**Statement of Tom Tarantino**
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*before the*
**Senate Committee on Veterans' Affairs**
*for the hearing on*
**The State of VA Health Care**

**May 15, 2014**

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

On behalf of Iraq and Afghanistan Veterans of America (IAVA), I thank you for the opportunity to share our views and recommendations regarding the current state of health care within the Department of Veterans Affairs (VA).

As the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan, IAVA's mission is critically important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we aim to help create a society that honors and supports veterans of all generations.

For nearly a decade, IAVA has been a tireless leader working on behalf of veterans and their families to ensure that VA meets the the needs of our community. After spending 13 years at war, VA has been confronted with significant challenges administering timely care and services to veterans. Many have been overcome, but still far too many remain. Despite these challenges, IAVA has worked to ensure that veterans continue to have faith in VA and it's ability to stay true to its commitments.

In the past few weeks, serious allegations of misconduct have arisen from several VA medical facilities, indicating that records are being intentionally doctored in order to falsely portray patient wait times as reasonable and satisfactory. Recently, several VA employees have come forward and alleged what IAVA members have been reporting anecdotally for some time: that wait times at some VA medical facilities are far longer than reported.

Disturbingly, long wait times are alleged to have resulted in the deaths of 40 veterans who perished while waiting for care at the Phoenix VA medical facility alone.[1] It has been alleged that those and many other veterans at the Phoenix VA were placed on a "secret waiting list" in order to hide actual wait times so VA officials could report that department goals were being achieved. Since the Phoenix VA story broke, more allegations of misconduct by VA personnel at other facilities from coast to coast are painting a similar picture. Unfortunately, these types of incidents are not new, nor apparently are they unique.

Immediately following these allegations of gross misconduct, IAVA members began voicing their anger and outrage about this scandal. It is time for bold reform and new measures of accountability and oversight. Our members expect substantive and meaningful evidence that long standing inefficiencies are being appropriately addressed and appropriate VA personnel are held accountable. Veterans must be assured that quality care can be delivered by their VA in a timely manner. Veterans are tired of business as usual.

Recent outreach from the Secretary to VSOs has been constructive and serves as a sobering reminder of just how critical the responsibilities shared by VA and the VSO community are for the millions of veterans that we serve. At the end of the day, everyone is working to improve the lives of veterans and their families. But VA's overt outreach to the VSO community should not be done on a "crisis-to-crisis" basis. Such ad-hoc methods prevent the VSO community from conveying the needs and concerns of the veterans community in a more predictable manner. There should be no doubt that while IAVA has highlighted a number of flaws within VA health care and management procedures, we are its biggest advocates in ensuring veterans maximize any and all VA services available to them.

IAVA also expects the VA to fully comply with the subpoena issued by the House Committee on Veterans' Affairs. Full and swift compliance with this subpoena would be a good first step in not only figuring out what happened in Phoenix, but also in demonstrating how allegations of misconduct will be addressed at other VA facilities. Just like the Secretary, we are also awaiting the results of the Office of the Inspector General's investigation of alleged misconduct in Phoenix. But we cannot just sit around idle while that investigation is under way. We applaud the full audit of all 1700 points of care at VA. However, we expect results and action

taken in weeks, not months. Additionally, we support and encourage concurrent investigations that are completely independent of the VA. Additionally, veterans need to see the Secretary step out in front on this issue and lead; we want a proactive Secretary, not a reactive one. Controlling the public message is critical, and if it can't be done by the Secretary, veterans and the American public will continue to lose faith in the VA system.

Accountability is a fundamental principle necessary for any organization to properly function. Yet, VA's incidents of mismanaged care would indicate that such a thing is missing from the highest levels at VA. Secretary Shinseki has finally started to emerge publicly and address these allegations, but we need to be clear that short-term, reactive measures will not eradicate the more pervasive problems that are causing veterans to lose faith in the system. VA has a long way to go to earn back the trust and confidence of the millions of veterans shaken by this growing controversy.

Although recently exposed by whistleblowers, allegations of long wait times at VA are nothing new. The Government Accountability Office (GAO) has conducted numerous studies over the last decade touching on scheduling inefficiencies at VA. Their findings continue to center around a lack of oversight, inadequate training, and ambiguous policies and procedures. In other words, weak leadership.

Long wait times are one thing. Essentially, they are a management and process problem that can be solved with a combination of time, people, resources and more efficient business practices. They are solvable as long as good leaders have the information they need to fix it. That does not seem to be the case here. Instead of leaders coming forward to help fix the system, they appear to be fixing the books. This is indicative of a culture of failed oversight and accountability.

Reasons for highlighting VA mismanagement and bureaucratic flaws are not done lightly. The worst thing that could happen to our community is a sense that VA is so inefficient and terrible at administering care, that veterans lose faith in the system designed to take care of their needs. Of course the right answer to this is not to cover up problems in VA, but to either solve them or keep them from happening in the first place.

This isn't just a matter of public relations. It's a matter of lives. Of the estimated 22 veterans who die by suicide per day, 17 have not sought care at VA. Despite VA's many problems, seeking help works and can save lives. It is absolutely critical that veterans who need care feel encouraged to seek it.

In order to improve the system of care and reassure veterans about VA's capabilities, legislation - such as the Suicide Prevention for American Veterans (SAV) Act and the VA Management Accountability Act - should be enacted into law immediately. Our membership, and the veterans community as a whole, needs to be reassured by VA and Congress that, despite these issues, the VA is there to serve them and that any charges of misconduct will be addressed and swiftly corrected.

We also need to ensure that we know the full scope of mismanagement and cover-up within the VA system. That is why IAVA is proud to work with the Project on Government Oversight (POGO) to protect VA whistleblowers. VA employees can come forward, confidentially, by going to VAOversight.org.

Mr. Chairman, we again appreciate the opportunity to offer our views on this critically important and urgent topic, and we look forward to continuing to work with each of you, your staff, this Committee, and the VA to improve the lives of veterans and their families.

Thank you for your time and attention.

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[1] http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/
[2]http://www.thedailybeast.com/articles/2013/02/09/veterans-die-waiting-for-benefits-as-va-claims-backlog-builds.html
[3] http://www.gao.gov/products/GAO-13-130
[4] http://www.gao.gov/assets/660/651077.pdf