DAV believes that whenever an enrolled veteran is unable to receive care directly from VA within established timeframes, VA must take responsibility to find alternative means to provide and coordinate such care, regardless of where the veteran lives.

In the near term, VA must do a better job of providing non-VA care when VA is unable to provide timely care. The determination of which and how many veterans receive care paid for by VA is left to the discretion of each facility; however they must balance the fact that funding to purchase care comes out of the same pot of money for direct VA health delivery. Each dollar used to pay for non-VA care is one dollar less that is available to hire new VA staff required to treat veterans in a timely manner. If the VA's purchased care program is to truly function as intended, the first step is for VA to provide accurate, complete and transparent estimates of the amount of funding required to purchase care from the private sector. Once VA provides an accurate estimate, Congress must appropriate the amounts necessary to support both VA provided and purchased care if we are to avoid rationing care.

However, even with sufficient funding, there remain many questions to be answered and challenges to be overcome before VA's purchased care program can be successful. For example, how will non-VA care be coordinated with VA care so that the holistic needs of the veterans are met? How will non-VA providers integrate their medical records into VA's electronic health record system so that there is seamless record keeping ensuring integrated care and patient safety? Even if VA has the resources to pay for non-VA care, are there sufficient, qualified providers available in each community to provide such care? Simply giving a veteran a plastic card and wishing them good luck in the private sector is no substitute for a fully coordinated system of health care.

The fourth challenge is even with sufficient infrastructure and resources, VA can only manage and improve what they can measure. VA currently uses the Medical Scheduling Package (MSP), a component in its VistA electronic health record (EHR) system, to perform multiple interrelated functions to coordinate clinical and administrative resources as well as to capture data that allows VA to measure, manage, and improve access to care, quality of care, operating efficiency, and operating and capital resources. VA's current MSP is more than 26 years old and does not meet current requirements or provide the flexibility to support new and emerging models of care.

On October 16, 2012, VA announced its intention to replace the current MSP by open competition for a product that effectively performs VA's scheduling and related legacy business functions. The winners of the competition were announced on October 3, 2013; however, no plans have been made public about next steps or when an actual replacement will occur. VA must quickly come forward with a detailed plan to replace and modernize their scheduling software, including an accurate estimate of all the funding and other resources needed to make it operational. In addition, this new system should have the capability to provide real-time measures of waiting times on a facility-by-facility basis and other metrics needed for effective management. In addition, VA must develop a public method or regularly reporting such data to

Congress, veterans and the American public, similar to how the Veterans Benefits Administration reports detailed data about claims processing timeliness and accuracy.

Mr. Chairman, looking at the VA health care system today, and putting it into the proper perspective of the entire American system of health care, we continue to have confidence that the vast majority of veterans are well served by seeking their care at the VA. We recognize that there continue to be access problems at some locations for some services, and there are troubling questions about how VA has responded to these problems that must be answered. In addition, there are serious questions about whether access challenges have led to negative health outcomes or even untimely deaths. And while we believe that VA can and must address any administrative or management challenges related to scheduling, the underlying problem has been and remains one of insufficient resources to meet veterans' needs. Until and unless both the Administration and Congress openly and honestly work to align VA's resources to veterans' needs for care, problems related to access, such as waiting lists, will remain a threat to the health of veterans. However, we remain confident that VA and Secretary Shinseki, working together with stakeholders and Congress, can, will and must address these challenges. America's veterans deserve nothing less.