S. HRG. 113–614

THE STATE OF VA HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

MAY 15, 2014

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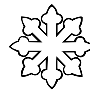

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THE STATE OF VA HEALTH CARE

THURSDAY, MAY 15, 2014

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

The Committee met, pursuant to notice, at 10:02 a.m., in room 106, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

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

Also present: Senator McCain.

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

Chairman SANDERS. Thank you all for coming, and I want to thank our panelists for what is going to be a very important hearing.

The format will be that I will make some opening remarks. Senator Burr, the Ranking Member, will make some opening remarks. Members will each have 3 minutes—and I will keep people to 3 minutes because it is going to be a long hearing. We are then going to hear from Secretary Shinseki and Under Secretary Petzel. Afterward, we have an excellent second panel made up of service organizations. We look forward to hearing from them. We have a very good third panel, as well. So, it is going to be a long hearing.

Let me begin by just making a few basic points. Very serious allegations have been made about VA personnel and their doings in Phoenix and in other locations. I take these allegations very seriously, as I know every Member of this Committee does, which is why I have supported an independent investigation by the VA Inspector General.

As we speak right now, the Inspector General's Office is in Phoenix doing a thorough examination of the allegations, and my hope is that their report to us will be done as soon as possible. And what I have stated and repeat right now is that as soon as that report is done, this Committee will hold hearings to see what we learn from that report and how we move forward, as soon as we possibly can after their investigation is completed.

I think there is no Member of this Committee who disagrees, nor anybody in the United States, that this country has a moral obligation to provide the best quality care possible to those who have put their lives on the line to defend this Nation. And I believe every Member of this Committee will do everything we can to get to the truth of these allegations.

But if we are going to do our job in a proper and responsible way, we need to get the facts and not rush to judgment. And one of the concerns that I have, to be very honest, is there has been a little bit of a rush to judgment. What happened in Phoenix? Well, the truth is, we do not know, but we are going to find out.

Now, let me say a word about VA health care in general, which is what this hearing is about. What we want to know about VA health care is what is going well and what is not going well, and in terms of what is not going well, how do we improve that.

Today, we must understand that when we talk about VA health care, we are talking about the largest integrated health care system in the United States of America. VA has 150 medical centers, has over 800 community-based outreach clinics, and some 300 Vet Centers. Every year, the VA is serving 6.5 million veterans. Today, tomorrow, and next week. VA serves more than 200,000 veterans every single day.

Now, what does that mean? And here is my point. If Senator Burr and I were to run around the country and visit every VA medical center, this is, I suspect, what we would find; we would find people coming out and saying, "I got pretty good health care. I like my doctor. I was treated courteously." And then we would find people who say, "You know what? I had a bad experience. I did not like my doctor."

The point I want to make is that when you are dealing with 200,000 people, if you did better than any other health institution in the world, there would be thousands of people every single day who would say, "I do not like what I am getting," and we have to put all of that in the context of the size of VA.

Does VA, in general, provide good quality care to veterans? It is a simple question. The answer is that some people think that it provides a very good quality care. The American Customer Satisfaction Index ranks VA's customer satisfaction among veteran patients amongst the best in the country. And if you go out and you talk to veterans, generally speaking—I will tell you in Vermont—not 100 percent, but people say, yes, we get pretty good health care, not perfect. Are there problems? Absolutely, and we are going to talk about those problems.

The National Commander of the Disabled American Veterans—these are folks who are dealing with people who have service-connected injuries, people who were hurt in war—said this before the Committee in February, "Across the Nation, VA is a model health care provider that has led the way in various areas of biomedical research, specialized services, graduate medical education and training for all health professions, and the use of technology to improve health care." DAV went on to say, "Such quality and expertise on veteran-specific health needs cannot be adequately replicated in the private sector."

The Paralyzed Veterans of America today will testify, "The simple truth is, the VA is the best health care provider for veterans. In fact, VA's specialized services are incomparable resources that often cannot be duplicated in the private sector."

Today, the President of the National Association of State Directors of Veterans Affairs, representing all 50 States, will tell us, "The state of VA health care in our Nation is strong."

Further—and here is another point that has to be made, and I know that it does not fit within a 12-second sound bite, but this is a point that has to be made—there is no question in my mind that VA health care has problems, serious problems. But, it is not the case that the rest of health care in America is just wonderful. Everybody who walks in, gets immediate care, gets great care at no cost, which is all affordable. That is not the world we live in. Let me give you one example of that, because it is important to put VA health care in context.

A *Scientific American* article from September 20, 2013, less than a year ago, states, "How many die from medical mistakes in U.S. hospitals? An updated estimate says it could be at least 210,000 patients a year, more than twice the number in a frequently quoted Institute of Medicine report." It goes on to summize that medical errors are now the third-leading cause of death in America, behind cancer and heart disease.

What does that mean? Have deaths been reported through medical errors in the VA? The answer is, yes, and every one of those deaths is a shame and something we have got to address, but it is not just the VA. The third leading cause of death in America are medical errors in hospitals. That is an issue we have to address.

Now, having said all of that, trying to put this debate in context, there is no doubt in my mind that there are serious problems facing VA health care and we have got to do everything we can to address those problems. Let me just discuss a few.

Does the VA have adequate staffing? When we talk about patient wait times, which is a major concern in certain parts of the country—and this issue just came up the other day in Phoenix, where a town meeting was held by the American Legion—the issue of wait times came up. Is the VA adequately staffed? Do we have enough doctors and nurses in various parts of the country? I do not know the answer to that, but that is something I want to find out.

Further, is VA doing a good job in allocating its resources to where the staffing is needed most? There are some places in the United States where VA's load is going down, fewer people are coming in, other places where it is increasing. Are we allocating resources appropriately? And let us remember that in the midst of all of that, we are dealing with 200,000 men and women who have come back from Iraq and Afghanistan with PTSD and TBI, not easy problems to address.

A few years ago VA changed their wait time measure to an ambitious 14 days. If you call up, you are going to get seen in 14 days. Was that appropriate? Can they accommodate that with the level of staffing that they have? We need to discuss that. And, what happens at those facilities that are unable, in fact, to bring patients in within the 14-day period? Is it possible that, in some cases, unrealistic expectations have created a situation where some staff is, in fact, cooking the books? I want to look at that.

So, I look forward to this hearing to get at the root of some of the health care problems facing VA, and with that, I want to give the microphone to Ranking Member Senator Burr.

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

Senator BURR. Thank you, Mr. Chairman. Thank you for calling this hearing.

Secretary Shinseki, welcome, and to all the other witnesses today, thank you for your willingness to be here with us.

The issue before the Committee today is the state of the VA health care system, which we have a sacred obligation to ensure that those who have fought for this Nation receive the highest quality of services from the Department of Veterans Affairs.

Now, in the Chairman's opening remarks, he was correct. We are not here to analyze a poll that was taken about VA. But, we are here, rather, to look at the investigations that have already taken place and addressed certain deficiencies within the Veterans system that no action was taken on, or at least not corrective action.

In fiscal year 2013, VA reported 93 percent of specialty and primary care appointments and 95 percent of mental health appointments were made within the 14 days of the patient's or provider's desired date. At first glance, these numbers appear to demonstrate veterans are receiving the care they want when they want it. However, we know this is not the case. I think if VA had asked hard questions regarding these statistics, we would not be here today discussing recent allegations surrounding many—and I stress, many—VA facilities.

More specifically, we are here to discuss today when senior leadership in the Department became aware local VA employees were manipulating wait times to show that veterans do not wait at all for care. It seems that every day, there are new allegations regarding inappropriate scheduling practices, ranging from zeroing out patient wait times to scheduling patients in clinics that do not even exist, and even to booking multiple patients for a single appointment. The recent allegations were not only reported by the media, but have even been substantiated by the Government Accountability Office, the Inspector General's Office, and the Office of Medical Inspector.

Here are a few examples. The GAO released a report on the reliability of reported outpatient medical appointment wait times and scheduling oversight in December 2012 and has testified multiple times on this issue. Several IG reports have been issued regarding delays in care and scheduling irregularities, including reports on Temple, Texas, in January 2012, and up to the most recent and egregious report in September 2013 at the Columbia VA medical center. Two publicly released Office of Medical Inspector reports related to whistleblower allegations at Jackson VA medical center and the Fort Collins community-based outpatient clinics.

Even more troubling is that with the numerous GAO, IG, and Office of Medical Inspector Reports that have been released, VA senior leadership, including the Secretary, should have been aware that VA was facing a national scheduling crisis. VA's leadership has either failed to connect the dots or failed to address this ongoing crisis, which has resulted in disability harm and in-patient death.

The question we must answer today is, even with all the information available to the Secretary starting over a year and a half

ago and specific instances of patient harm and death directly related to delays in care, why were the national audits and statements of concern from the VA only made this month?

I thank the Chair. I yield back.

[The prepared statement of Senator Burr follows:]

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

Good morning, Mr. Chairman. I would like to welcome all of today's witnesses and thank you for being here. The issue before the Committee today is the state of the VA healthcare system. We have a sacred obligation to ensure those who have fought for this Nation receive the highest quality of services from the Department of Veterans Affairs.

In fiscal year 2013, for established patients, VA reported that 93 percent of specialty and primary care appointments and 95 percent of mental health appointments were made within 14 days of the patient's or provider's desired date. At first glance, these numbers appear to demonstrate that veterans are receiving the care they want and when they want it. However, we know this is not the case. I think, if VA had asked hard questions regarding these statistics, we would not be here today discussing recent allegations surrounding many VA facilities.

More specifically, we are here to discuss when senior leadership in the Department became aware that local VA employees were manipulating wait times to show that veterans do not wait at all for care. It seems that every day there are new allegations regarding inappropriate scheduling practices ranging from "zeroing out" patient wait times, to scheduling patients in clinics that do not even exist, and even to booking multiple patients for a single appointment.

The recent allegations were not only reported by the media, but in some cases have even been substantiated by the GAO, IG, and the Office of the Medical Inspector. Here are a few examples:

- The GAO released a report on the reliability of reported outpatient medical appointment wait times and scheduling oversight in December 2012 and has testified multiple times on this issue.
- Several IG reports have been issued regarding delays in care and scheduling irregularities, including reports on Temple, TX, in January 2012, and up to the most recent and egregious report in September 2013 at the Columbia VA medical center.
- Two publicly released Office of the Medical Inspector reports related to whistleblowers' allegations at the Jackson VA medical center and the Fort Collins Community Based Outpatient Clinic.

Even more troubling is that, with the numerous GAO, IG, and Office of the Medical Inspector reports that have been released, VA senior leadership, including the Secretary, should have been aware that VA was facing a national scheduling crisis. VA's leadership has either failed to connect the dots or failed to address this ongoing crisis, which has resulted in patient harm and even death.

The question we must answer today is, even with all of the information available to the Secretary, starting over a year and a half ago, and specific instances of patient harm and death directly related to delays in care, why were the national audits and statements of concern from VA only made this month?

I thank the Chair, and I yield back.

Chairman SANDERS. Thank you, Senator Burr.

Senator Murray.

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

Senator MURRAY. Well, thank you very much, Mr. Chairman. I am really glad you called this hearing.

Like most Americans, I believe that when it comes to caring for our Nation's heroes, we cannot accept anything less than excellence. The government made a promise to the men and women who answered the call of duty, and one of the most important ways we uphold that is by making sure our veterans can access the health care they need and deserve.

So, while the Department generally offers very high quality health care and does many things as well as or better than the private sector, I am very frustrated to be here once again talking about some deeply disturbing issues and allegations. It is extremely disappointing that the Department has repeatedly failed to address wait times for health care.

So, I was encouraged when you announced a nationwide review of access to care and I am pleased the President is sending one of his key advisors, Rob Nabors, to assist in overseeing and evaluating that review. His perspective from outside the Department will make this review more credible and more effective.

But, announcing this review is just the first step. These recent allegations are not new issues. They are deep, systemwide problems and they grow more concerning every day. When the Inspector General's report is issued and when the access report is given, I expect the Department to take them very seriously and to take all appropriate steps to implement their recommendations.

But, there are also cases where the facts are in right now. There are problems we know exist, and there is no reason for the Department to wait until the Phoenix report comes back before acting on the larger problem.

The GAO reported on VA's failures with wait times at least as far back as the year 2000. Last Congress, we did a great deal of work around wait times, particularly for mental health care. The Inspector General looked at these problems in 2005, 2007, and again in 2012. Each time, they found schedulers across the country were not following VA policy. They also found in 2012 that VA has no reliable or accurate way of knowing if they are providing timely access to mental health care.

But now, the IG recommendations are still open and the Department still has not implemented legislation I authored to improve this situation. Clearly, this problem has gone on far too long. It is unfortunate that these leadership failures have dramatically shaken many veterans' confidence in this system.

Secretary Shinseki, I continue to believe you take this seriously and want to do the right thing, but we have come to the point where we need more than good intentions. What we need now is decisive action to restore veterans' confidence in VA, to create a culture of transparency and accountability, and to change the systemwide years' long problems. This needs to be a wake-up call for the Department.

The lack of transparency and the lack of accountability is inexcusable and cannot continue. The practices of intimidation and cover-ups have to change, starting today. Giving bonuses to hospital directors for running a system that places priority on gaming the system and keeping their numbers down rather than providing care to veterans has to come to an end.

But, Mr. Secretary, it cannot end with just dealing with a few bad actors or putting a handful of your employees on leave. It has to go much further and lead to systemwide change. You must lead the Department to a place where we prioritize the care our veterans receive above everything else. The culture at VA must allow people to admit where there are problems and ask for help from

the hospital leadership, from the VISN leadership, or from you. This is the time to make real changes.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Murray.

Senator Isakson.

Senator ISAKSON. Well, thank you for calling the hearing, Mr. Chairman.

Mr. Chairman, I would like to ask unanimous consent that the complete statement of Senator John Boozman be entered for the record.

Chairman SANDERS. Without objection.

[The prepared statement of Senator Boozman appears in the Appendix.]

Senator ISAKSON. And, also, our best wishes from the Committee for his speedy recovery from heart surgery.

Chairman SANDERS. Absolutely.

Senator BURR. Mr. Chairman, could I ask unanimous consent that all Members' opening statements be included in the record.

Chairman SANDERS. Of course.

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Dr. Petzel, Secretary Shinseki, thank you for being here today.

The Chairman has said we should not rush to judgment, and that is always true, but we should have a rush to accountability. Even before Phoenix, even before Durham, even before some of the others—Cheyenne, Fort Collins, the others that have come to matter—we have already known and VA has admitted to at least 23 deaths that took place, in part because of delays in GI consults. Seven of those were in my area, two in North Florida, three in Augusta, GA, four in Atlanta, GA, at the VA Hospital in Atlanta, GA, all mental health issues.

Dr. Petzel was in my State on August 22 of last year for a two-and-one-half hour hearing on the Atlanta situation, and we knew and determined then that it was problems with delays in setting appointments for mental health patients that caused an open period of time where, in fact, they took their life because of a failure to get the services they should have gotten.

So, while we need to complete the IG's report and find out every problem where things are wrong, we have had 50 IG reports since 2013, and in those reports, we have found repeatedly, over and over again, where there has been a gaming of the system, where the system is more important than the patient. I think our veterans, and I think you, Secretary Shinseki, deserve better from the members of the Veterans Administration and the VA health system.

I told you yesterday on the phone when you were generous enough to call and have a long discussion, I think the veterans and yourself have been misserved by the senior management of VA. We need accountability. What is going on in VA is not a mystery anymore. We will find out more from the IG's report. But, I would hope we would get an accountability in the chain of command at VA likened to the accountability of the chain of command in the U.S. Air

Force when I was in the service, where you are held accountability for your responsibility, mistakes are not tolerated—one mistake might be tolerated, but the second mistake on the same decision should never be tolerated.

I thank you for being here today. On behalf of all the veterans in Georgia and in the United States of America, let us get this right. Let us hold the system accountable. Let us make sure no veteran dies because of a failure of the system; and see to it they get appointments for the care they need when they need it.

I yield back.

Chairman SANDERS. Thank you, Senator Isakson.

Senator Blumenthal.

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

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you very, very much for holding this hearing, which I hope and believe will be bipartisan and as non-political as it possibly can be.

Let me thank you, Secretary Shinseki, for your service to our Nation. Over many years, you have served and sacrificed for this Nation and I deeply respect and thank you for all you have given to the United States of America, including your 6 years as Secretary of VA. I know you are determined, as the President is determined, to unravel and reveal any wrongdoing, to remedy any damage, and to restore trust and confidence in VA's Health Care System.

I agree with the Chairman that we should avoid a rush to judgment. But, we have more than allegations at this point. We have evidence, solid evidence of wrongdoing within the VA system, and it is more than an isolated instance of wrongdoing. It is a pattern and practice, apparently, of manipulating lists and gaming the system, in effect, cooking the books, creating false records, which is not just an impropriety or misconduct, it is potentially a criminal act. And it is a pattern, as the chart submitted by the American Legion as Addendum C shows. There is a pattern across the country, in more than ten States, of this misconduct occurring. In addition, there is a history. The GAO has reported and your own Inspector General has reported these kinds of problems in the past.

So, there is a need now for more than just an investigation. There is a need for action to restore trust and confidence, to assure accountability and transparency. Our Nation's veterans deserve the best medical care, nothing less. The situation now presenting serious, pressing, unanswered allegations and uncertainty is intolerable.

I have very severe and grave doubts that the resources now at the disposal of the Inspector General are sufficient to meet this challenge. I think there is a need for more than just the kind of appointment the President has made of Rob Nabors to oversee the Department of Veterans Affair's investigation. There is a need for resources going to the Inspector General and possibly involvement of other investigative agencies from the Federal Government, because the resources currently available to the Inspector General simply may be insufficient.

In addition, there are 3,000 job openings across the country in VA. They are listed on USAJobs.gov. I urge that positions relevant

to access to medical care be filled immediately and action be taken to restore not only the transparency and accountability we all expect from VA, but also to deal with the disability claims backlogs that continue to plague VA.

The question now is, what does the evidence show? Is it criminal or simply civil? And that judgment has to be made as soon as possible.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Blumenthal.

Senator Heller.

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

Senator HELLER. Thank you, Mr. Chairman and Ranking Member Burr, for holding this hearing today.

I want to thank the Secretary and Dr. Petzel for also being here. The other witnesses, thank you for taking time to be with us today. And also for the veterans that are in the room with us today, those that may be watching this hearing, thank you very much for your service.

What has come to light about VA in recent months has proven to Congress, to veterans, and to the American people that there is a real problem with accountability at all levels within the Veterans Administration. Poor management and care from VA is also a problem that Nevada veterans are facing, and it is not something that is new, and, in fact, it is something I have raised repeatedly with VA to no avail. I believe it is long overdue for this Committee to exert its oversight and hold leadership within VA accountable.

Just last week I sent a letter to Secretary Shinseki asking for immediate answers about the lack of accountability on the local level and whether VA leadership finally plans to do something about it. I look forward to receiving a timely response and action on the concerns that I highlighted.

As Nevada's representative on this Committee, I believe it is also my role and responsibility to get answers for Nevada's veterans about the problems they are facing with VA care and benefits. In Las Vegas, veterans have complained of excessive wait times in the emergency room, which in itself is too small to meet demand. Just a month ago, the VA Inspector General investigated VA's treatment of a blind female veteran who waited over 5 hours in the emergency room and 2 weeks later died. The IG also found a quarter of the veterans in the emergency room wait over 6 hours before receiving care. Furthermore, a Las Vegas veteran wrote me a letter recently and said he had to find care elsewhere because the wait time for an appointment at VA was longer than 2 months.

Given these concerns, as VA completes its face-to-face audits of VA facilities, I want assurance that all of Nevada's VA medical centers and clinics will be thoroughly audited and I will receive and be able to review the results immediately.

As the Co-Chair of VA's Backlog Working Group, I am also extremely concerned with the claims backlog in Nevada. Although the Secretary promised me there would be changes, Nevada veterans are still waiting the longest, at 355 days, on average, for their claims to be processed. When my office requests the status of vet-

erans' claims, the Reno VARO is unresponsive. It is unacceptable that local VA officials would limit any Congressional office's ability to get answers for their veterans constituents. Despite my repeated requests, these ongoing issues have not been resolved.

At some point, I have to ask if these problems in Nevada are the demonstration of failed leadership at the top. VA leadership is not holding local officials accountable and is failing to care for those who sacrificed on our behalf. Promises to change and do better for our veterans have not produced results. I want changes. I do not want empty promises. If VA continues on this course, I think it is ultimately time to look to the top for these changes.

Thank you, Mr. Chairman.

Chairman SANDERS. Well, thank you, Senator Heller.

Senator Hirono.

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

Senator HIRONO. Thank you, Chairman Sanders, for providing this forum for us to drill down to the roots of the many issues facing veterans hospitals and finding solutions to these problems.

I certainly echo the sentiments of my colleagues in expressing concerns regarding VA culture, the lack of enough accountability, the probable need for structural and systemwide changes.

The Veterans Health Care System is a promise we made to America's veterans—that we will take care of them in return for their service and sacrifice. The close to ten million veterans that access care through VA's system need to trust that they are receiving high-quality care when they need it. And I do note, ten million veterans signed up for this health care system is huge. That is greater than the population of a number of States, including the State of Hawaii.

When we fail to provide proper care for our veterans, we not only fail them, but their families, as well, which these families have also sacrificed for our Nation's security and provide essential care and support for our veterans.

While the immediate focus may be on the Phoenix case and similar allegations regarding a number of other VA hospitals, it is important to see what is happening systematically at VA to provide veterans high-quality care, and so we must look at the totality of the VA system to see what is working and what is not. I look forward to hearing from the panel about exactly what the challenges and problems are, what actions have been taken and need to be taken to serve our veterans better.

And while the VA Inspector General is investigating and Secretary Shinseki has called for a national face-to-face audit of the VA Health System, my hope is that this is the first of a number of hearings by this Committee to identify other changes that should be implemented. I look forward to hearing from you once again, Mr. Secretary and the other VA officials, on your plans to resolve the underlying issues and restore confidence in the veteran community, and, very importantly, to listen to what the veterans' community has to say about the changes that need to be made.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Hirono.

Senator Moran.

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

Senator MORAN. Mr. Chairman, thank you and Senator Burr for conducting this hearing.

Mr. Secretary, good morning.

I arrived a few minutes late this morning because I just returned from the World War II Memorial, where I visited with a Kansas Honor Flight group. I had conversations with Kansas veterans again this morning. It is a moving experience each and every time I have the opportunity to visit with our World War II veterans, and again, the conversation was about, "VA is failing them. Please make certain, Senator Moran, that that does not continue."

Thousands of veterans across the country, but hundreds of veterans in Kansas visit with me on an ongoing basis and they tell me their struggling and suffering stories because of circumstances they find at the Department of Veterans Affairs. They would tell me about the sacrifice they encountered—if they were willing to say this less than humble sentence, they would ask, why can we not have the services we earned and deserve? And the reality is, they earned and deserve that service, and in my view, the Department of Veterans Affairs is not providing those worthy veterans what we have committed to do.

The sad story is many veterans across the country, and certainly those Kansans that I speak to, have lost hope in the Department of Veterans Affairs and just believe things are never going to get any better.

Your announcement of a face-to-face review across the system, Mr. Secretary, I find lacking in what needs to be done. The reality is we have had review after review, Inspector General report after Inspector General report, questions by this Committee and the House Veterans' Affairs Committee, that, as far as I can tell, has resulted in no action by the Department of Veterans Affairs.

The idea that you can conduct a systemwide—as you indicate in your opening testimony—review of VA using 220 VA employees and visiting 153 medical facilities, Mr. Secretary—we have 1,700 VA points of access to care, and you indicate in your testimony this will provide a full understanding of VA's scheduling policy and continued integrity in managing patient access to care. I do not see a review that lasts 2 weeks using 220 employees and looking at 153 medical facilities as capable of providing that information. So, I would suggest this seems to me to be more damage control than solving the problem.

I actually think we do not have the need for more information, although it is always welcome. What we need is action based upon the information that has already been provided to the Department of Veterans Affairs. I have served 18 years on the Veterans' Affairs Committee. I have worked with nine Secretaries of Veterans Affairs. And what is seemingly true to me today is the quality of service and the timeliness of that service is diminishing, not increasing, and that was not true until recently.

We have a significant number of veterans that we serve today, but, Mr. Secretary, we can anticipate more as our military men and

women retire from service in Afghanistan and Iraq. We have an aging World War II veteran population. If we cannot care for the veterans we are trying to care for today, how do we expect the Department of Veterans Affairs to care for those as the numbers and seriousness of their condition increase?

So, Mr. Secretary, I look forward to hearing what you have to say today. I welcome that conversation. But, in my view, an additional review by your Department is not the answer. The answer is action by the Department of Veterans Affairs that changes the system you are leading and that changes the culture and nature of the folks that are your employees.

I look forward to your testimony. I look forward to making certain we keep our commitment to those who served our country.

Thank you.

Chairman SANDERS. Thank you, Senator Moran.

Senator Begich.

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

Senator BEGICH. Thank you very much, Mr. Chairman, for holding this meeting, and Ranking Member Burr, for offering an opportunity to have this discussion and oversight of VA and the issues surrounding scheduling, but also many other issues VA faces.

Let me first say to our two panelists, thank you for your service to this country in both the ways that you have done.

But, Secretary Shinseki, immediately after the Phoenix story broke, I sent a letter very quickly, because I was outraged. It was unbelievable what I was hearing. But after a few weeks, it has now become a systemic issue that I am now seeing in others, as you have indicated through the conversations that I have had with you, it seems to be an issue that is occurring in other VA clinics.

I will say, from a State that has 77,000 veterans, the highest per capita in the Nation, it is impactful in determining where they get their care. We have been fortunate, to be very frank with you. The work we have done with VA to be able to create access to Indian Health Care Services which has been able to cut some of that wait time and get better services throughout the State. But when we look at veterans, may they be in Alaska today, tomorrow, they might be in Arizona. Tomorrow, they might be in North Carolina. So, it is critical that we figure out the systematic problem.

I do agree with my colleagues here that we have report after report after report. I have been here now a little over 5 years, and all I have seen is GAO reports and other reports that always indicate systematic problems we need to correct. So, I am going to be anxious for your commentary, as well as others, on how we are going to fix this once and for all.

I know you have been burdened in some cases because we have had two wars and VA started to be funded aggressively in the last 3 or 4 years after we have already started to wind down in Iraq and now Afghanistan, which had caused a lot of pressure. So, I need to understand how that has impacted some of the work of VA.

Also, as you look at the issues and you examine what we need to be doing, I want to know from your perspective, what things are we doing through more regulation or more laws that are creating

more hurdles and red tape. If there is stuff that we should be eliminating to create a more streamlined process, I want to know that.

But, to not have the service delivered at the highest level to our veterans is a disservice. They earned it. They fought for this country. They served our country. And we need to do everything we can to make sure the service is delivered at the highest possible level.

So, today will be a little contentious, no question about it. I hope tomorrow, we take what we have learned today and move toward increased capacity and performance of VA.

I thank you both for being here, but I will tell you, I was outraged and it is unbelievable what I have now seen over the last few weeks. Yet, I am anxious to work with you to get our veterans the best care possible, as we have started to do aggressively in Alaska. We have a very unique arrangement between Indian Health Care Services and VA, which I think is delivering better care than ever before; but more work is to be done.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Begich.

Senator Tester.

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

Senator TESTER. Yes, thank you, Mr. Chairman, and Ranking Member Burr for convening this hearing. I want to thank the witnesses for being here—this panel and the next two.

You know, as an elected official, the most meaningful and most difficult decision I confront is the question of sending men and women into harm's way, and Montanans tend to enlist in high numbers. We have the second highest per capita of veterans in our State. It is a very personal issue for me and it is why I am very proud to serve on this Committee.

I am encouraged that folks in Washington are suddenly interested in access to health care for veterans. In most cases, that is long overdue. Before I got here, VA did not even have mandatory funding. They certainly did not have forward funding. So, this is a topic many of us have been trying to address for years.

Given my close association with veterans issues, I am approached by veterans every time I go home, which is almost every weekend, and an overwhelming majority of those folks are appreciative of the care from VA in Montana. Yet when they have issues or concerns, they are not bashful, as veterans are not, about telling me about them. When I get back to my office on Monday, I work on those concerns, often with you two.

The allegations they hear and the allegations I am hearing now are very troubling. If any of these allegations in Phoenix or elsewhere turn out to be true, swift and appropriate action needs to happen. If the issues are systemic, we need to make some fundamental changes and we need to make them now. If the issues are about employees' misconduct and incompetence, specific heads should roll.

Now, in order to move forward effectively and smartly, we do need the facts. I hope we get those today, in part. And, if we are truly interested in honoring our veterans by doing them right, the

facts will drive a productive conversation about access to health care for our veterans.

So, let us talk about ways we can address VA medical workforce shortfalls, particularly in rural areas. Let us talk about ways we can improve transportation options for veterans or expanding telemedicine initiatives. Let us talk about buildings and partnerships between VA's local providers and providing VA with the resources it needs to address its patient workloads. Let us have these conversations so we can provide veterans with meaningful action items, not just political talking points.

Veterans deserve our best. They have sacrificed much. Let us demonstrate our best by having a productive, constructive, truthful conversation about what needs to be done to fix the problems out there in our VA.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Tester.

Senator McCain of Arizona is not a Member of this Committee, but given that very serious allegations have been raised about treatment in Phoenix, Senator McCain requested to come before the Committee and we welcome him today. Senator.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA

Senator MCCAIN. I thank you, Mr. Chairman. I want to thank you for the opportunity to make a brief statement this morning, particularly given that many of the serious allegations that will be discussed at today's hearing involve the treatment of veterans in my homestate of Arizona.

Since our Nation's founding, Americans have been fighting in far away places to make this dangerous world safer for the rest of us. They have been brave. They have sacrificed and suffered. They bear wounds from war losses they will never completely recover from and we can never fully compensate them for. But, we can care for the injuries they suffered on our behalf and for their physical and emotional recovery from the battles they fought to protect us.

Decent care for our veterans is the most solemn obligation a nation occurs, and we will be judged by God and history how well we discharge ours.

That is why I am deeply troubled by the recent allegations of gross mismanagement, fraud, and neglect at a growing number of VA medical centers across the country. It has been more than a month since allegations that some 40 veterans died while waiting for care at the Phoenix VA were first made public. To date, the Obama administration has failed to respond in an effective manner. This has created in our veterans' community a crisis of confidence toward VA, the very agency that was established to care for them.

At a town hall forum I hosted in Phoenix last week, the families of four veterans who passed away in recent months stood before a crowded room to tell their stories. With tears in their eyes, they described how their loved ones suffered because they were not provided the care they needed and deserved. They recalled countless unanswered phone calls and ignored messages, endless wait times,

mountains of bureaucratic red tape, while their loved ones suffered debilitating and ultimately fatal conditions.

No one should be treated this way in a country as great as ours. But, treating those to whom we owe the most so callously, so ungratefully, is unconscionable. We should all be ashamed.

Since the initial reports in Arizona last month, we have seen this scandal go nationwide, surfacing in at least ten States across America. Secretary Shinseki has ordered a nationwide audit to look at the management practices at VA medical centers. Several employees have been placed on administrative leave. And, the VA Office of Inspector General is investigating the Phoenix VA.

I respect the important role of the Inspector General, but my fellow veterans cannot wait the many months it may take it to complete its report. They need answers, accountability, and leadership from this administration and Congress now.

Clearly, VA is suffering from systemic problems in its culture that require strong reform-minded leadership and accountability to address. At the same time, Congress must provide VA administrators with greater abilities to hire and fire those charged with caring for our veterans. Most importantly, we must give veterans greater flexibility in how they get quality care in a timely manner rather than continue to rely on a Department that appears riddled with systemic problems in delivering care.

How we care for those who risked everything for us is the most important test of a Nation's character. Today, we are failing that test. We must do better tomorrow, much better.

For the nine million American veterans enrolled in VA today and for the families whose tragic stories we heard last week in Phoenix, who I know are still grieving their losses, it is time we live up to President Lincoln's injunction, which serves as VA's model today—to care for him who shall have borne the battle and for his widow and his orphan.

As I said, it is time for answers, accountability, and leadership from this administration, and I look forward to hearing from Secretary Shinseki.

I thank you, Mr. Chairman, and I thank Ranking Member Burr and the Members of this Committee.

[The prepared statement of Senator McCain follows:]

PREPARED STATEMENT OF HON. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA

Thank you, Mr. Chairman. I want to thank you for the opportunity to make a brief statement this morning, particularly given that many of the serious allegations that will be discussed at today's hearing involve the treatment of veterans in my home state of Arizona.

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That is why I am so deeply troubled by the recent allegations of gross mismanagement, fraud and neglect at a growing number of Veterans Administration medical centers across the country.

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ministration has failed to respond in an effective manner. This has created in our veterans' community a crisis of confidence toward the VA—the very agency that was established to care for them.

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As I said before, it's time for answers, accountability and leadership from this Administration, and I look forward to hearing from Secretary Shinseki. I thank Chairman Sanders, Ranking Member Burr, and the Members of the Committee.

Chairman SANDERS. Thank you, Senator McCain.

I would like to now welcome Retired U.S. Army General Eric K. Shinseki, Secretary of Veterans Affairs, to the first panel. As I think most people know, Secretary Shinseki is a graduate of West Point, served as the Chief of Staff for the Army from 1999 to 2003. He retired from active duty in 2003, after nearly 40 years in the U.S. Army.

Following the September 11, 2001, terrorist attacks against our country, Secretary Shinseki led the Army during Operations Enduring Freedom and Iraqi Freedom. He previously served simultaneously as Commanding General, U.S. Army Europe, and Seventh Army Commanding General, NATO Land Forces, Central Europe, and Commander of the NATO-led Stabilization Force, Bosnia-Herzegovina.

I want to also note a few of the many awards Secretary Shinseki received during his career: The Defense Distinguished Service Medal, the Legion of Merit with Oak Leaf Clusters, the Bronze Star Medal with "V" Device with two Oak Leaf Clusters, and the Purple Heart with Oak Leaf Clusters.

Mr. Secretary, thank you very much for being with us today.

Secretary Shinseki is accompanied by Dr. Robert Petzel, who is the Under Secretary for Health.

Mr. Secretary, your prepared remarks will be submitted for the record. What I would like to do now is, if both of you could rise and take the oath.

Do you solemnly swear or affirm that the testimony you are about to give before the Senate Committee on Veterans' Affairs will be the truth, the whole truth, and nothing but the truth, so help you God?

Secretary SHINSEKI. I do.

Dr. PETZEL. I do.

Chairman SANDERS. Thank you very much. Please be seated.

Mr. Secretary and Dr. Petzel, the floor is yours.

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH

Secretary SHINSEKI. Chairman Sanders, thank you very much for that more than generous introduction. To you and Ranking Member Burr and the Members of this Committee, thank you for this opportunity to discuss the state of VA health care.

I have been taking oaths most of my life, Mr. Chairman, so I—whenever I appear before this Committee, whether I am sworn or not, you have my best answers based on what I know, as truthful a presentation as I can make.

I deeply appreciate your unwavering support for our Nation's veterans. That has been true for 5 years, now, that I have worked with Members of this Committee.

Mr. Chairman, I would also like to recognize that in the room here are others with whom I have worked very closely for 5 years developing good dialog, good collaboration. They have been very helpful in shaping what we thought was the priority in the Department of Veterans Affairs, and they have been good strong relationships, and I thank them for their partnership. I know some of them will be testifying before you today. In those cases where we have not always seen eye to eye, we have always managed to find common ground on behalf of veterans, and I expect we will do that again.

We at VA are committed to consistently providing our veterans the high-quality care, timely benefits, and safe facilities necessary to improve their health and well being. This commitment mandates a continuous effort to improve quality and safety. America's veterans deserve nothing less. Our quality and safety meet high standards and veterans should feel safe using VA health care.

That said, in health care, Mr. Chairman, as you point out, there are always areas in need of improvement. Any allegation about patient care or employee misconduct are taken seriously.

And, based on the background you just described that I followed most of my life—38 years in uniform—and I now have this great privilege of being able to care for people I went to war with many years ago people I have sent to war, and people who raised me in the profession when I was a youngster.

Any allegation, any adverse incident like this makes me—makes me mad as hell. I could use stronger language here, Mr. Chairman, but in deference to the Committee, I will not. But, at the same time it also saddens me, because I understand that out of those adverse

events a veteran and a veteran's family is dealing with—the aftermath—and I always try to put myself in their shoes.

In response to allegations about manipulation of appointment scheduling at Phoenix, I am committed to taking all actions necessary to identify exactly what the issues are, to fix them, and to strengthen veterans' trust in VA health care.

First, the Office of the Inspector General, as many of you have pointed out, is now conducting a thorough and timely review. If any of these allegations are true with regard to scheduling at Phoenix and elsewhere, where we have invited the IG to come and look at issues that surfaced—if any allegations are true they are completely unacceptable to me, to veterans. And I will tell you, the vast majority of dedicated VHA employees come to work every day to do their best by those veterans. If any are substantiated by the Inspector General, we will act. And I take Senator Murray's encouragement here to do something different, and Senator, I will. It is important, however, to allow the Inspector General to complete his duty, which is to conduct an objective review and provide us the results.

Second, I have directed VHA, as some of you have noted, to complete a nationwide access review of all other health care facilities to ensure full compliance with our scheduling policy. As we have begun that, we have already received reports where compliance is under question, so we have asked the IG in a number of those cases to also take a look.

Third, I have asked for and received the assistance from President Obama. The President has agreed to let his Deputy Chief of Staff for Policy, Rob Nabors, assist us in our review of these allegations and in any other issues we may find during these reviews. We start with scheduling, but we will go wherever the reviews take us.

Rob is a fresh set of eyes. He is the son of a veteran and he is a proven performer who brings broad and significant management experience to this task. I welcome his assistance. I have known the Nabors family for a long time. Rob's dad and I served together for many years; I know his mom and dad well, and I welcome the assistance of Rob Nabors.

Even as we take these proactive measures, it is important to remember that VHA conducted approximately 85 million outpatient clinic appointments last year. As a large integrated health care system, VHA operates, as has been noted, over 1,700 points of care, including 150 medical centers, 820 community-based outpatient clinics, 300 Vet Centers, 135 community living centers, 104 domiciliary rehabilitation treatment programs, and 70 mobile Vet Centers attempting to reach the most remote of our veterans. This is a demonstration of concern by this Department, trying to make sure that every veteran, no matter where they live in this country, and even our overseas locations, have an equal opportunity to have access to quality health care.

As the Chairman has noted, VHA conducts approximately 236,000 appointments every day. Over 300,000 VHA employees provide exceptional care to the 6.5 million veterans and other beneficiaries annually. VA health care is comparable to that in the private sector, meeting or exceeding standards in many areas. We al-

ways endeavor to be fully transparent, fostering a culture that reports and evaluates errors in order to avoid repeating them.

Every VA medical facility is accredited by the Joint Commission, the independent organization that assures the quality of U.S. health care through comprehensive evaluations. In 2012, the Joint Commission recognized 19 VA hospitals as among its top performers and last year that number increased to 32.

Additionally, as the Chairman has pointed out, the most recent American Customer Satisfaction Index ranks VA customer satisfaction among the best in the Nation, equal to or better than the ratings for private sector hospitals. An overwhelming 95–96 percent of veterans who use VA health care today indicated they would use us again the next time they needed inpatient care, 96 percent; and 95 percent for outpatient care. I want them to continue to have that level of trust.

Veterans deserve to have full faith in their VA. VHA is committed to a process of full and open disclosure to veterans and their families whenever any adverse event occurs. We participate in multiple external independent reviews every year to ensure the safety and quality of health care. VA will continue to aggressively develop and sustain reliable systems and train employees to detect and prevent health care incidents before they happen. I have detailed some of our many significant health care accomplishments of VHA over the past 5 years in my written testimony.

I appreciate the hard work and dedication of VA employees, our partners from the veterans service organizations, as I indicated, in this room, community stakeholders, many of whom we deal with on a daily basis, and then our dedicated VA volunteers. I deeply respect the important role that Congress and the Members of this Committee play in serving our veterans, and I look forward to continuing our work with Congress to better serve them all.

Again, Mr. Chairman, thank you for the opportunity to appear here today.

[The prepared statement of Secretary Shinseki follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI, 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) healthcare system. We, at VA, are committed to 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 under our care.

It is important to understand the size and scope of VA care—the largest integrated healthcare delivery system in the United States.

The Veterans Health Administration (VHA) operates over 1,700 points of care, including 150 medical centers, 820 community-based outpatient clinics, 300 Vet Centers, 135 community living centers, 104 domiciliary rehabilitation treatment programs, and 70 mobile Vet Centers. VHA conducts approximately 236,000 health care appointments—each day—and approximately 85 million appointments each year. Over 300,000 VHA leaders and health care employees strive to provide exceptional care to approximately 6.485 million Veterans and other beneficiaries annually.

VA provides safe, effective healthcare, equal to or exceeding the industry standard in many areas. We care deeply for every Veteran we have the privilege to serve. VA is committed to operating with unmatched transparency and fostering an environment that reports and evaluates errors in order to avoid repeating them in the future; one of our most important priorities is to keep our patients safe in our facilities.

That said, there are always areas that need improvement. We can, and we must do better. VA takes any allegations about patient care or employee misconduct very seriously. I am personally angered and saddened by any adverse consequence that a Veteran might experience while in, or as a result of, our care.

In response to allegations about scheduling and delays at the Phoenix VA Health Care System (PVAHCS), I invited an independent investigation by the VA Office of Inspector General (OIG) to conduct a comprehensive, thorough and timely review. If these allegations are true, they are completely unacceptable—to Veterans, to me, and to our dedicated VHA employees. If they are substantiated by OIG, responsible and timely action will be taken.

It is important to allow OIG's independent and objective review to proceed until completion, and OIG has advised VA against providing information that could potentially compromise their ongoing review. However, at the request of OIG, I have placed three PVAHCS employees on administrative leave until further notice, including two senior executives.

We will work with OIG to ensure that the need to keep the public informed is balanced with our obligation to preserve the integrity of an important OIG investigation I have also directed VHA to complete a nationwide access review. The purpose of this review is to ensure a full understanding of VA's scheduling policy and continued integrity in managing patient access to care.

Veterans deserve to have full faith in their VA. Any adverse event for a Veteran within our care is one too many. Where challenges occur, VA takes direct action to review each incident, and puts in place corrections to improve system issues and quality of care provided. We hold employees accountable for any misconduct; we incorporate lessons learned to avoid and mitigate future incidents throughout the entire healthcare system. VHA's first priority is to notify the Veteran or their representative of the adverse event, as well as the patient's rights and recourses.

VHA is committed to a process of full and open disclosure to Veterans and their families. We participate in multiple external, independent reviews every year to ensure safe and quality healthcare. VA will continue to develop and sustain reliable systems and train employees to prevent and detect avoidable harms before they happen. When this does not happen, we act to take necessary corrective actions in order to restore the confidence and trust in the system that serves so many.

QUALITY OF CARE

Every year, our dedicated VA employees, many of whom are Veterans themselves, provide 6.3 million Veterans with the excellent care they have earned and deserve. VA provides a broad range of primary care, specialty care, and related medical and social support services. We have established a record of safe, exceptional care that is consistently recognized by independent reviews, organizations, and experts on key health care quality measures. Every VA medical facility is accredited by The Joint Commission, the independent, non-profit organization that ensures the quality of U.S. healthcare by its intensive evaluation of more than 20,000 healthcare organizations. In 2012, The Joint Commission, recognized 19 VA hospitals as top performers, and that number increased to 32 in 2013.

The American Customer Satisfaction Index (ACSI) is the Nation's only cross-industry measure of customer satisfaction, providing benchmarking between the public and private sectors. In their most recent, independent customer service survey, ACSI ranks VA customer satisfaction among the best in the Nation—equal to or better than ratings for private sector hospitals.

Since 2004, on average, the ACSI survey has consistently shown that Veterans give VA hospitals and clinics a higher customer satisfaction score than patients give private sector hospitals. Veterans strongly endorsed VA healthcare, with 91 percent offering positive assessments of inpatient care and 92 percent for outpatient care.

Additionally, when asked if they would use a VA medical center the next time they need inpatient or outpatient care, Veterans overwhelmingly indicated they would (96 and 95 percent, respectively).

Of our over 300,000 employees in the VA healthcare system, our medical providers and appointment scheduling personnel were considered highly courteous with scores of 92 and 91, respectively, while VA medical providers ranked high in professionalism (90 percent positive). Despite these and other favorable statistics, we know that we can always improve.

IMPROVING AND EXPANDING ACCESS

The number of Veterans receiving VA benefits and services has grown steadily and is projected to continue to rise as ongoing conflicts end and more Servicemembers transition to Veteran status. In 2015, the number of patients treated with-

in VA's healthcare system is projected to reach 6.7 million, an increase of nearly one million patients (17.4 percent) since 2009.

VA continues to improve access to VA services by opening new facilities and points of care, and improving current facilities and points of care closer to where Veterans live. Since January 2009, we have added approximately 55 community-based outpatient clinics (CBOC), for a total of 820 CBOCs, and the number of mobile outpatient clinics and Mobile Vet Centers, serving rural Veterans, has increased by 21, to the current level of 79.

While opening new and improved facilities is essential for VA to provide world-class healthcare to Veterans, so too is enhancing the use of ground breaking new technologies to reach other Veterans. VA continues to invest in "bringing care to the Veteran"—through expanded access to telehealth, sending Mobile Vet Centers to reach Veterans in rural areas, and by deploying social media to share information Veterans on the VA benefits they have earned.

VA is using innovative telehealth primary care services to overcome geographic access barriers and improve the efficiency of care to rural areas. In fiscal year (FY) 2013, VHA provided more than 1.7 million episodes of care to 608,900 Veterans through telehealth services linking 151 VAMCs and 650 CBOCs, as well as by connecting via telehealth with 146,804 Veterans in their own homes, of which 2,284 were via video. The scope of VA's telemental health services includes all mental health conditions with a focus on Post Traumatic Stress Disorder (PTSD), depression, bipolar disorder, behavioral pain, and evidence-based psychotherapy.

VHA is aggressively working to increase Veterans' access to high quality care. While we are progressing in delivering timely care to our Veterans and improving the reliability of reporting wait time information, VA is committed to honoring America's Veterans and there are a number of ongoing and future actions to improve wait times:

- No measure of wait times is perfect. However, with evidence from VHA's 2012 wait time study, ongoing VHA performance measures, as well as findings and recommendations from others, VHA's action plan is designed to ensure the integrity of wait time measurement data collected from our access points of care;
- VHA is constantly evaluating access and scheduling policies and technologies, and aggressively monitors reliability through oversight and audits;
- We have implemented much of this plan, and we are working to implement the remainder of the plan in the next 12 months. VHA has also instituted site visits to audit patient access to care using the electronic wait list.

Today, Veterans experience primary care at VA differently than they did five years ago. VA's Patient Aligned Care Teams (PACT), the model for more personalized and team based primary care delivery, is improving both access to healthcare and Veteran satisfaction. Patients are assigned a PACT team that to help coordinate and personalize their care.

Since its inception in 2010, the PACT program has transformed the way Veterans receive their care by offering a coordinated team approach squarely focused on Veterans' wellness and disease prevention. PACTs provide the right combination of healthcare professionals to develop personalized health plans for Veterans and conveniently deliver care at primary care clinics with a goal of personalized, proactive and patient-driven care. Veterans are also communicating with healthcare professionals through secure electronic means with increasing frequency as services are available. Despite the increase of primary care patients, access to primary care has improved and continuity of care is better. Veteran access to primary care during extended, non-business hours has increased 75 percent since January 2013.

IMPROVING ACCESS TO MENTAL HEALTH SERVICES

After numerous military operations over almost 13 years, the state of Servicemembers' and Veterans' mental health is a national priority. Meeting the individual mental health needs of Veterans is more than a system of comprehensive treatments and services; it is a philosophy of ensuring that Veterans receive the best mental healthcare possible, while focusing on the overall well-being of each Veteran. VA remains committed to doing all we can to meet this challenge.

Through the strong leadership of the President and the support of Congress, Veterans' access to mental healthcare has significantly improved. Since 2006, the number of Veterans receiving specialized mental health treatment has risen from 927,000 to more than 1.3 million in 2013. Vet Centers are another avenue for mental healthcare access, providing services to 195,913 Veterans and their families in 2013.

Since March 2012, VA has added over 2,000 Mental Health professionals—exceeding requirements in the President's August 31, 2012 Executive Order to improve ac-

cess to mental healthcare for Veterans, Servicemembers, and military families. VA has also hired 915 peer specialists, exceeding the goal of 800, to augment the work of those clinicians.

We proactively screen all Veterans for PTSD, depression, Traumatic Brain Injury, substance abuse, and military sexual trauma to identify issues early and provide treatments and intervention opportunities. We know that when we diagnose and treat people, they get better.

VA is a pioneer in mental health research and high-quality, evidence-based treatments. We strive to maintain and improve the mental health and well-being of today's Veterans through excellence in healthcare, social services, education, and research. In the last three years, VA has devoted additional people, programs, and resources toward mental health services to serve the growing number of Veterans seeking mental healthcare.

We are developing new measures to gauge mental healthcare effectiveness, including timeliness, patient satisfaction, capacity, and availability of evidence-based therapies. We are working with the National Academy of Sciences to develop and implement measures and corresponding guidelines to improve the quality of mental healthcare. To help VA clinicians better manage Veteran patients' mental health needs, VA is developing innovative electronic tools. Clinical reminders give clinicians timely information about patient health maintenance schedules, and the High-Risk Mental Health National Reminder and Flag system allows VA clinicians to flag patients who are at-risk for suicide. When an at-risk patient does not keep an appointment, clinical reminders prompt the clinician to follow up with the Veteran.

Since its inception in 2007, the VA's Veterans' Crisis Line (1–800–273–TALK (8255), press 1) in Canandaigua, New York, answered nearly 1,000,000 calls and responded to more than 143,000 texts and chat sessions from Veterans in need. The Veterans' Crisis line provides 24/7 crisis intervention services and personalized contact between VA staff, peers, and at-risk Veterans, which may be the difference between life and death.

In the most serious calls, approximately 35,000 men and women have been rescued from a suicide in progress because of our intervention—the rough equivalent of two Army divisions. VA offers expanded access to mental health services with longer clinic hours, telemental health capability to deliver services, and standards that mandate rapid access to mental health services.

ENDING VETERAN HOMELESSNESS

VA is committed to ending Veteran homelessness in 2015. No one who has served our country should ever go without a safe, stable place to call home. VA's programs provide individualized, comprehensive care to Veterans who are homeless or at risk of becoming homeless. Veterans' homelessness fell by 24 percent between 2010 and 2013, and we expect another reduction when this year's point-in-time counts released. Last year, VA helped more than 42,000 Veterans find permanent housing and awarded about $300 million in grants to our community partners for supportive services for Veteran families. Nearly 260,000 Veterans and family members were served through VA's specialized homeless programs in FY 2013.

OTHER HEALTHCARE ACCOMPLISHMENTS

President Obama signed the "Caregivers and Veterans Omnibus Health Services Act of 2010," into law which helps our most seriously injured post-9/11 Veterans and their family caregivers with a monthly stipend, access to health insurance, mental health services and counseling, and comprehensive VA caregiver training. To date, more than 16,800 caregivers have been trained to care for our most seriously injured post-9/11 Veterans. VA also has a Caregiver Support Coordinator stationed at every VA medical center, as well as a national Caregiver Support Line (1–800–260–3274) and Web site (www.caregiver.va.gov) to provide support and resources to Caregivers of Veterans from all eras.

VA initiated a multi-faceted approach to reduce the use of opioids among America's Veterans using VA healthcare, seeking to reduce harm from unsafe medications and/or excessive doses while adequately controlling Veterans' pain. To achieve this, VHA has established nine goals for safe, evidence-based, Veteran-centric pain care as part of VHA's Opioid Safety Initiative (OSI). Launched in October 2013, in Minneapolis, OSI is already successful in lowering dependency on these drugs. At eight sites of care in Minnesota, OSI practices have decreased high-dose opioid use by more than 50 percent.

OSI places an emphasis on patient education, close patient monitoring with frequent feedback, and Complementary and Alternative Medicine practices like acupuncture. These join pain management guidelines encourage the use of other medi-

cations and therapies in lieu of habit forming opiates. OSI is an example of VHA's personalized, proactive and patient-centered approach to healthcare through an innovative and comprehensive plan that monitors dispensing practices system-wide, includes patient and provider education, testing and tapering programs, and alternative therapies like behavior therapy.

SUMMARY

These accomplishments are the results of VA's focus over the past five years—during which time we have worked to increase Veterans' access to high quality healthcare, education and training, and employment opportunities in both the public and private sectors. There is always more work to do, and VA is focused on continuous improvement to the care we provide to our Nation's Veterans.

I appreciate the hard work and dedication of VA employees, our partners from Veterans Service Organizations—important advocates for Veterans and their families—our community stakeholders, and our dedicated VA volunteers. I also respect the important role Congress and the dedicated Members of this Committee play in serving our Veterans, and I look forward to continuing our work with Congress to better serve them all. Again, thank you for the opportunity to appear before you today and for your unwavering support of those who have served this great Nation in uniform.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

VA has been actively downgrading—that is changing the GS–pay scale for employees downward for the same job they currently have; same job, same service to VA but with lower pay and promotion potential. These have devastating effects on morale, recruitment, and retention.

Question 1. The position of "Scheduling Clerk" is one of the 17 VA is considering downgrading. These are the employees in charge of wait lists. Has VA reconsidered its policy of downgrading or done any analysis on the effect that downgrading employees has on VA performance?

Response. Title 5, United States Code, Chapter 51 governs the classification of positions in the Federal service. This law states that positions shall be classified based on the duties and responsibilities assigned and the qualifications required to do the work. Section 5104 of Title 5 provides definitions for the grade levels of the General Schedule.

The law requires the Office of Personnel Management (OPM) to define (via regulations) Federal occupations, establish official position titles, and describe the grades of various levels of work. To fulfill this responsibility, OPM approves and issues position classification standards that must be used by agencies to determine the Title, series, and grade of positions covered by Title 5.

In order to comply with OPM's Regulations, VA must review and possibly reclassify multiple VA positions within 17 occupational series, which may include changing some positions to a lower grade. VA must do this to ensure employees are classified in accordance with governmentwide OPM standards, and they are receiving equal pay for equal work. Employees impacted by this decision will not experience a decrease in their existing rate of pay, as they are protected by grade and pay regulations. However, VA recognizes that future earning potential may be affected and we will work with employees, union partners, and other key stakeholders to identify ways to mitigate any adverse effects where appropriate.

The majority of positions performing patient scheduling duties as a major duty of their work time (25 percent or more) are excluded from this Title 5 classification review and will not be impacted by the reclassification of positions within the 17 occupational series. These positions are covered by the GS–0679 Medical Support Assistant Series. This series was converted to hybrid Title 38 coverage on July 1, 2012, and is no longer subject to Title 5 classification laws, rules, and regulations. VA currently has approximately 16,000 employees assigned to this series with over 15,000 at the GS–5 to GS–12 levels. While the review of the 17 occupational series positions may include positions performing patient scheduling duties, these duties would represent a minor duty in the overall composition of work assigned to the position. During the review, if a position is identified as performing scheduling work as a major duty, it will be reviewed critically for conversion to the GS–0679 Medical Support Assistant Series.

While the position of "Scheduling Clerk" is not specifically listed as one of the 17 occupational groups targeted for consistency review, no downgrade of any position has occurred as a result of the pending reviews. No action will be taken until a thor-

ough analysis of each job series is completed by each impacted office. VA expects that this process will take approximately 15 months to complete. As the Department takes action to comply with Federal regulations (5 Code of Federal Regulations (CFR) 511.612.), it will work with its union partners, OPM, and VA human resources experts to ensure that the fewest possible employees are affected and that we provide employees with the highest possible degree of protection in terms of their position and pay.

Question 2. 1,500 GS–6 Claims Assistants are facing downgrades. Has VA considered what this would mean to recruiting and retaining the people on the front lines of attacking the backlog?

Response. The Claims Assistant GS–0998 position review is required by 5 CFR 511.612 due to OPM's adjudication and issuance of employee initiated appeal decisions C–0998–05–01, C–0998–05–02, and C–0998–05–02. The Claims Assistant positions included in this review are primarily located in the Veterans Health Administration (VHA) and are responsible for accepting/disputing/processing/payment of bills/claims against VA for medical services Veterans receive from outside of the VA health care system.

The Claims Assistant position in the Veterans Benefits Administration (VBA) is also part of this review. VBA believes this position is properly classified for the work these employees perform pertaining to claims for benefits. VBA is participating in a work group, in partnership with the Office of Personnel Management (OPM), to ensure any changes to classifications do not negatively impact the timeliness and accuracy of benefits decisions for Veterans and their families.

Question 3. If shortages in staffing and number of inpatient beds can be fixed with more funding, why is VA not asking this Committee and the appropriators for more money? Why isn't it more in line with the *Independent Budget*?

Response. The 2015 President's Budget is requesting $367.9 million in additional funding above last year's advance appropriations request of $55.634 billion to meet Veterans' medical care needs, for a total direct appropriations request of $56.002 billion, a 3.0 percent increase over the 2014 enacted level. In addition to the 2015 appropriation request, VA anticipates the Medical Care Collections Fund (MCCF) to reach $3.065 billion. VA also estimates that it will receive $258 million in reimbursements and begin 2015 with $450 million in unobligated balances, which will allow VHA to meet its 2015 total obligation authority of $59.498 billion and support over 6.7 million unique patients, 9.3 million enrolled Veterans, a staffing level of 275,122 FTE and Inpatient Care exceeding $11.5 billion.

Final 2016 funding levels will be determined during the 2016 budget process when updated data and metrics on these programs' funding needs are available. VA's budget estimates are primarily based on an actuarial model that includes population changes that can significantly impact VA's requirements, such as when Veterans become eligible for Medicare or the increased number of women Veterans in the current conflicts. *The Independent Budget* does not use such data, estimating future requirements as growth from the latest available obligations.

a. The Chillicothe Medical Center, for example, has had a high turnover of primary care providers in the last 18 months—15 of 20 individuals have left—they are heavily relying on "extenders." What can we do to correct this?

Response. Chillicothe VA Medical Center (VAMC) leadership has authorized recruitment of up to 25 primary care providers, which include both physicians and nurse practitioners or physician assistants. This authorized staffing level is intended to support the long- term strategy of fully operating all Patient Aligned Care Teams (PACTs) year round, at the main facility and the Community-Based Outpatient Clinics (CBOC), even during planned or unexpected provider absences. This increase in PACTs is also meant to assure the smaller more rural clinics (such as those in Cambridge and Marietta, Ohio), whose patient enrollment would normally support only one provider, have the availability of two providers to support Veterans' continuous access to care, even during planned or unexpected provider absences or turnover.

There are currently 21.5 primary care providers in place with three new providers in pre-employment processes expected to come on board within the coming months. Additionally, the Chillicothe VAMC established a Locum Tenens contract for primary care providers and is now utilizing that resource, as well as assigning providers from administrative and leadership roles, to assist in clinic coverage.

Recruiting primary care physicians is very difficult given the rural location of the facility; escalating practice complexity and demands; and the limitation of VA's pay scale compared to the private sector, which is rapidly increasing pay for such providers. The Chillicothe VAMC prefers to engage primarily physicians to serve as primary care providers. However, like many rural practices, the Chillicothe VAMC

must rely on highly qualified nurse practitioners and physician assistants to augment provision of primary care services for Veterans across the region. Aggressive recruitment efforts continue to add to the Chillicothe VAMC's clinical staff and provider team.

Question 4. Talk to me about the Nation-wide access review at VA that you ordered. Will AFGE and others have a role?

Response. The American Federation of Government Employees (AFGE) and the National Partnership Council were briefed before the Nation-wide access reviews were conducted. The local unions were invited to the opening and closing meetings with facility leadership, and all statutory and contractual requirements were followed. Changes to scheduling practices are also being communicated locally to assure that union and labor organizations are informed of revisions in policies and procedures as well as training and performance plans.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 5. What steps has the Veterans Health Administration (VHA) taken to ensure consistency and oversight in scheduling policy implementation and practices across the Veterans Integrated Service Networks (VISNs)?

Response. The Secretary of Veterans Affairs directed VHA to complete a Nation-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff, identify any inappropriate scheduling practices used by employees regarding Veteran preferences for appointment dates, and review waiting list management. This audit was designed to:

- Gauge front-line staff understanding of proper scheduling processes;
- Assess the frequency and pervasiveness of both desired and undesirable practices employed to record Veteran preferences for appointment dates, manage waiting lists, and process requests for specialty consultation; and
- Identify factors that interfere with schedulers' ability to facilitate timely care for Veterans.

As a result of this audit, VHA has taken a number of immediate actions to address the very serious issues identified in our audit.

- Mobilized staff and financial resources to ensure that patients waiting for care get their needs addressed in a timely manner. VHA will either provide care in a timely manner or purchase care, to the extent it exists in the private sector. VHA will also contact Veterans to see if they desire care sooner than the current scheduled date.
- Initiated an across-the-board assessment of VHA's internal capacity to meet needs for care.
- Removed the 14-day performance metric from individual performance plans.
- Suspended VHA Senior Executive Service performance awards for fiscal year 2014.
- Updated guidance on VHA's utilization of non-VA medical care, to ensure use of all appropriate resources in the community to provide Veterans care when, where, and how they want it. Guidance included briefings held with VHA Veterans Integrated Service Network (VISN) Directors, virtual training sessions accessible electronically by all VA staff, communications to targeted staff of the electronic training sessions and written guidance targeted toward field staff disseminated though email and placed on internal intranet sites. Additionally, updated guidance was provided on VHA's utilization of non-VA medical care (NVC), to ensure use of all appropriate resources in the community to provide Veterans care when, where, and how they want it. This guidance includes offering NVC to the Veteran in an effort to ensure they receive care in a timely manner. Updated guidance was also provided on the coordination of care to include appropriate authorizations, use of contracts, sharing agreements or individual authorizations, scheduling of appointments and receipt of medical documentation.
- Directed field leadership to continue the process of inspection of practices to ensure VHA's leaders have personal accountability for the integrity of the practices followed in VA facilities.
- Renewed efforts to improve transparency of performance data. VHA will increase the measurement and use of data regarding Veterans' satisfaction with access to care and overall experience.
- Examined Medical Support Assistant staffing levels and compensation. Medical Support Assistants are central to the operation of VA medical facilities. VHA must reevaluate these positions to ensure staff compensation is fair. VHA will reassess

staffing requirements to ensure the appropriate internal capacity needed to provide timely care, and find cost effective options to purchase that care when necessary.

- Work to modernize software scheduling solution that facilitates the processes of modern health care.

In addition, there are many long-term actions that will need to be addressed and assessed as VHA moves forward.

Question 6. What is the main issue impacting veterans waiting times for medical appointments? What are the biggest obstacles to reducing those waiting times?

Response. At the direction of the Secretary of Veterans Affairs, VHA conducted an Access Audit which assessed the scheduling practices across VA. This audit identified the following obstacles: 1) significant lack of clarity regarding scheduling policies and practices across our system; 2) an inflexible and unrealistic 14 day performance target for new appointments; 3) inadequate staffing of providers and clerical support at many of the sites that were experiencing the greatest surge in patient demand; 4) rigid and obsolete scheduling software. The greatest single barrier identified was the lack of provider slots.

Question 7. To what extent do VHA's access issues reflect the same challenges in the delivery of private sector health care? To what extent are they VA-specific?

Response. A recent national survey of Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates offers a snapshot of physician availability in 15 large metropolitan markets, many of them with physician-to-population ratios higher than the national average. For a new patient, the average appointment wait time to see a family physician ranged from a high of 66 days in Boston to a low of 5 days in Dallas. However, as the example of Boston illustrates, access to health insurance does not always guarantee access to a physician. In addition, the survey findings indicate that Medicaid is not widely accepted as a form of payment in most markets surveyed. http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf.

VA-specific challenges involve the increasing complexity of combat-related injuries from Vietnam and Persian Gulf conflicts which typically require specialty care, such as Traumatic Brain Injury, Post Traumatic Stress Disorder, amputations, and environmental exposure-related illnesses.

Question 8. What are the current accountability measures in place for facilities, or leadership officials at those facilities, if timeliness goals are not met on a consistent basis? Are those measures appropriate? Do you need additional authorization to enforce stronger accountability measures?

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 Phoenix VA Health Care System (PVAHCS), and VA has directed an independent site team to assess scheduling and administrative practices at PVAHCS. This team began their work in April, and VA is taking action on multiple recommendations from the teams' 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. That breach of integrity is indefensible and VA will use all authorities at its disposal to enforce accountability among senior leaders.

To help regain Veterans' trust, Congress' trust, the trust of the American people, and the trust of our employees, when we do hold employees accountable we are going to continue to transparently share information to the degree permitted by law, while respecting an employee's privacy rights. For cases involving senior executives, the Veterans Access, Choice, and Accountability Act of 2014 allows us to take expedited action when VA has determined that a senior manager has committed misconduct or has performed poorly. VA's newly established Office of Accountability Review (OAR) is monitoring the progress of all ongoing OSC and Office of Inspector General (OIG) investigations, and as they are completed, will help VA leadership determine appropriate accountability measures.

Question 9. Understanding the goal of the VHA nationwide access review is to ensure facilities are scheduling appointments appropriately, will the review also provide feedback on why employees might have been motivated to manipulate numbers in the first place? To what extent will the review inform ways we can improve or reform the system?

Response. Based on the findings of the audit, VA will critically review its performance management, education, and communication systems to determine how performance goals were conveyed across the chain of command such that some frontline, middle, and senior managers felt compelled to manipulate VA's scheduling

processes. This behavior runs counter to VA's core values; the overarching environment and culture which allowed this state of practice to take root must be confronted head-on if VA is to evolve to be more capable of adjusting systems, leadership, and resources to meet the needs of Veterans and families. It must also be confronted in order to regain the trust of the Veterans that VA serves.

Question 10. To what extent has the VHA invested in workforce training for those involved in scheduling appointments for veterans?

Response. VA recently implemented mandatory supplemental training for all employees involved with scheduling appointments. Using existing internal web-based resources, subject matter development, and distributed learning expertise, four new courses were introduced during the past 2 months. These courses were developed and produced internally so total course cost is primarily staff time with minimal contract costs for video production. Details are provided in the table below:

TMS Item #	Course Title	Modality	Total Completions	Total Course Cost
7532	Scheduling Training—Recall Reminder	Web-based/eLearning	90,118	$3,494
7533	Scheduling Training—Soft Skills	Conference/Workshop (conducted face-to-face at local VA medical facilities).	76,496	$37,044
7534	Scheduling Training—Business Rules	Web-based/eLearning	95,092	$3,285
7535	Scheduling Training—Make Appointment.	Web-based/eLearning	91,740	$3,494
		Total	353,446	$47,317

Question 11. To what extent have information technology (IT) investments been made to ensure the VHA is operating the most reliable and effective scheduling system? Do you believe advanced appropriations for medical-related IT would help the VHA connect veterans to care in a more timely manner?

Response. VA has invested in upgrades to the scheduling system over the last 10 years. The current scheduling application investment includes these maintenance upgrades as well as ongoing support. However, the current scheduling system is based upon a 25-year old scheduling system which consists of a roll-and-scroll system that is susceptible to error. The software is segmented into components that do not automatically communicate with or connect with each other, but require manual processes to operate. VA began an effort, the Replacement Scheduling Application (RSA), to replace the legacy scheduling system in 2000. This effort failed to deliver a replacement system and was stopped in 2009. During this timeframe, major enhancements to the legacy system were delayed due to the anticipation of a new system which unfortunately, never materialized.

VA's scheduling system needs improved interfaces for both schedulers and patients to increase scheduling efficiency and decrease errors—this includes improvements to Clinical Video Teleconferencing, Scheduling Manager Applications, and Patient Directed Scheduling Applications. Enhancements are also needed to the Core VistA Scheduling Software, including a resource management dashboard, aggregated clinical schedule and single queue of request lists. The long-term solution is to complete the Medical Appointment Scheduling System, which will be a commercial solution building on the interfaces delivered during the Medical Scheduling Contest. The goal is to leverage a commercial solution to provide a proactive resource management-based scheduling system. VA expects to deliver a core capability of the scheduling system within two years (in six months increments) after award using a series of six month incremental enhancements until full operational capability is reached.

Question 12. To what extent can workforce shortages be mitigated by more collaboration between the VHA and private providers to deliver care at local access points for veterans?

Response. VA has the authority to utilize non-VA medical care to provide care to Veterans where capacity doesn't exist for many reasons, including workforce shortages. Non-VA medical care can be purchased using contracts. There are local contracts available as well as the recently awarded national Patient Centered Community Care (PC3) contracts for specialty and primary care. When a VA facility cannot readily provide needed care in-house or the care is not feasibly available to the Veteran, VAMCs will first look to provide specialty care at another VAMC or through

existing health care resources sharing agreements with the Department of Defense (DOD) medical treatment facilities. When it is not feasible to provide the care within the VHA system or DOD, the VAMC will consider its options for purchasing the care. Consideration will first be given to the availability of the care through currently awarded PC3 contracts. However, VAMCs retain the authority to execute local contracts with Academic Affiliates (VA Directive 1663) or other private sector health care providers when deemed to be in the best interests of VA. A goal is to order most necessary contract health care from the already awarded PC3 contracts to reduce administration burdens associated with additional acquisition actions.

Additionally, Pub. L. 113–146, the Veterans Access, Choice and Accountability Act (VACAA), provided $10 billion for the new Veterans Choice program and $5 billion to improve access at VA health care facilities. As specified in the law, these funds will be used to increase the access of veterans to care and to help ensure VA is increasing its capacity to meet the current and projected future demand for services.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 13. What is VA's official definition of "delay in treatment" and "delay in care?"

Response. VA uses the terms "delay in treatment" or "delay in care" to reflect a situation where a patient has received care beyond the timeframe that the medical profession has determined to be the standard of care for addressing a medical condition.

Question 14. I and others believe that veterans should have the freedom to choose their own physician to meet their medical needs. Several of the VSO panelists cited a lack of access to specialty medicine, including a particular case in which a veteran diagnosed with skin cancer cells has been on a waiting list for eight months to see a dermatologist. What is the Department of Veterans Affairs currently doing to ensure continuity of care, particularly specialty care? And do you agree that allowing access to specialty care outside of the VA could improve continuity of care for veterans?

Response. Non VA Care (NVC) is used when the facility cannot provide the care in a timely manner and is primarily used for specialty care. When a Veteran needs care, a determination is made if the care can be provided at VA. If VA is unable to provide the care timely to meet the clinical need of the Veteran, then the use of NVC is reviewed. When authorizing for NVC, consideration is taken as to where the care can be provided in a timely manner to ensure the clinical need is met. While allowing Veterans access to specialty care outside of VA may improve access to care, it does not necessarily improve continuity of care. Therefore, the VA has developed a Non VA Care Coordination model to ensure the care is appropriately authorized, scheduled and medical documentation is received in an effort to improve the continuity of care.

The Non VA Care Coordination (NVCC) model provides several steps to help in the coordination of care for our Veterans. Once a Veteran is notified of the approval of non-VA medical care, they are contacted to identify availability, preferences, and needs. Once this information has been obtained, the non-VA medical care provider is contacted by NVCC staff to schedule an appointment for the Veteran. The appointment is then captured in VistA. The Veteran and non-VA medical care provider are sent the authorization and the appropriate release of information form(s), to ensure the medical records are received by VA.

After the appointment date, the Veteran is contacted to verify that the authorized non-VA medical care has been received. If the Veteran missed or did not attend his/her medical appointment, VA staff will work with the Veteran to reschedule the missed appointment. NVCC staff will then work with the non-VA medical care provider to obtain the required clinical documentation. The documentation will then be scanned into the appropriate system, and uploaded to the Veteran's electronic medical record. If additional review and follow-up action is required from the referring VA provider once the clinical documentation is received, an alert will be sent to notify the VA provider of the required action.

Question 15. Physician anesthesiologists possess 12,000 to 16,000 hours of clinical training and nurse anesthetists have 1,500 hours of training on average. How is the care provided to veterans improved by replacing a physician anesthesiologist with a nurse anesthetist as the anesthesia team leader?

Response. The presence of anesthesiologists or certified registered nurse anesthetists (CRNA) in VHA health care facilities helps ensure that our Veterans have access to safe, high quality anesthesia care, as well as the procedures and services

that anesthesia care enables. The peer-reviewed literature points to the high quality of care provided by both provider types practicing together or separately. VHA does not require anesthesiologist or physician supervision of CRNAs; in a number of VHA facilities CRNAs are the sole anesthesia providers. Currently either anesthesiologists or CRNAs may serve as part of the anesthesia care team. Private hospitals, ambulatory surgery centers and the Department of Defense commonly use CRNAs to provide anesthesia services for patients without physician supervision. The proposed nursing handbook would not authorize CRNAs to replace or act as anesthesiologists, but rather increase access to care, decrease variability throughout VHA, and ensure continuity of the highest quality of care for veterans. CRNAs would not be authorized to provide any anesthesia services that are beyond the scope of their clinical education, training or competencies.

Question 16. Are there specific examples of deficiencies or delays in care that led to the decision to change the VHA Nursing Handbook? What stakeholders were consulted in the development of the proposed handbook?

Response. The Office of Nursing Services began the development of a VHA nursing handbook in 2009 to establish policy for the process of care delivery and the elements of practice for nursing. Within the nursing handbook, VHA is proposing the authorization of FPA for all APRNs without regard to their individual State Practice Acts, except for the dispensing, prescribing, and administration of controlled substances. This proposed change to nursing policy would standardize APRN practice throughout the VA system, and increase access to the highest quality of care for all the Nation's Veterans. Implementation of FPA would increase patient access by alleviating the effects of national health care provider shortages on VA staffing levels, as well as enabling VA to provide additional health care services in medically underserved areas.

The 2010 Institute of Medicine (IOM) landmark report, *The Future of Nursing: Leading Change, Advancing Health*, recommended removal of scope-of-practice barriers, to allow APRNs to practice to the full extent of their education and training. This evidenced-based recommendation by the IOM prompted VHA to propose FPA for APRNs. Thus, VHA's proposed nursing handbook is consistent with the IOM recommendation to remove barriers including the variation in APRN practice that exists across VHA as a result of disparate state regulations. The proposed change is being driven by the efficacious use of resources and to standardize APRN practice throughout the VA system. As an integrated Federal health care system, the proposed policy parallels current policies in DOD and Indian Health Service. In 2012, all VA Program Offices provided input and concurred on the nursing handbook including Anesthesia Services. VHA has conducted meetings with several outside stakeholders including the American Society of Anesthesiologists and the American Medical Association.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR ON BEHALF OF HON. JEFF FLAKE TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 17. According to GAO and OIG reports, some VHA facilities do not always follow VHA's scheduling policies and processes.

a. Do certain VHA facilities have any leeway regarding the scheduling policies that they are obligated to follow?

Response. No, VHA facilities are expected to follow scheduling policies. However, the Access Audit findings illustrate that eight percent of scheduling staff indicated they used alternatives to the Electronic Wait List (EWL) or the Veterans Health Information Systems and Technology Architecture (VistA) package. Some of the respondents indicated that the scheduling policy was not well-understood. VA recently implemented mandatory supplemental training for all employees involved with scheduling appointments. Using existing internal web-based resources, subject matter development, and distributed learning expertise, four new courses were introduced during the past 2 months. These courses were developed and produced internally so total course cost is primarily staff time with minimal contract costs for video production. Details are provided in the table below:

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7535	Scheduling Training—Make Appointment.	Web-based/eLearning	91,740	$3,494
		Total	353,446	$47,317

b. If not, what disciplinary measures does the VA typically pursue when presented with evidence of VHA facilities not complying with scheduling policies and processes?

Response. VHA has progressive disciplinary policies that are followed per human resource guidelines. Disciplinary measures can vary based on the nature of the offense.

c. What is the existing recourse for any VA employee, service provider, or patient that believes scheduling policies and processes are not being followed? Specifically who would they report such instances to and what actions would the VA take subsequent to the report?

Response. Employees and service providers who believe that scheduling policies and processes are not being followed are encouraged to report this through their supervisory chain of command. Patients may report this to their patient advocate, clinic supervisor, or Medical Center Director. Facility leadership is responsible for ensuring that training and education is provided to all employees involved in scheduling appointments.

Question 18. In December 2012, GAO reported that some VHA facility officials stated that they did not use the electronic waiting list, which the VHA uses to track patients with whom the facility does not have an established relationship. In some instances, it was reported that patients were tracked by printing paper copies of consult requests from the electronic medical record.

a. What measures have you taken to ensure that the electronic waiting list is used properly at VHA facilities? Has there been any progress in this regard?

b. Currently, what ability do you or any of your subordinates have to terminate the employment of anyone found to be operating afoul of these procedures?

VA Response (a. and b.): VA has taken aggressive action through its Accelerating Care Initiative, launching a coordinated, Nation-wide effort to accelerate care to Veterans throughout the VA system and in communities where Veterans reside. This effort increases timely access to care for Veterans and improves standardization of ongoing monitoring, productivity, and access to care. While the Accelerating Care Initiative is a near-term activity, VA will continue to monitor productivity, capacity, and access to care at local, regional, and national levels.

VA will establish follow-up accountability actions based on the results of the audit. Senior leaders will be held accountable to implement policy, process, and performance management recommendations stemming from this audit and other reviews. Where audited sites identify concerns within the parent facility or its affiliated clinics, the VA will trigger administrative procedures to ascertain the appropriate follow-on actions for specific individuals.

Based on the findings of the audit, VA will critically review its performance management, education, and communication systems to determine how performance goals were conveyed across the chain of command such that some front-line, middle, and senior managers felt compelled to manipulate VA's scheduling processes. This behavior runs counter to VA's core values; the overarching environment and culture which allowed this state of practice to take root must be confronted head-on if VA is to evolve to be more capable of adjusting systems, leadership, and resources to meet the needs of Veterans and families. It must also be confronted in order to regain the trust of the Veterans that VA serves.

To help regain Veterans' trust, Congress' trust, the trust of the American people, and the trust of our employees, when we do hold employees accountable we are going to continue to transparently share information to the degree permitted by law, while respecting an employee's privacy rights. For cases involving senior executives, the Veterans Access, Choice, and Accountability Act of 2014 allows us to take expedited action when VA has determined that a senior manager has committed mis-

conduct or has performed poorly. VA's newly established Office of Accountability Review (OAR) is monitoring the progress of all ongoing OSC and Office of Inspector General (OIG) investigations, and as they are completed, will help VA leadership determine appropriate accountability measures.

Question 19. It is my understanding that the VA officials who have been placed on administrative leave in Phoenix and elsewhere are still being paid while the office of the VA Inspector General conducts its investigation.

If these allegations are found to be true, what measures will you consider to not only discipline those responsible for the practices in question, but also to reform VA policies and procedures to ensure that the department is better able to provide timely and adequate care to veterans?

Response. VA takes the allegations and findings of misconduct seriously, and has moved quickly to address the situation. Since allegations of delayed care and employee misconduct surfaced at Phoenix VAHCS, 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 PVAHCS, and VA has directed an independent site team to assess scheduling and administrative practices at PVAHCS. Final decisions on the senior leader actions will be made when all relevant evidence is available.

On May 23, 2014, VHA executed the Accelerating Care Initiative, a coordinated, Nation-wide initiative to accelerate care to Veterans throughout the VA system and in the communities where Veterans reside. This initiative was designed to increase timely access to care for Veteran patients; decrease the number of Veteran patients on the Electronic Wait List (EWL) and waiting greater than 30 days for care; and standardize the process and tools for ongoing monitoring and access management at VA facilities. VA will continue to accelerate access to care for Veterans nationwide who need it, utilizing care both in and outside the VA system.

Question 20. Earlier this year, before allegations of manipulated wait time reporting at the Phoenix VA hospital came to light, you stated in a letter to Chairman Jeff Miller of the House Committee on Veterans' Affairs that you believe that "the VA has sufficient authority to take swift action to hold employees and executives accountable for performance." You went on to say that one of the ways in which the VA holds these individuals accountable is through "a rigorous performance appraisal program." While VA employees and executives failure to meet performance goals is one thing, accusations of intentional manipulation and mismanagement resulting in delayed care for hundreds of veterans is another.

a. In a letter to Chairman Jeff Miller of the House Committee on Veterans' Affairs, you noted that "it does not appear that PVAHCS patients who were not able to be seen within 90 days were handled consistently." What will be the repercussions for those involved in the already discovered inconsistent handling of patient appointments at the Phoenix facility?

b. Beyond these apparent inconsistencies, if the troubling allegations related to the Phoenix facility are found to be true, would you agree that decisive and incontrovertible action—to include the possibility of termination—against those responsible for the sort of practices in question at the Phoenix VA hospital is warranted?

VA Response (a. and b.): VA takes the allegations and findings of misconduct seriously, and has moved quickly to address the situation. Since allegations of delayed care and employee misconduct at Phoenix VAHCS surfaced, VA has been conducting internal reviews to evaluate appointment scheduling procedures and patient care in Phoenix and nationwide. VA recognizes there is a leadership and integrity problem among some of the leaders of its health care facilities, which can and will be fixed. That breach of integrity is indefensible and VA is using all authorities at its disposal to enforce accountability among senior leaders as quickly as possible within the bounds of the law. VA has also directed an independent site team to assess and improve scheduling and administrative practices at PVAHAC. This team began their work in April, and VA is taking action on multiple recommendations from their findings.

Question 21. In the past, GAO has studied and been critical of VA bonus awarding practices.

a. Since 2012, how many employees of VA facilities in the state of Arizona have received bonuses? What percentage of the entire VA workforce received bonuses? What was the range of bonuses awarded, in dollar value and percentage of the recipients' salary? What is the total dollar figure associated with bonuses awarded by the VA in Arizona?

Response. The following data excludes Senior Executive Service (SES) employees and SES Equivalents.

Since 2012, how many employees of VA facilities in the state of Arizona have received bonuses?

FY	Number of employee of VA facilities in the state of Arizona that have received bonuses
2012	2,710
2013	2,199

What percentage of the entire VA workforce received bonuses?

FY	Percent of entire VA Workforce that received bonuses
2012	55% (180,728 awards divided by 325,889 employees)
2013	58% (195,954 awards divided by 338,932 employees)

What was the range of bonuses awarded, in dollar value and percentage of the recipients' salary?

Dollar Amounts of Bonuses Awarded

FY	Minimum	Maximum
2012	$11.00	$23,091.00
2013	$6.00	$16,173.00

Percent of Salary

FY	Minimum	Maximum
2012	0.02%	99.91%
2013	0.01%	46.72%

What is the total dollar figure associated with bonuses awarded by the VA in Arizona?

Dollar Amount of Bonuses Awarded in Arizona.

FY	Award Amount
2012	$2,589,793
2013	$2,647,236

The following data represents SES and SES Equivalents.

NOTE: For reporting purposes, the data below reflects the fiscal year in which awards were actually paid.

Since 2012, how many employees of VA facilities in the state of Arizona have received bonuses?

FY	Count
2012	4
2013	4
Total	8

What percentage of the entire VA workforce received bonuses?

FY	Percent of Workforce
2012	71% (468 rated/331 awards)
2013	60% (459 rated/276 awards)

What was the range of bonuses awarded, in dollar value and percentage of the recipients' salary?

Dollar Amounts of Bonuses Awarded

FY	Minimum	Maximum
2012	$6,705.00	$23,091.00
2013	$7,604.00	$16,173.00

Percent of Salary

FY	Minimum	Maximum
2012	5.0%	14.0%
2013	5.5%	9.0%

What is the total dollar figure associated with bonuses awarded by the VA in Arizona?

Dollar Amounts of Bonuses Awarded at PVAHCS

FY	Award Amount
2012	$42,860.00
2013	$40,791.00

b. Has the Department at any point explicitly linked bonuses to efforts to decrease patient wait times?

Response. Performance Awards are monetary awards given to high-performing employees based on annual job performance appraisals. Senior Executives are held specifically accountable for achieving realistic, but challenging performance targets within defined timeframes, identified within the five critical elements: Leading Change, Leading People, Business Acumen, Building Coalitions, and Performance Results. Within those five critical elements, each Senior Executive is rated against position specific performance requirements. Among those requirements, leadership skills in managing wait times may be one of many factors considered in the evaluation. SES performance is evaluated through a minimum of five levels of review. The result of this evaluation is a rating and score. Performance awards are given based on the individual's final approved rating/score.

It is significant to note that VHA's evaluation of SES performance is conducted annually in accordance with VA Handbook 5027, VA SES and Title 38 SES-Equivalent Performance Management System policy, and all applicable laws. VHA's internal process includes a multi-level review process which increases transparency and accountability and ensures meaningful distinctions in ratings and awards. The rating official (supervisor) provides an initial narrative summary and submits to the reviewing official who provides an overall narrative evaluation. Next, VHA's Performance Review Committee (PRC) reviews the evaluation and makes a rating recommendation to the VA Performance Review Board (PRB). The PRB reviews and makes a rating recommendation to the Secretary. The criteria for determining who receives a monetary award and the amount of the award is determined through collaboration between Corporate Senior Executive Management Office (CSEMO) and the Office of the Secretary. The Secretary has the final approval authority for the rating of record and any monetary award given.

c. Did any of those placed on administrative leave or associated with the inconsistency related to patient scheduling received a bonus within the last two years?

Response.

Position/Title	FY 2013	FY 2012
Medical Center Director	$0 (rescinded)*	$9,345 (effective 5/22/13)
Associate Director	$5,000 (effective 11/06/13)	$3,000 (effective 11/19/12)
Third Employee	$3,000 (effective 11/20/12)	$3,000 (effective 11/25/13)

*The process to recoup this FY 2013 payment was initiated, but is on hold pending an appeal.

Question 22. Regardless of the VA Inspector General's findings, there is clearly a need to reform VA scheduling practices, and to ensure that the department is better able to provide timely and adequate care to veterans.

a. Aside from conducting a nationwide audit of the scheduling practices at VA medical facilities, what steps is your office currently taking to reduce the backlog for disability claims, and ensure that veterans are able to receive timely appointments at VA medical facilities?

Response. VA is committed to improving the quality, efficiency, and effectiveness of the delivery of benefits and services to Veterans, Servicemembers, and their families. VBA is currently undergoing the largest transformation in its history to eliminate the backlog of disability compensation claims, and substantially improve the way Veterans, their families, and Survivors receive benefits and services. VA is aggressively implementing its plan to eliminate the backlog using a series of actions targeted at reorganizing and retraining its people, streamlining its processes, and deploying technology designed to achieve VA's goal of processing all claims within 125 days in 2015.

Since April 2013, VA has focused on completing its oldest claims, resulting in benefit determinations for those who have been waiting the longest, many of whom are awarded VA compensation benefits for the first time or who have medical conditions that have worsened. As a result of its transformation initiatives and the focus on the oldest claims, VA has made significant progress, reducing the claims backlog (i.e., claims pending over 125 days) from its peak of 611,073 in March 2013 to 254,778 as of September 22, 2014—a 58.3-percent reduction. Veterans are now waiting less time for their decisions and benefits. As of September 22, 2014, claims in the inventory have been pending an average of 153 days, a 46-percent reduction from the peak of 282 days in February 2013.

At the same time, the accuracy of our rating decisions continues to improve. VA's national "claim-level" accuracy rate, determined by dividing the total number of cases that are error-free by the total number of cases reviewed, is currently 90 percent—a seven-percentage-point improvement since 2011. When measuring the accuracy of rating individual medical conditions inside each claim, the 3-month accuracy level is 96 percent.

VBA and VHA work together to support the Compensation and Pension (C&P) disability examination process for Veterans. In FY 2013, VHA clinicians completed nearly two million disability examinations. Additionally, VBA and VHA are maximizing the use of disability contract examiners to help maintain and improve VA disability examination services. In FY 2013, VHA contractors completed approximately 178,000 disability examinations, and VBA contractors completed over 225,000 disability examinations. Utilizing contract examiners ensures timely scheduling of examination appointments and ultimately more timely completion of disability claims. Contract exams also ensure Veterans receive quality disability examinations in locations near their homes.

VBA and VHA have instituted several initiatives to improve the timeliness and accuracy of claims processing based on medical evidence. For example, 71 different Disability Benefits Questionnaires (DBQ) are available to support Veterans' claims. DBQs are designed to more efficiently gather medical evidence from VHA clinicians and private physicians, including disability contract examiners, by capturing all the medical information needed to process a claim for a specific condition at once and up front.

Similarly, in the Acceptable Clinical Evidence (ACE) process, VHA clinicians review existing medical evidence and determine whether that evidence can be used to complete a DBQ without requiring the Veteran to report for an in-person examination. For many Veterans, this means they no longer need to travel and take time off for an examination, which can be a significant burden. Clinicians also have the option to supplement medical evidence with telephone interviews with the Veteran, or to conduct an in-person examination if determined necessary.

VHA is providing certified C&P clinicians at VBA regional offices. The clinicians provide medical opinions, answer staff questions, correct insufficient examinations, and serve as a key communication link between VBA and VHA. Along with communication at the local level, the Administrations have weekly meetings to discuss the disability examination process and established mailboxes for any questions employees may have about the process. VBA and VHA also collaborate on training programs and development of national policy and procedures to ensure consistency and quality.

Question 23. Although the VA Inspector General has yet to conclude its investigation, you stated in your testimony before the House Committee on Veterans' Affairs that an administrative team from the VA has visited Phoenix and found "no evidence of a secret list," and no indication that patients had "died because they have been on a wait list." However, an NBC report indicates that internal VA memos show that in 2010, the VA's deputy undersecretary for health, William Schoenhard,

was aware that some VA employees were using inappropriate scheduling practices to cut down on the officially reported time that patients wait for care.

a. In light of this report by NBC, do you believe that your testimony before the House Committee on Veterans' Affairs was inconsistent?

b. According to the report from NBC, Deputy Under Secretary Schoenhard was aware of inappropriate scheduling practices at some VA medical facilities—were you aware as well?

c. Given that the VA Inspector General has yet to conclude its investigation, do you believe that your statements regarding the conclusions of the preliminary findings of the VA administrative team that recently visited Phoenix were premature and unwise?

d. What, if any, steps are you taking to ensure that swift and decisive disciplinary action will be taken if the allegations are found to be true?

Response. While VHA has made efforts to address health care appointment scheduling and wait times for health care, further improvement is needed. On May 16, 2014, Robert Petzel, M.D., resigned as VHA's Under Secretary for Health. VHA's testimony was based on the data that was available at that time. However, we acknowledge that within many of our health care facilities there were systemic and unacceptable scheduling practices. VA is taking corrective action to address these issues.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR ON BEHALF OF HON. JOHN CORNYN TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 24. Secretary Shinseki, according to recent reports, you have ordered a "face-to-face audit" of all Department of Veterans Affairs clinics. Can you describe in detail how you intend for this audit to be conducted, its timeline for completion, and what measures are being taken to ensure these audits are conducted in an independent and transparent manner? If the allegations are substantiated, what type of action are you willing to take to right these wrongs, and how will the responsible officials be held accountable?

Response. On May 23, 2014, VHA executed the Accelerating Care Initiative, a coordinated, Nation-wide initiative to accelerate care to Veterans throughout the VA system and in the communities where Veterans reside. This initiative was designed to increase timely access to care for Veteran patients; decrease the number of Veteran patients on the Electronic Wait List (EWL) and waiting greater than 30 days for care; and standardize the process and tools for ongoing monitoring and access management at VA facilities.

The Nation-wide Access Audit covered a total of 731 separate points of access, and involved over 3,772 interviews of clinical and administrative staff involved in the scheduling process at VAMCs, large Community-Based Outpatient Clinics (CBOC) serving at least 10,000 Veterans and a sampling of smaller clinics. VA released the results of this audit on June 9, 2014, which can be accessed online at the following link: http://www.va.gov/health/access-audit.asp. VA will continue to accelerate access to care for Veterans nationwide who need it, utilizing care both in and outside the VA system.

We are in the midst of following up on the Nation-wide audit, interviewing senior leaders at facilities that had been flagged for further review but where OIG is not conducting scheduling-related investigations, or where the OIG has completed its investigation and found no basis for criminal action. This is in follow—up to the access audit and is intended to determine which supervisors, managers and employees may have intentionally directed or carried out inappropriate scheduling practices. We are also following up on OIG's scheduling-related investigations, as OIG releases its findings to us, and will ensure accountability for anyone implicated in wrongdoing by the IG.

Question 25. Secretary Shinseki, a whistleblower in Texas claims that during his time as a scheduling clerk for VA facilities in Austin, San Antonio, and Waco, he was directed by supervisors to hide true wait times by inputting false records into the VA's scheduling system. VA officials in San Antonio deny this, while VA officials in Austin claim employees may have been discouraged from using the electronic scheduling tool that would reveal long wait times, but that those orders did not come from "executive leadership." Can you confirm that supervisors at VA facilities in Texas have not and are not ordering employees to "game the system" by concealing wait times?

Response. April 25–28, 2014, an internal fact-finding review by South Texas Veterans Health Care System (STVHCS) was completed and claims made by the em-

ployee could not be substantiated. STVHCS and Central Texas Veterans Health Care System (CTVHCS) leaders have made it clear to scheduling clerks that no wait list formats of any kind other than VistA Scheduling software should be used.

Officials do confirm that scheduling clerks were not using the Electronic Wait List (EWL) and once leadership became aware, they conducted training sessions for clerks to begin using the EWL. The EWL is a valuable tool to help monitor appointments and determine where more resources might be needed.

VA encourages employees to bring forth any concerns they may have regarding scheduling of patients so their concerns may be addressed. If during any external or internal review, allegations of employee misconduct are substantiated, swift and appropriate action will be taken. In addition, as a part of positive employee relations, VA management continues to meet with scheduling clerks both in Central and South Texas to encourage the hard work they do on a daily basis and to hear their concerns.

Question 26. Secretary Shinseki, an Austin-based surgeon recently contacted my office to inform me he is not accepting any further subcontracts from the VA due to failures in patient care that he has personally witnessed. Specifically, he saw a veteran in August 2013 who was referred to him by the VA after they detected a lesion they suspected was cancerous. Already two months had lapsed between the time they detected the lesion and the time he saw the veteran. This surgeon performed a biopsy and diagnosed it as laryngeal cancer. He informed the VA that the veteran needed immediate chemotherapy—that they had a real chance to treat his cancer if they started chemotherapy right away. Almost two months later, he followed up on his case only to learn the VA never provided chemotherapy, with no good excuse as to why. The veteran died several days later. Can you confirm that veterans diagnosed with cancer of any kind that requires chemotherapy are provided that treatment in a timely manner by the VA?

Response. VHA is committed to timely care for all Veterans including those undergoing treatment for cancer. The referenced case was reviewed by clinical leadership in Central Texas and Veterans Integrated Service Network 17. At this time, the information provided indicates no evidence was found indicating that patients with cancer of any kind undergoing chemotherapy treatment experienced that care in an untimely manner. VHA investigates allegations of less than adequate care, and when warranted, takes appropriate corrective actions.

Question 27. Secretary Shinseki, a whistleblower in South Texas who formerly served as associate chief of staff for the VA Texas Valley Coastal Bend Health Care System in Harlingen, TX, told the Washington Examiner this week that roughly 15,000 patients who should have had the potentially life-saving colonoscopy procedure either did not receive it or were forced to wait longer than they should have. He also claims that approximately 1,800 records were purged to give the false appearance of eliminating a backlog. Can you confirm that veterans requiring colonoscopies to detect cancer are provided with the procedure in a timely manner?

Response. The claims against VA Texas Valley Coastal Bend Health Care System (VATVCBHCS) by the former Associate Chief of Staff are outlined in the Office of Special Counsel (OSC) report OSC File # D–11–3558 available on their Web site: https://osc.gov/Pages/PublicFiles-FY 2014.aspx . In the report, the allegations of poor patient care are unsubstantiated. In FY 2012, the completion rate within 90 days for VATVCBHCS Veterans requiring diagnostic colonoscopies to detect cancer, following positive fecal occult blood test results, was 82 percent (65 percent were completed within 60 days). In FY 2013, the completion rate within 90 days for VATVCBHCS Veterans requiring diagnostic colonoscopies to detect cancer, following positive fecal occult blood test results, was 86 percent (57 percent were completed within 60 days). All diagnostic colonoscopies are reviewed quarterly by the Invasive Procedures Committee.

Question 28. In 2012, VA medical facilities in Central Texas reported that 96 percent of veterans were seen by providers within 14 days of their preferred appointment date. In the South Texas region that includes San Antonio, the statistics were even more impressive: 97 percent of veterans were seen within two weeks, according to annual performance reports. Can you produce documents that show the original dates of veterans' requests for appointments for 2012?

Response. There is no mechanism in the VistA program to allow for a retrospective review of the original dates of a Veteran's request for an appointment after the Veteran has been seen for that appointment.

Question 29. Secretary Shinseki, according to public records, the director of the Phoenix VA hospital, where news investigations have discovered at least 40 veterans died while waiting for care and languishing on secret lists, received more than $9,000 in bonus pay in 2013. Can you confirm that any bonuses or pay raises are

on hold for senior leaders at VA facilities in San Antonio, Austin, Waco, Harlingen, and all VA facilities where similar allegations have been made?

Response. Acting Secretary Sloan Gibson announced on June 9, 2014, that VHA SES performance awards were suspended for FY 2014. FY 2013 performance incentives were paid in accordance with VA established recommendations and timelines for leaders at CTVHCS, STVHCS, and VATVCBHCS.

Question 30. Secretary Shinseki, my staff attended a Quarterly Congressional Staffer and Veterans Service Organization Representative Meeting at the Central Texas Veterans Health Care System (CTVHS) Friday, May 9, 2014. Sallie Houser-Hanfelder, director of the Central Texas Veterans Health Care System, told meeting attendees that, as part of the face-to-face audits you have ordered, a quality systems manager from CTVHS would be sent to another VA facility to assist with investigations there. Can you confirm that staff at facilities currently under investigation for allegations of falsified reports will not be assigned to investigate other VA facilities?

Response. The individual from CTVHCS that served on the phase one portion of the VA-directed site visits has no oversight or involvement with the scheduling of appointments.

Question 31. Secretary Shinseki, former VA employee at the VA Greater Los Angeles Medical Center told the Daily Caller that employees at the Center destroyed veterans' medical files in a systematic attempt to eliminate backlogged veteran medical exam requests. The former employee said, "The waiting list counts against the hospital's efficiency. He said the chief of the Center's Radiology Department initiated an "ongoing discussion in the department" to cancel exam requests and destroy veterans' medical files so that no record of the exam requests would exist, thus artificially reducing the backlog. In addition, you have been subpoenaed by the House Veterans' Affairs Committee over concerns by Chairman Jeff Miller that evidence in Phoenix may have been destroyed after the Committee issued a document-preservation order on April 9. A top VA official testified on April 24 that a spreadsheet of patient appointment records, which may have been a "secret list" proving misconduct, was shredded or discarded. Can you confirm that documents are being preserved at all Texas VA facilities?

Response. All four VISN 17 facilities are in receipt of the Memorandum from General Counsel "Subj: Litigation Hold Concerning Alleged Consult and Appointment Delays with VA Health Care System (VHA)" dated May 13, 2014. They confirm that the message has been distributed and all records are being preserved that leadership is aware of.

Chairman SANDERS. Thank you very much for your testimony, Mr. Secretary.

I am going to start off with a simple question, and then I am going to ask some harder questions, and you or Dr. Petzel can answer.

First, a very simple question. VA's Health Care System is the largest integrated health care system in the United States of America. Six-point-five million veterans access it every single day. Gen. Shinseki or Dr. Petzel, what are the strengths of VA's Health Care System? What are its problems, in your judgment? Is it a good system?

Secretary SHINSEKI. Mr. Chairman, it is a good system and it is comparable to any other health care system in the country. In some areas and some specific occasions, we exceed even those good systems.

For 5 years now, we have focused on three major goals for VA, all of it focused on doing better by veterans, which is what the President asked me to do when I came here. The first was to increase access. I think we have been successful at this. We have enrolled two million more veterans into VA health care. I think there is a net here somewhere around 1.4 million, 1.5 million who are net overall increases. But, over 5 years, we have enrolled 2 million more veterans.

The second focus was to go after this thing called the backlog, and we have had this discussion for a number of years now. But,

we did not simply go after the backlog just to end what was then, 5 years ago, a set of claims. We also acknowledged that we had not done very well by veterans of previous conflicts. And so even as we committed to ending the backlog in 2015, we also went and tried to bring justice to those who had never had an opportunity to submit a claim. I called on the good people in the Veterans Benefits Administration to take this on, and they did. And I promised them we would give them a new tool called the Veterans Benefits Management System, and in 3 years, we fielded this new automation tool that make them——

Chairman SANDERS. How did we used to do benefits?

Secretary SHINSEKI. All paper.

Chairman SANDERS. All paper.

Secretary SHINSEKI. All paper, and if you wanted to go faster, Mr. Chairman, you had to hire more people, which we had done over many years. I think we have, I do not know, 11,000 people who process claims, which is——

Chairman SANDERS. What I want to do now, Mr. Secretary, is pick up on some of the points, I think legitimate points, made by Democrats and Republicans. And the major allegation—I think everybody here understands that when you treat 230,000 people a day, mistakes are going to be made, which is true of any institution of that size. But, here is the major criticism that I hear from Senator Burr, Senator Murray, Senator Begich, and others, that this is not new news. These concerns did not arise yesterday. They did not arise in Phoenix. But, in fact, there have been reports by the Inspector General, by the Government Accountability Office, on numerous occasions about problems having to do with scheduling and waiting lists. Could you address how it could happen that, year after year——

Secretary SHINSEKI. Sure.

Chairman SANDERS [continuing]. These reports were made and there has not been significant action.

Secretary SHINSEKI. Yes. I think it is important here to look at the GAO and the IG reports and what they intend to do, and they come in and give us some sense of where we could be doing better. And we get in there and we address those issues and take corrective action and, in essence, close out the report. It does not mean that we have solved every issue. It does mean that we have taken care of addressing those issues, and then when they come back, there may be another set of issues to deal with.

I do understand Senator Murray's suggestion that we ought to take a comprehensive look at this——

Chairman SANDERS. I think what you are hearing from a number of Senators including myself, is that everybody knows problems will arise tomorrow. That is not the criticism. The criticism is that year after year reports have been made talking about these problems and the problems continue to exist. Can you give us some assurance of what happens tomorrow? Where do we go from here so that we do not have this hearing next year or 2 years from now?

Secretary SHINSEKI. Sure. And I think that is what the audit that we have created is intended to do. So, while the Inspector General is looking at Phoenix for evidence of employee misconduct and evidence that 40 veterans may have perished awaiting sched-

uling, the IG is going to get to the bottom of that. What we are attempting to do is to address the Senator's broader question, to take a look at ourselves and not wait for the IG's outcomes. And already, we have begun to see some evidence that—people are coming forward and saying, hey, I think there is an issue here, which I encourage. I mean, that is what we are after here. And if there were performance issues in the past, if they are continuing today, we want to put a stop to——

Chairman SANDERS. All right. My last question is, in your judgment, based on what you know, are people, "cooking the books?" Is that, in fact, a problem within VA's health care system?

Secretary SHINSEKI. I am not aware, other than a number of isolated cases where there is evidence of that. But, the fact that there is evidence in a couple of cases behooves us to go and take a thorough look, and that is why we have structured this audit so that a set of clinicians are not going to inspect their own areas. We have offset them so that a VISN 1 will inspect a VISN 10, and we will get a comprehensive—a good look. But I——

Chairman SANDERS. I apologize, but my time has long expired. Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Mr. Secretary, again, welcome. These questions are for you, and I will try to go as quickly as I can for the time constraints.

Mr. Secretary, were you aware that on October 25, 2013, the Office of Special Counsel requested that VA conduct an investigation into the allegations of the inappropriate scheduling at the Fort Collins Community Outpatient Clinic, and that since then, the media has reported about Mr. Freeman's e-mail of June 19, 2013, that explains how to game the system to avoid being on the bad boy list. Were you aware of those?

Secretary SHINSEKI. Senator, I became aware of that screen shot, I believe is what it was, of an employee who was suggesting there are ways to game. I put that employee on administrative leave——

Senator BURR. When was that?

Secretary SHINSEKI. That was last Friday.

Senator BURR. OK. Mr. Secretary, it is my understanding that on June 21, 2013, VA received a report from the Office of Medical Inspector regarding chronic understaffing issues at the Jackson VA medical center and that report described multiple patient scheduling problems, including scheduling two patients for the same appointment slot, and scheduling patients for a clinic that does not have any assigned providers, often referred to as ghost clinics; and that on September 17, 2013, the Office of Special Counsel submitted a letter to the President of the United States, on which the VA was courtesy copied, describing the findings of that June 21 Office of Medical Inspector report on the Fort Jackson Medical Center, including the practice of double-booking patients and the use of ghost clinics. Do you remember reading that report and receiving that copied letter to the President?

Secretary SHINSEKI. I cannot say that I remember it today, here——

Senator BURR. OK. There was a December 23, 2013, report by the Office of the Medical Inspector regarding the Cheyenne Medical Center and Fort Collins Clinic that found that several medical sup-

port assistants reported that, "medical center's Business Office training included teaching them to make the desired date the actual appointment, and if the clinic needed to cancel appointments, they were instructed to change the desired date to within 14 days of the new appointment." Did you read that report?

Secretary SHINSEKI. That report has come to my attention here recently.

Senator BURR. OK. On February 25, 2014, your Chief of Staff, Mr. Riojas, submitted a response to the Office of Special Counsel which included the December 23, 2013, Office of the Medical Inspector report on Fort Collins, and in that letter, Mr. Riojas states, "However, as OMI," Office of Medical Investigation, "was not provided any specific veterans' cases affected by these practices, it cannot substantiate the failure to properly train staff resulting in danger to public health or safety." Were you aware of what your Chief of Staff wrote?

Secretary SHINSEKI. I was.

Senator BURR. OK. Mr. Secretary, were you aware that the GAO report entitled, "VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement," which was publicly released in January 2013, and then on December 11, 2012, to that same report, your former Chief of Staff, John Gingrich, sent a letter to the GAO which stated, "VA generally agrees with the GAO conclusions and concurs with GAO recommendations to the Department." Do you remember that letter, that report and your Chief of Staff's response?

Secretary SHINSEKI. In general, I do remember that report.

Senator BURR. Mr. Secretary, you knew that there were specific issues relating to scheduling and wait times as early as June 21, 2013, at Jackson; December 23, 2013, at Fort Collins; as well as numerous IG reports related to excessive wait times in January 2012 in Temple, TX; September 2012, in Spokane, WA; October 2012, in Cleveland, OH; September 2013, in Columbia, SC; and December 2012, a GAO report which questions the validity and the reliability of the reported wait time performance measures, which brings us to today and Phoenix.

On May 1, you publicly stated that you had removed Ms. Hellman as the Medical Director, and you stated then that that was to ensure the integrity of the IG's current investigation. On May 5, Dr. Petzel conducted a conference call with all VISN Directors, all Medical Directors, and the Chief of Staffs—a rather large group—to discuss the ongoing face-to-face audits of all VA centers and large community-based outpatient clinics. I have been told by sources that were on that call that during that call, Dr. Petzel made the statement that the removal of Ms. Hellman was, "political and that she has done nothing wrong."

If you are asking us to wait until the investigation is over, does the same not apply to people who work for you? And, Mr. Secretary, from all I have described to you and the current investigation that is currently going on, why should this Committee or any veteran in America believe that change is going to happen as a result of what we are going through?

Secretary SHINSEKI. I was not aware of the phone call you referred to, and I will look into it. I would just tell you that my removal of the Director, placing her on administrative leave, was at the request of the IG. He is the lead in this comprehensive review. I do not get out ahead of him. He requested it and I put Director Hellman and two other individuals on administrative leave.

Senator BURR. I thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Burr.

Senator Murray.

Senator MURRAY. Secretary Shinseki, as I said in my opening, the announcement that the President is sending one of his top advisors to assist in this nationwide review is good news and I am confident Mr. Nabors will help make sure that this review is comprehensive and accurate. It is critical that this review is effective, because at a hearing of this Committee that I called in November 2011, I asked Dr. Mary Schoen, VA's Director of Mental Health Operations, whether facilities were gaming the system and not fully reporting wait times, and she told me she was unaware of any facilities doing that and that VHA was doing audits to make sure it was not happening. But there, as you know, have been an overwhelming number of allegations systemwide that wait times are being doctored, and the oversight organizations have reported on it for years.

The Department, so far, has been unable to provide me even the most basic information on how this nationwide review is going to be conducted or what it will look like, and I hope that is about to change. I want you to explain how this review is going to be conducted.

Secretary SHINSEKI. Let me call on Dr. Petzel to give you details.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Murray, there are going to be several phases to what we do. This week, we are auditing with in-person teams and an anonymous survey the first tranche of facilities, all 151 medical centers and our largest clinics. Starting next week, we are going to work our way down to all of the other sites of care, gathering information—and I think the anonymous nature of the questionnaire is particularly important—information about whether or not people have felt forced to do things that were inappropriate and lacking trust and integrity in the scheduling system.

The second part of this is an assessment, as a number of people have mentioned, as to whether or not we have our resources deployed appropriately, whether or not we have the appropriate amount of resources, and just as importantly, whether or not we are using those resources in the best way in each one of—at each one of our sites.

I think everybody needs to remember that we do 85 million outpatient visits every year. Ninety-five percent of those visits are with established patients and those are all accomplished within 14 days.

Senator MURRAY. I appreciate that. I just want the details of how this is going to occur so that we get good information.

Dr. PETZEL. So, we are going to focus on the new patient and the scheduling system that we have for new patients and all the other

access points besides our clinics and our medical centers that we have got available for new patients. So, first is the review——

Senator MURRAY. OK——

Dr. PETZEL [continuing]. To see how the scheduling system is being done. Second——

Senator MURRAY. The assessment.

Dr. PETZEL [continuing]. The look at whether or not we have——

Senator MURRAY. OK. Well, I would like to get the details from you on that, I do not want to use all my time, but it is important that we know how that is going to be used and we know that real change occurs.

But, I just have a minute and one half left and I want to ask you, Secretary Shinseki, Deputy Under Secretary for Health, Bill Schoenhard, told me at a hearing in 2012 that gaming is so prevalent, as soon as new directives are put out, they are torn apart to find out how to get around the requirements. Testimony from a VA mental health employee said the exact same thing.

And, at that same hearing, Linda Halliday from the IG's Office told us, "If we have seen scheduling practices that resulted in gaming the system to make performance metrics look better at the end of the day over the past 7 days, they need a culture change. To get that culture change, I think they really need to hold the facility directors accountable for how well the data is actually being captured."

That was more than 2 years ago, and the standard practice at VA seems to be to hide the truth in order to look good. That has got to change once and for all. And I want to know how you are going to get your medical directors and your network leaders to tell you—whether it is through this survey or in the future—when they have a problem and will work with you to address it, rather than pursuing these secret lists and playing games with these wait times.

Secretary SHINSEKI. Well, Senator, if there is anything that gets me angrier than just hearing allegations is to hear you tell me that we have folks that cannot be truthful because they think the system does not allow it.

Senator MURRAY. Right.

Secretary SHINSEKI. You know, trust is an important aspect of everything we do here, and it has been in my previous life, as well. In order to do that we have to be transparent and we have to hold people accountable. So, what I will say to you is we are going to get into this; and it is important for me to assure veterans, to regain their trust, whatever has been compromised here, that when they come to VA they come to a good, safe, caring system and that they will be cared for.

And for all the employees that are listening in today, I expect our employees to provide the highest quality, safest care we can provide, given all the comments about how tough it is in the health care industry, and provide access to benefits as quickly as we can. That is our mission. We only have one mission. It is taking care of these veterans, and not "these" veterans, I am one of them, a hundred thousand of our employees at VA are veterans. We have a vested interest here to get this right.

Senator MURRAY. OK. This is absolutely critical. This review will not work if those people who are telling you the information do not tell you the truth.

Secretary SHINSEKI. Agreed.

Chairman SANDERS. Thank you, Senator Murray.

Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman.

For both of you gentlemen, do you remember or do you know William Schoenhard?

Secretary SHINSEKI. I do.

Dr. PETZEL. Yes.

Senator ISAKSON. Do you know him, Dr. Petzel?

Dr. PETZEL. I do.

Senator ISAKSON. On the 26th of April in 2010, he sent out a memo to all the VISN Directors throughout VA entitled, "Inappropriate Scheduling Practices." Paragraph two begins, "It has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices, sometimes referred to as gaming strategies."

Then, paragraph three, and I am going to read the whole paragraph because this is the key to the question and, I think, is the key to the issue at VA. "For your assistance"—and there is an eight-page attachment to this—"for your assistance, attached is a listing of the inappropriate scheduling practices identified by a Multi-VISN Working Group chartered by the System Redesign Office. Please be cautioned that since 2008, additional new or modified gaming strategies may have emerged, so do not consider this list a full description of all current possibilities of inappropriate scheduling practices that need to be addressed. These practices will not be tolerated."

Are you familiar with that memorandum?

Secretary SHINSEKI. I am—I was not. I am not.

Senator ISAKSON. Dr. Petzel?

Dr. PETZEL. I am familiar with that memorandum, yes.

Senator ISAKSON. Well, if it is not going to be tolerated, and over 4 years ago you had eight pages of known practices for gaming the system, what action, if any—and I do not think any took place—did VA take to respond to William Schoenhard's memorandum to see to it the VISN and the hospital directors followed the orders?

Dr. PETZEL. We have worked very hard, Senator Isakson, to root out these inappropriate uses of the scheduling system and these abuses. We have been working continuously to try to identify where those sites are and what we need to do to prevent that from happening. It is absolutely inexcusable. The scheduler's responsibility is to be sure that that program is administered with integrity?

Senator ISAKSON. What do you do when you uncover one? Surely, you have uncovered one. What do you do to hold them accountable?

Dr. PETZEL. The individuals are, as you mentioned, held accountable. I cannot give you an example specifically, but if someone were found to be manipulating inappropriately the scheduling system, they would be disciplined.

Senator ISAKSON. So, would they lose their job?

Dr. PETZEL. I do not know whether that is the appropriate level of punishment or not.

Secretary SHINSEKI. Senator, we can probably give you a little better answer to this, because you are focused on scheduling. What I can tell you is that in 2012, we involuntarily removed 3,000 employees for either poor performance or misconduct. In 2013, another 3,000 employees were involuntarily removed, and among them, there were some senior executives, as well.

Senator ISAKSON. Are those removals a reassignment within the VA Health Care System?

Secretary SHINSEKI. Some may be reassignments. Others were departure, some by retirement and others by, in effect, being let go by VA.

Senator ISAKSON. Well, I just—I have read this entire eight-page memorandum and there is no gray area. It is not saying we think this is happening. It is saying we know this is happening; and there may be other ways of gaming the system. It talks about being done specifically for the purpose of improving scores on assorted access measures, which I guess means the way in which their performance is evaluated as an employee. Is that correct?

Secretary SHINSEKI. I—I am going to take your direction here.

Senator ISAKSON. No, no, no——

Secretary SHINSEKI. I have not read the memo——

Senator ISAKSON. No, no, no. I——

Secretary SHINSEKI [continuing]. So, I would assume that that is the——

Senator ISAKSON. And I would assume, if the System Redesign Office had a Multi-VISN Working Group—do you know what the System Redesign Office is?

Secretary SHINSEKI. Dr. Petzel?

Dr. PETZEL. Yes. That——

Senator ISAKSON. What is that?

Dr. PETZEL. That is the group that is responsible for ensuring that we are designing the work within our clinics and operations in the most effective and efficient way; and they have been given—at that time, they were given responsibility for monitoring and keeping track of access.

Senator ISAKSON. It says that the listing of inappropriate scheduling practice was identified by the Multi-VISN Working Group. So, you had a group within the Veterans Administration that identified on August 26, 2010, various and numerous practices where numbers were being manipulated for the purpose of better outcomes, I presume, in terms of how those people would be rated. It would seem to me like there should have been a systematic, written practice where the chain of command would see to it that was not tolerated, as the memo said, and there was accountability to be had, including the loss of a job.

Dr. PETZEL. I absolutely agree with you. And we did institute that appropriate level of accountability. I will find out—I do not know whether anybody was specifically disciplined around that issue, but this has been a very important thing to us for at least the last 4 years, Senator Isakson. We have tried to root out those places where the scheduling system was being used inappropriately.

Senator ISAKSON. So——

Dr. PETZEL. It is intolerable.

Senator ISAKSON. I know my time is up, but let me just say two things. One is, for the sake of the integrity of the Veterans Administration, you need to find out if there is an accountability system to respond to this memorandum from August 26 and what it was.

And, second, I would like to ask unanimous consent to submit this Memorandum for the record.

[The Memorandum from August 26, 2010, is posted in the Appendix under Senator Isakson.]

Chairman SANDERS. Without objection.

Senator ISAKSON. Thank you both.

Chairman SANDERS. Thank you.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman. Again, thank you to you and the other veterans who are here and who are listening for their interest and involvement in this issue.

Secretary Shinseki, can you tell me how quickly we will have some preliminary results to both the review and the IG investigation?

Secretary SHINSEKI. The Inspector General has his own time table and I do not have insight into what that is. On our audit, we are taking care of most of the large facilities this week. There will be some follow-up next week. Perhaps in about 3 weeks we will have been able to assemble all the data, do a good analysis, and then respond in detail in a way that Members have asked.

Senator BLUMENTHAL. Can you commit that within 3 weeks, you will have a report for us?

Secretary SHINSEKI. I—I think we should be able to do that, but that is preliminary right now. I do not know what data is being assembled and——

Senator BLUMENTHAL. And——

Secretary SHINSEKI [continuing]. Collating it every day, but we will shoot for 3 weeks.

Senator BLUMENTHAL. And I apologize for interrupting, but as you know, all of our time is limited.

Secretary SHINSEKI. Sure.

Senator BLUMENTHAL. As part of your management responsibility, do you not believe as I certainly believe, that there is a responsibility from the IG to complete this report as quickly as possible, within a matter of days and weeks, not months?

Secretary SHINSEKI. I agree that it would be helpful for the IG to complete his report as quickly as——

Senator BLUMENTHAL. And can you give the IG a deadline?

Secretary SHINSEKI. I am not able to do that. The IG is an independent reviewer here, and once I turn this over to him, I am primarily supporting his needs here. So, in terms of——

Senator BLUMENTHAL. Let me raise sort of the elephant in the room. Is there not evidence here of criminal wrongdoing, that is, falsifying records, false statements to the Federal Government? That is a crime under the——

Secretary SHINSEKI. It should be, yes.

Senator BLUMENTHAL. And would it not be appropriate to ask for assistance from the Federal Bureau of Investigation or some other

similar agency, given that the IG's resources are so limited, that the task is so challenging, and the need for results is so powerful?

Secretary SHINSEKI. Again, I will work with the IG to make that available to him if that is his request.

Senator BLUMENTHAL. Well, may I suggest, respectfully, Mr. Secretary, that it is your responsibility to make that judgment about the IG's resources, and without rushing to judgment, without reaching any conclusions——

Secretary SHINSEKI. Sure.

Senator BLUMENTHAL [continuing]. To involve appropriate Federal criminal investigative agencies if there is sufficient evidence of criminality, which, in my judgment, there is more than sufficient reason to involve other investigative agencies here in light of the evidence—more than allegations, but evidence—of potential false statements to the Federal Government, and the need for timeliness and promptness in results to restore trust and confidence.

What I am hearing from my colleagues is the background about the systematic failures here and the need for also greater transparency and accountability, so let me ask my next question.

Secretary SHINSEKI. Well, that is a discussion on resources that I have had repeatedly with the IG to make sure. But, again, every discussion about, do you have enough resources, based on what is underway, each new discovery adds to that workload, and, fair enough. I will have that discussion with him again.

Senator BLUMENTHAL. Let me ask, will you change your management team given that the background here shows systematic failings over a period of, apparently, years, not just months?

Secretary SHINSEKI. Yes. Senator, I do not want to get ahead of myself or ahead of the IG here. I want to see the results. I want to see the results of the audit, and if changes are required, I will take those actions.

Senator BLUMENTHAL. If this evidence that we have seen already is as probative and powerful as it seems to be, would not changing your management team be appropriate?

Secretary SHINSEKI. Perhaps. I am still waiting for the results of the audit.

Senator BLUMENTHAL. Thank you very much, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Blumenthal.

Senator Heller.

Senator HELLER. Thank you, Mr. Chairman.

Mr. Secretary, I pointed out in my opening statement about the IG investigation revealed the treatment of a blind female veteran and the way she was treated at the emergency room in the VA hospital in Las Vegas. Have you had an opportunity to see the results of that investigation?

Dr. PETZEL. Senator Heller, I have had an opportunity to review that investigation, yes.

Senator HELLER. What was the conclusion?

Dr. PETZEL. The—without revealing details about the individual——

Senator HELLER. Sure.

Dr. PETZEL [continuing]. It was that she did wait too long and that there were others that waited too long in the emergency room. It did not have, in the estimation of the inspector, an impact on

the eventual course of her illness, but it was inappropriate that a service-connected blind veteran should have to wait that long in our emergency room.

Senator HELLER. Thank you for the answer.

Mr. Secretary, do you agree?

Secretary SHINSEKI. I do not think any veteran, whatever the condition, should have to wait that long in any of our facilities, whether it is an emergency room or a clinic.

Senator HELLER. Mr. Secretary, have you received complaints about patients' wait times, scheduling practices, for any other facility in Nevada?

Secretary SHINSEKI. I am not aware of another facility——

Dr. PETZEL. I am not, either.

Secretary SHINSEKI [continuing]. In Nevada. Dr. Petzel?

Dr. PETZEL. I am not aware of it, either. We are not—I do not know the results of our visits to either Reno or the Las Vegas hospital, but I have not heard anything.

Senator HELLER. Will all of Nevada's VA hospitals and clinics have face-to-face audits?

Dr. PETZEL. Yes, they will.

Senator HELLER. Will VA conduct more thorough audits later with the IG?

Dr. PETZEL. If we find that there were instances where there might have been inappropriate criminal activity, we certainly will enjoin the IG to come. That is difficult to predict, depending on what we find.

Secretary SHINSEKI. Senator, are you talking about a continuing series of audits?

Senator HELLER. Correct.

Secretary SHINSEKI. I think, based on what we find, if there is a widespread, systemic issue here, we will set up a program of sustaining looks to make sure that we have rooted out the kind of behaviors that we are talking about, either alleged or in fact.

Senator HELLER. After conducting those investigations, will you make that available to myself and my staff?

Secretary SHINSEKI. Yes.

Senator HELLER. To any member of the Nevada delegation?

Secretary SHINSEKI. Yes.

Senator HELLER. Great. To go back, obviously, with the issues, Mr. Secretary, with what is going on in Phoenix, the waiting room, the time waits that we are seeing across the country and, of course, in my State of Nevada, and, of course, the disability claims backlogs that we are seeing three times longer in the State of Nevada than what it should be, do you believe that you are ultimately responsible for all this?

Secretary SHINSEKI. I am. You and I had this discussion yesterday. I think I need to provide you data that would be a little more current than three times the national average on waits on backlog claims. Perhaps true at one time, I am told that those numbers are down.

Senator HELLER. OK. Today's numbers are 355 days.

Secretary SHINSEKI. That is on——

Senator HELLER. That is still three times longer than the national average.

Secretary SHINSEKI. OK.

Senator HELLER. Would you explain to me, after knowing all this information, why you should not resign?

Secretary SHINSEKI. Well, I tell you, Senator, that I came here to make things better for veterans. That was my appointment by the President. Every day, I start out with the intent to, in fact, provide as much care and benefits for the people I went to war with and the people that I spent a good portion of my life doing. This is not a job. I am here to accomplish a mission that I think they critically deserve and need, and I can tell you, over the past 5 years, we have done a lot to make things better. We are not done yet, and I intend to continue this mission until I have satisfied either that goal or I am told by the Commander in Chief that my time has been served.

Senator HELLER. Mr. Secretary, thank you for being here today. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Heller.

Senator Hirono.

Senator HIRONO. Thank you, Mr. Chairman.

In his testimony, Acting IG Mr. Griffin states that VA's core mission is to provide quality health care. Is providing quality health care still VA's core mission, or have the goals of VA shifted over time as they have expanded into providing other benefits to veterans, as well? Of course, I note that Congress has tasked VA to provide job training, housing assistance, education assistance, and reduce homelessness. So, can you share your thoughts about what is the core mission now, with all these other tasks that you now have, programs that you now have, are there—are you able to focus on your core mission of providing quality health care to our veterans?

Secretary SHINSEKI. Yes. Providing quality, safe, accessible health care for our veterans who have earned them is a core mission. But, in order to provide that kind of health care, they still have to access the system, and that means we have to do a good job at dealing with disability claims. If we are not able to process those claims, the opportunity to access health care is something less.

For the current generation of Iraq and Afghanistan veterans, it is automatic that they have 5 years of health care from VA. So, for that group, that generation of veterans, it is a little different than others.

So, disability claims becomes an issue here because that then renders the opportunity to take advantage of health care benefits.

I would say homelessness is also part of our responsibility. Five years ago, we talked about homelessness as though it were a thing out there, and what we have learned in 5 years, because we have focused on ending it, is that depression—major factors that lead to homelessness—depression, insomnia, pain, substance abuse, substance use disorders, and then——

Senator HIRONO. Mr. Secretary, I am sorry to interrupt, but my time is rapidly expiring. The point of my question is that all of these areas that we have asked you to address with regard to our veterans—education needs, homeless issues, all of that—whether that is making it much harder for you to meet your core mission?

That may be a rhetorical question, so let me just move on to another area.

As we look at the potential need for making systemic changes to how VA operates, I again note the IG's testimony today on page eight where he says that there is no national process to establish what are deemed essential positions to the delivery of health care. There is no standard organizational chart for VA hospitals and clinics. So it is very hard to determine what clinics are doing better than others. Would you consider these two areas to be potential systemic changes that we should be looking at making within the VA operations?

Secretary SHINSEKI. I think that is good insight here, and we will take a look at that. Part of our challenge is the complexity of VA Health Care System. We have a series of hospitals that go from the very largest and most sophisticated, comprehensive kind of health care—organ transplants, you know, brain surgery. We call them 1As; and then there are 1Bs and 1Cs; and then Level 2 and Level 3s, all of this distinguishing between the level of care that can be provided there. It is a complex system, but I think standardizing the definitions of key leaders within that kind of framework would be helpful and sensible.

Senator HIRONO. This next question may be one for Dr. Petzel to very briefly respond to. We have heard that VA has used bonuses and compensation as staff incentives to help bring down the patient wait times, and my question is, are these individual bonuses? Are these clinic bonuses? Are these individual compensations that occur? And, how do you hold staff accountable to ensure that these incentives are earned in an appropriate manner? What do you have in place to make sure that the gaming of the system is not occurring?

Dr. PETZEL. What you are referring to, I think, Senator, is the performance awards that are given at the end of the year, and each senior executive has a performance contract that has many, many elements, one of which, a subset of which, may relate to access. It could be stated in a variety of different ways. Has access improved, and then the percentage of improvement. Very few of them would state the absolute. Most of them are statements of what has been the improvement. So, it is a part of a much more comprehensive evaluation system for senior executives.

Senator HIRONO. But, if you do not have accountability systems in place, I think it certainly encourages the kind of activities that we are scrutinizing today.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you very much.

Senator Johanns.

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Thank you, Mr. Chairman. Thanks for holding this important hearing, which I hope is the first of many, many hearings.

Mr. Secretary, as you know, I occupied a Cabinet post for a part of my career. There are some Cabinet posts, as you know, by their nature, that are kind of a lightening rod. If you are going to be the

Attorney General or the Secretary of State, you are going to get fired at every day. It is just part of the job description. The VA, on the other hand, in my judgment, does not fit into that category.

And the other thing about VA is, because of the Ranking Member and Chair and those who preceded them, it is a pretty nonpartisan committee. We do not sit around and talk about Republican or Democrat stuff. We talk about how to improve the lives of veterans who have served our country. And I have always applauded that. I think that we need more of that in Washington and not less.

The other thing I would mention is that there have been tough budget cycles. We know that. And yet, you, yourself, have come to this Committee many times and said you are resourcing us appropriately and generously under the circumstances and we thank you for that. We applaud you for that. So, then I look at this stuff and I go, what the heck?

Mr. Secretary, one of the submissions we got from the American Legion was a map. Have they shared that with you, or has that come to your attention?

Secretary SHINSEKI. I think I may have seen a copy of that last evening.

Senator JOHANNS. This map is entitled, "Epidemic of VA Mismanagement," and it goes down through Burlington, VT, Pittsburgh, PA, Durham, NC, Columbia, SC, Augusta, GA, Atlanta, GA, Jackson, MS, Chicago, IL, St. Louis, MO, Austin and San Antonio, TX, Cheyenne, WY, Fort Collins, CO, Phoenix, AZ, just place after place where the American Legion has thrown up their hands and said, my goodness, what the heck is going on here? Do you dispute what they are saying in this map? Do you think they are saying something here that is not true?

Secretary SHINSEKI. I am not aware of the basis for that map, but I accept that there are places that are listed here where we have had adverse events, and I would also point out that, I do not know if in all, but in a good number, maybe a majority of those events, they were self-identified, initiated from within the Veterans Administration, Veterans Health Administration, which then allows us to go and investigate, figure out what happened, get to the root causes, and then be transparent, tell people what happened.

Senator JOHANNS. But, here is where I am going with this. So many hearings I have come to where we have talked about the waiting lists and the disability claims, just kind of one thing after another. I just walk out of the hearing like I have been given an explanation so I will quiet down and let you go back to work, yet I do not see the change that is necessary. And, what worries me about this and what worries me about what we are dealing with here is it is systemic. It is cultural. It is people have just adopted this mode of operation as the way of doing business.

Do you share my concern? Do you feel that VA culture is such that every rule you put out, even after this, you say, OK, folks, from now on, we are going to do A, B, C, and D. That is an order. It comes from the very top, the Secretary. Do you fear that people say, how do we game that? How do we get around that?

Secretary SHINSEKI. I am sure someplace in a large organization, you are always going to have something like that, but this is part of the reason why I engage the Veterans Service Organizations on

a near-monthly basis. If there are any straight shooters here, it will be them in terms of being direct with this Secretary. This is why I have spent a good bit of time traveling the country, going to our facilities and talking to them about what is important and engaging veterans in those locations, as well.

The voices that are most important to me are the voices of the veterans I encounter out there, and I will say there is an occasional concern that is voiced to me, which I always bring back and go to work on. But I have not received that systemic look that is being described.

There is a distinction between a medical mistake and manipulation or cooking the books. In the case of a medical mistake, I want people to stand up and say, hey, something is wrong here. Something is not working, or we made a mistake, or I made a mistake. To do that, you have to have the confidence and honesty on the part of the workforce. And in many of those examples cited on that map, that is what initiated our concern. Manipulation, we will get to the bottom of.

Senator JOHANNS. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Johanns.

At this point, I would like to offer Senator Begich the opportunity to speak. Senator Begich, do you have some questions?

Senator BEGICH. Thank you, Mr. Chairman. I just wanted to catch that first vote as we were getting ready.

First, again, I want to thank you all very much for being here. Thank you for the work we have done in Alaska. Let me just say that some of the comments I want to follow up on that other Members have had, but let me first start with one. I am struggling here, I will be very frank with you, Mr. Secretary. I have—again, all the good work we have done in Alaska to really go after some of these issues. Even though we are a small State, we have been able to accomplish some things that, I think, have made an improvement in delivery of services for veterans. And to remind folks, having 77,000 veterans is a huge amount in Alaska.

But, the bigger issue, as I was listening to Senator Burr's note of the 4-year memo and regarding identification of the issues that talked about scheduling and other issues, we talked about trust a little bit earlier. That is important, that we have trust with delivery of services and that we trust the people who are delivering the services at VA.

But, if you have—and, I will tell you from my time as mayor, if you have people that have been identified to have manipulated records, I will tell you from the city side, we would fire them——

Secretary SHINSEKI. Yes.

Senator BEGICH [continuing]. Because we lost trust. If they are cheating, they are not trustworthy. If you just transfer them to another part of the government, then they just perpetuate what they have done, maybe in a different field.

So, my question is—I know you talked about the 3,000 people you have moved, dismissed, retired, whatever—but I want to know specifically on this issue, have you ever fired anybody on this issue, when you find out that they manipulated the records? To me, it is the fundamental question, because if it is just shifting around, then we are not changing the system to improve it. Help me—and if you

cannot answer that right now, I do want an answer later, because this, to me, is a fundamental issue. As a former mayor, we would fire them. They would be gone.

Secretary SHINSEKI. I would have to give you an answer that looked out across the specific reasons that we released 3,000 people, Senator. Manipulation, a very specific—this is something, for me, more recent. Without getting ahead of decisions, I would say manipulation of data, of the truth, is serious with me——

Senator BEGICH. Would you fire them?

Secretary SHINSEKI. I will do everything I can within the——

Senator BEGICH. That is not the question. I understand——

Secretary SHINSEKI. There is a process here, Senator. Let me not get out ahead of it, so that, in the end, it gets reversed because of predetermination.

Senator BEGICH. OK. Let me ask you this, then.

Secretary SHINSEKI. Yes.

Senator BEGICH. In the last—since that last document, was it Schoenhard's—William Schoenhard's? I cannot remember the memo, but——

Secretary SHINSEKI. Schoenhard.

Senator BEGICH [continuing]. That report——

Secretary SHINSEKI. Right.

Senator BEGICH. Clearly, that report identified some people who have been doing some manipulation. So, the question is, from that report—let us not talk about the future for a second. Let us talk about that report. Was anyone fired for that activity?

Secretary SHINSEKI. I do not know. I had not seen that memorandum, but I would say if there was any manipulation that identified individuals, I would expect to have seen their names in that list of 3,000, and that is what I cannot tell you today. I need to do some research.

Senator BEGICH. Can you submit that for the record?

Secretary SHINSEKI. I will. Let me just ask Dr. Petzel if he has any better insight.

Senator BEGICH. OK.

Dr. PETZEL. I do not have any specific information, Senator Begich, but we can go back and try to determine whether or not that has occurred.

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

Senator BEGICH. Because if we are going to try to rebuild the system—and again, I want to say that we saw this problem in Alaska when I first came in. We had backlogs on claims. We had scheduling issues. We had a lot of things. But we took—we went after it, right; we went after it jointly to figure out how to do this. We did MOUs with the Alaska Native Health Clinics. We went after it with the Care Closest to Home program, which I know is going to run out of money at the end of this fiscal year if we are not careful. There were a variety of things we went after to try to fix, so, I know we can fix this problem.

But, we still have challenges, and I think the biggest challenge is holding people accountable for actions that they manipulated or they redrafted the records to make them look better. Without accountability we are never going to solve this problem. And some-

times, you have got to have some heads roll in order to get the system to shape up, because sometimes if they think, well, I am just going to get transferred, or I am on leave and I still get paid, what is the real penalty? I can just tell you, again——

Secretary SHINSEKI. We are not in disagreement here, Senator.

Senator BEGICH. Great. OK. I just wanted to hear that clearly.

And let me again say, Mr. Chairman, I know this is just one of many opportunities we will have. I know you are waiting for the IG report. That will give us some more opportunity. I am hopeful that IG report, when it comes out, that there will be immediate action based on the report, not a further study of the report. When the IG says, here are the problems, we need to get after them, because if we do not get after them, the VAs in this country and in Alaska will be the ones who lose out at the end of the day. And I think you recognize that the veterans will be on the back end of this. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Begich.

Senator Burr wanted 2 minutes. I will take 2 minutes, as well, and those will be the last questions before we hear from the veteran service organizations.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Mr. Secretary, in your testimony, you said, "I invited an independent investigation by they VA Office of Inspector General to conduct a comprehensive, thorough, timely review. If any allegations are true, they are completely unacceptable to veterans, to me, and to our dedicated VHA employees. If they are substantiated by the OIG, responsible and timely action will be taken." How do you define responsible and timely action?

Secretary SHINSEKI. There is a process to be able to implement those findings—decisions regarding those substantiated findings. I will tell you, it will be as aggressive and swift as I can make it. But, there is a process here that is not entirely under my control.

Senator BURR. Mr. Secretary, I am sure you are aware of the IG report that was released April 17 of last year regarding the mismanagement of inpatient mental health care at the Atlanta VA medical center, because Senator Isakson and Dr. Petzel went personally and addressed it. And, I am sure you are aware of the IG report regarding the unexpected patient deaths in a substance abuse residential rehabilitation treatment program in the Miami VA Health Care Center, because that was released on March 27, 2014.

In the IG's testimony that Mr. Griffin will give later, it says that in both Miami and Atlanta, as the reports indicate, standard steps to ensure veterans were kept safe while under VA control were not taken and two veterans died. In each instance, VA managers did not ensure the hospital staff performed their jobs.

One, I would assume that you find Miami and Atlanta unacceptable, and if you will, tell me what we have done in a responsible and timely manner to remediate that problem.

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. In Atlanta, Senator Burr, there have been seven disciplinary actions, including the retirement or removal of three senior officials.

Senator BURR. And Miami?

Dr. PETZEL. And Miami is still in process, but we will do this as quickly as we are able to do.

Senator BURR. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Burr.

I have two questions in my brief time. Question number 1, you have heard serious problems about wait times in various locations around the country. I think Dr. Petzel informed us that in the last few years, we have seen 2 million additional veterans coming into the system. Is that correct, Dr. Petzel?

Dr. PETZEL. Two million new patients have arrived since 2009, with a net increase of 1.4 million.

Chairman SANDERS. OK. And, I would suspect some of those patients are coming in with some serious problems in terms of PTSD, TBI, and difficult issues, yes?

Dr. PETZEL. Yes, sir.

Chairman SANDERS. All right. So, let me ask you a very simple question. To what degree does VA not have the resources to address that increase in patients? Are a lot of patients coming in to certain parts of the country and are we seeing waiting lists because you simply do not have the resources? What is the answer?

Dr. PETZEL. The—may I—Mr. Chairman? The ability to, as I have said earlier, the ability to provide appropriate access to these groups of veterans depends on several things. One is the people. Do we have enough people?

Chairman SANDERS. Right.

Dr. PETZEL. Two, are we using these people most effectively.

Chairman SANDERS. Right.

Dr. PETZEL. And, three, are we using all the other things that are available to us—telehealth——

Chairman SANDERS. Right.

Dr. PETZEL [continuing]. The fee basis program, et cetera.

Chairman SANDERS. Those are the issues. What is the answer?

Dr. PETZEL. Yes. One of the things that we are going to do is we are going to look at those places that are having access difficulties as a result of this audit and make a determination as to whether or not we have adequate resources there. My feeling now, my thought now, is that we do, but we need to look carefully at those places where we are having access issues to see if it is a resource problem.

Chairman SANDERS. All right. Let me simply conclude, and we are going to get to the——

Secretary SHINSEKI. Mr. Chairman?

Chairman SANDERS. Yes?

Secretary SHINSEKI. May I add, this is not a once and done, or whenever we have a crisis, we do. This is an ongoing set of looks at ourselves.

Chairman SANDERS. OK.

Secretary SHINSEKI. Our patient load grows each year and the complexity of the issues, as you have described. So, this is an ongoing assessment that we try to get in the budget process so there is an orderly decisionmaking.

Chairman SANDERS. My time has expired. Let me thank both of you very much for being here, and I would like to call up our second panel.

[Pause.]

Chairman SANDERS. The VA is a little bit different than other agencies because, while it obviously serves and represents all of the people in our country, it has a very special constituency, who are men and women who have put their lives on the line to defend their country. Those are the people who utilize VA every day. And today, we are very pleased to have representatives from many of the major veterans service organizations here with us and I thank them all very much for being here.

We are all interested to hear about your members' experiences with VA health care services. You know more about it because your members access the system every day, so we look forward to hearing your suggestions and your criticisms.

I would like to remind each of you to keep your oral presentation to 5 minutes, and, of course, your full statement will be included in the record of the hearing.

Our guests today are Daniel M. Dellinger, who is the National Commander of The American Legion; Joseph A. Violante, the National Legislative Director for Disabled American Veterans; Tom Tarantino, Chief Policy Officer for Iraq and Afghanistan Veterans of America; Carl Blake, who is the National Legislative Director of Paralyzed Veterans of America; D. Wayne Robinson, President and CEO of Student Veterans of America; Ryan Gallucci, Deputy Director, National Legislative Service, Veterans of Foreign Wars of the United States; and Rick Weidman, Executive Director for Policy and Government Affairs of Vietnam Veterans of America.

I want to thank all of you for your honorable military service and for being with us today.

Commander Dellinger, we will begin with you, please.

STATEMENT OF DANIEL M. DELLINGER, NATIONAL COMMANDER, THE AMERICAN LEGION

Mr. DELLINGER. Good afternoon. Yesterday, we learned of a veteran in Vermont who died while trying to get mental health care from his local VA. His wife complained he would have to wait for hours, just to be bounced around to different counselors. The American Legion expressed our concern about this very issue before the House Veterans' Affairs Committee at the beginning of April and again before this Committee at the end of April. Our testimony is a matter of public record.

Chairman Sanders, Ranking Member Burr, and distinguished Members of this Committee, on behalf of the 2.5 million members of The American Legion plus another million of our Auxiliary and Sons family members, thank you for holding this hearing and inviting me to share the views of the largest Veterans Service Organization in the Nation.

Two days ago, I was in Phoenix, AZ, where I hosted a Veterans Hall meeting—a System Worth Saving—which lasted almost 4 hours. Attended by over 200, 62 spoke passionately about scheduling issues, overmedication, and various other concerns at the hospital. I will be happy to discuss the details of that meeting with

you during the question and answer period if you would like to hear more about that information gathering session.

I am here today to help you understand why The American Legion believes VA needs to address specific deficiencies and also to let you know that The American Legion fully supports the Department of Veterans Affairs.

We supported the creation of the Veterans Administration in 1930 and fought hard to get VA elevated to Cabinet-level in 1989. We donate hundreds of thousands of hours each year to VA, along with millions of dollars, and have scores of claims representatives. We helped fund a brain research center in Minnesota and are currently representing three-quarters of a million veterans as they file their claims with VA. Make no mistake about it, The American Legion believes in the VA.

The allegation of secret waiting lists at Phoenix Department of Veterans Affairs Medical Center that are now being investigated, along with the 40 or more patient deaths, have rocked the veterans' community. In addition to Phoenix, we now understand at least six additional VA locations have been identified as participating in veteran patient wait time manipulation.

The allegations in Phoenix were not the only reason The American Legion decided to call for a leadership change at the VA. They were simply the final straw in a long list of systematic leadership failures that include: construction delays and cost overruns; patient deaths due to Legionella; patient infections due to unsanitary colonoscopy equipment and dental equipment; unacceptable wait times for colonoscopies, resulting in patient deaths; the abandonment of efforts to create a true unified and interoperable Joint Health Care Record for use by both the Department of Defense and Department of Veterans Affairs; VA's refusal to answer Congressional inquiries; and VA's witnesses' failure to disclose all relevant truths when testifying before Congress.

On Tuesday, we heard that Senator McCaskill is concerned enough about mismanagement and mental health waits at the St. Louis VA that she drafted a bipartisan letter with Senator Blunt to get to the bottom of it. The list continues to grow.

When are things going to get better? It seems that a day cannot pass without a news report about the problems and difficulties VA faces with delays and quality of care challenges. While we wait for things to get better, hundreds of thousands of veterans are waiting for a decision on their initial disability claim or appeal, which prevents them from receiving VA health care. While we wait, transitioning servicemembers are falling through the cracks due to DOD and VA's inability to create a single interoperative medical record. While we wait, officials in VA's central office are preventing hospitals from being transparent during a crisis. While we wait, veteran suicides continue to plague our Nation at a rate of 22 per day, with no clear strategy from VA on proactively addressing suicides.

Again, I would like to thank you for this opportunity to speak with you today and welcome your questions.

[The prepared statement of Mr. Dellinger follows:]

PREPARED STATEMENT OF DANIEL M. DELLINGER, NATIONAL COMMANDER, THE AMERICAN LEGION

The Department of Veterans Affairs (VA) has come under scrutiny by Congress, Veteran Service Organizations, the media, and in the veterans' community for its failures in leadership, performance, and accountability which have resulted in quality of care or patient safety issues that have directly affected veterans. If there is a lack of performance and accountability among a senior executive service employee, the only disciplinary actions the Secretary of Veterans Affairs can take are to issue reprimands or transfer VA senior executive service employees to other VA facilities, even if that lack of performance results in the death of a veteran.

Chairman Sanders, Ranking member Burr, and distinguished Members of this Committee, thank you for inviting The American Legion to testify before you today and discuss our views on The State of Healthcare at the Department of Veterans' Affairs.

The allegations of secret waiting lists at the Phoenix Department of Veterans Affairs Medical Center that are now being investigated along with 40 or more patient deaths has rocked the veterans' community. In addition to Phoenix, we now understand that at least six additional VA locations have been identified as participating in veteran patient wait time manipulation just this week. The allegations in Phoenix were not the only reason The American Legion decided to call for leadership change at VA, they were simply the final straw in a long list of systemic leadership failures that include:

- Construction delays and cost overruns
- Patient deaths due to Legionella
- Patient infections due to unsanitary colonoscopy equipment and dental equipment
- Unacceptable wait times for colonoscopies resulting in patient deaths
- The abandonment of efforts to create a true, unified, interoperable joint healthcare record for use in the Department of Defense (DOD) and the Department of Veterans Affairs (VA)
- VA's refusal to answer congressional inquiries
- VA witnesses failure to disclose all relevant truths when testifying before Congress

And the list continues to grow.

Veterans are frustrated and concerned with VA's construction processes and the continued delays and cost overruns. Every day the construction goal is not met for medical centers in Denver, Orlando, or New Orleans, is a day VA is failing to take care of our Nation's veterans. According to a Government Accountability Office Report—Cost Increases and Schedule Delays at the Four Largest Projects—"cost increases ranged from 59 percent to 144 percent representing a total cost increase of nearly $366 million per project with average schedule delays ranging from 14 to 74 months with an average delay of 35 per VA major construction project." In one case, a hospital was completed, but they forgot to install an ambulance bay, which then had to be renegotiated, contracted for, and installed.

During a Subcommittee on Oversight & Investigations hearing in November 2013 on "Correcting Kerfuffles," there were several complaints on the G.V. (Sonny) Montgomery VA Medical center that cited poor sterilization procedures. The hearing also mentioned that pieces of bone were still attached to surgical instruments that were being used on other patients.

For nearly 18 years, the dental clinic at the Dayton VA Medical Center allowed unsanitary practices, potentially exposing hundreds of patients to hepatitis B and hepatitis C. Dayton VA Medical Center Director Guy Richardson then collected an $11,874 bonus despite an investigation into the exposures. After nine of the exposed patients tested positive Hepatitis B and Hepatitis C, Richardson was promoted.

The American Legion has also spoken out recently regarding the billion dollar botched development of the iEHR—Individual Electronic medical Health Record project. After years of promises and more than a billion dollars wasted, VA simply walked away from the mission and started over in January by reissuing a new procurement request. The American Legion believes that the introduction of a joint Department of Defense and VA electronic health records would have all but eliminated the disability backlog already, yet as of May 6, 2014, 308,285 (52.3%) of all disability claims have been backlogged over 125 days.

VA's claims adjudication accuracy is questionable. The American Legion does not question the ethics of the accuracy, we question the formula utilized. The American Legion's Regional Office Action Review (ROAR) conducts comprehensive and holistic

claims reviews, while VA's review looks solely at the claim and not how it may interrelate with other service-connected conditions.

Nearly three years ago The American Legion partnered with the White House and the VA to institute the Fully Developed Claim (FDC) pilot program. The goal for this initiative was for VA and American Legion Service Officers to submit claims that were complete and ready for a rating decision, and wasn't absent any supporting evidence or documentation. VA agreed that they would then process these Fully Developed Claims within 90 days or less. Today, only four VAROs nationwide are meeting the objective for claims with Legion Power of Attorney (POA), four years after the publishing of the fast letter and nearing two years after nationwide implementation. Eight VAROs exceed 200 days on average with Legion POA.

During one of our most recent ROAR visits earlier this year in Seattle, Undersecretary of Benefits Alison Hickey attempted to impede our ROAR team from attending the necessary meetings to satisfy the visit, and then did not allow the proper access for The American Legion to adequately complete the visit. As a result, The Chairman of the House Veterans' Affairs Committee sent a letter to VA and offered to accompany The American legion on future visits.

Local facilities are not empowered to address a crisis when it happens. With 152 medical centers to look after nationwide, the VA cannot manage every crisis from Washington. Instead, The American Legion believes VA needs to empower its leadership at medical centers to respond to crises—quickly. With incidents such as the Legionella outbreak in Pittsburgh, the facility had a press release ready to disseminate but VA Central Office never approved it to be sent publicly.

The allegations of secret wait lists in Phoenix have caught some by surprise, and some may call for caution, waiting until the results of VA's Office of the Inspector General (VAOIG) are complete before leaping to conclusions about VA's healthcare system. Unfortunately, Phoenix is not an isolated event, nor is it the first such event to be investigated by VAOIG. Between January 2013 and the present day, VAOIG has conducted 18 investigations in response to concerns about the VA healthcare system. The majority of these investigations dealt with delays in appointment scheduling,[1] delays in lab results,[2] and lapses in notifying patients of biopsy results.[3] More serious investigations addressed patient deaths under emergency care.[4]

The veterans of The American Legion have a vested interest in ensuring that VA operates efficiently and we were instrumental in seeing that the VA became a cabinet position in the first place. We did so, in order that the Secretary would have the power and authority to serve and fight for the best interests of veterans through the second largest agency within the Federal Government.

On Monday, May 5, 2014, American Legion staff scheduled a conference call with Dr. Mike Davies, National Director of Systems Redesign to discuss national wait times and was told three days later that Dr. Davies would not be able to meet with The American Legion until June.

The American Legion has a dedicated team that travels around the country visiting VA hospitals, conducts veteran town halls, and speaks directly with VA healthcare and administrative staff. This program is overseen by our System Worth Saving Task Force, and had conducted visits over the past year to problem areas in Pittsburgh, Jackson, Atlanta, Augusta, and Columbia, South Carolina, as well as Phoenix, to attempt to understand the challenges these centers face while trying to provide the best possible healthcare to our Nation's veterans. A brief overview of some of these visits can be found in addendum "A" of this testimony.

Overwhelmingly, our taskforce finds that veterans are extremely satisfied with their healthcare team and medical providers. We also find that administrative oversight of VA operations is a constant concern and growing frustration among patients. We've found veterans who are happy when they can get care, but struggling with a system that makes it difficult even to get primary care appointments. While a veteran might wait more than two weeks for most primary care appointments, specialty care appointments can take many months or even years. And when it comes to informing patients of potential problems within the VA system, we find that local facilities are not empowered to interact with the community and are under restrictive communications lockdowns imposed by VACO.

In addition to our System Worth Saving Taskforce, which is now in its 10th year, American Legion volunteers donate nearly 900,000 hours of service in VA facilities annually at a value of over $19 million, and maintain a network of over 2,900 ac-

[1] http://www.va.gov/oig/pubs/VAOIG–12–04108–96.pdf
[2] http://www.va.gov/oig/pubs/VAOIG–13–00636–104.pdf
[3] http://www.va.gov/oig/pubs/VAOIG–13–00940–193.pdf
[4] http://www.va.gov/oig/pubs/VAOIG–13–00505–348.pdf

credited service officers who assist nearly three-quarter of a million veterans with their disability claims. Wherever veterans interact with VA, The American Legion is there attempting to work within the system to ensure that the VA continues to serve the best interests of veterans. Not only has The American Legion donated millions of dollars to create and support VA programs; we have even sponsored a brain research center that is named after us in Minnesota.[5]

Over the past two weeks The American Legion has received over 500 calls, emails, and online contacts from veterans struggling with the healthcare system nationwide. They cite concerns ranging from the common complaint of substantially delayed appointments, to an inability to receive specialty care. One parent of a veteran in Phoenix spoke painfully of losing their daughter while she waited for care, and one veteran reported calling his local VA medical center for an appointment only to be told "there are no appointments within the next 30 days, please call back in 4 weeks to schedule an appointment." Even if there is not a formal "secret" list at many of these facilities, administrative staff are finding a variety of ways to game the system.

According to Dr. Sam Foote, one of the first whistleblowers to come forward regarding VA's waiting list manipulation accusations, the attempts to create a work around on appointments grew out of a response to VA's attempts to address scheduling problems[6] (More information on this and other recent whistleblower complaints are attached as Addendum "B"). Because there were previous complaints about lengthy wait times at VA facilities, VACO officials made changes to the appointment system to automate the process and prevent employees from lying about wait times. The new electronic system was designed to automatically enter the time the appointment was requested and provide a more accurate assessment of how long it was taking to find appointments for veterans. To circumvent this, VA employees developed strategies to wait until they could guarantee an appointment within two weeks, and only then enter the information into the electronic system.[7]

A VA employee in Cheyenne, Wyoming, provided documentation to CBS News that explicitly details how VA employees need to "game the system a bit * * * when we exceed the 14 day measure, the front office gets very upset, which doesn't help us.[8]" There is a culture created, and enforced by leadership within VA that the most important measure is meeting the numbers. This is true whether in the Veterans Health Administration (VHA) or Veterans Benefits Administration (VBA). VA schedulers who can't find appointments for veterans resort to keeping secret lists. VA claims workers who can't keep up with the demanded number of claims per day shred vital documents that could help prove a veteran's disability.

A year later, as the problems continue to mount and the VA appears no closer to solutions, we sadly feel there must be change. VA is in need of a real reformer who is not afraid of exposing the full extent of the problems and bringing all stakeholders in to forge a VA for the 21st century and beyond. When Arlington National Cemetery was beset with a disgusting scandal involving mismarked graves in 2010, they brought in Kathryn Condon to right the ship. During the time of transition, Director Condon reached out to stakeholders including The American Legion for guidance and support. During the crisis, officials at Arlington did not dismiss further discovery of mismanagement issues but rather sought to expose everything while accepting responsibility, and then engaged stakeholders to express how they were amending the system to ensure these problems would never occur again at the Nation's most prestigious resting place for our military fallen. The handling of the Arlington crisis is indicative of courageous leadership that owns their own failures and sincerely works to correct deficiencies.

Unfortunately, the response from Undersecretaries Petzel and Hickey at VA has been to question those who would impugn VA's reputation. When VA's accuracy figures were questioned, VA's response was to limit access of those who advocate for veterans,[9] rather than sincerely attempt to reform the process and retrain employees to actually end the error prone processing practices. When allegations of dangerous medical practices emerged, Dr. Petzel's first response is to be dismissive.[10] The tone is consistent. The pattern is consistent. It is perhaps most telling that when The American Legion Health Policy Unit contacted the VACO staff respon-

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[5] http://brain.umn.edu/about—us.shtml

[6] http://onpoint.wbur.org/2014/05/12/veterans-affairs-scandal-death

[7] Ibid—Dr. Foote

[8] http://www.cbsnews.com/news/email-reveals-effort-by-va-hospital-to-hide-long-patient-waits/

[9] http://www.military.com/daily-news/2014/02/21/lawmaker-says-va-obstructed-legion-quality-review.html

[10] http://www.cnbc.com/id/101187855 "There have been some public kerfuffles in the paper that don't in my mind reflect the Jackson VA facility."

sible for the nationwide scheduling operations last week, that VA staff chose not to engage the community or work with stakeholders to better understand this problem. Instead VACO staff informed The American Legion they could not possibly schedule a meeting until sometime in June to discuss the topic.

We can't wait months for a solution. How many more veterans will die waiting to see doctors? Hearings, reports, analyses and testimonies won't fix this. America's veterans deserve a solution that starts today.

The solution MUST include input in correct measures from the Department of Veterans Affairs, Congress and most importantly the stakeholders—it is absurd to make decisions about what veterans need in their healthcare system without consulting the veterans. As the Nation's largest wartime service organization for veterans, The American Legion will not shy away from providing a voice for those veterans.

For many years now, going back to the budget troubles of 2006, Congress has asked VA if they had the resources they need to accomplish their mission. All parties on the Hill, from both sides of the aisle, and both the Senate and House of Representatives, have made abundantly clear that even in this austere time of belt-tightening budget measures, if VA needed funds to provide proper care for veterans, they would find them the money they need. VA has consistently answered that they could execute their plan with the budget they had asked for, a budget usually increased by Congress in the final tally. If VA needs more to accomplish their mission, and many VSOs including The American Legion have questioned whether their budget meets their needs, they need leadership with the courage to be honest about those needs.

The American Legion has testified in nearly every hearing before this Committee, and the House Committee on Veterans' Affairs concerning the VA, in which stakeholder testimony is considered and has seen firsthand how the VA has stonewalled congressional requests for information. The American Legion has followed the investigations and requests for information with special concern, as VA has developed a pattern of unresponsiveness to Congress and crises while developing a tendency to downplay legitimate concerns of veterans that do not do service to the veterans in these communities.

While addressing patient deaths at the Jackson VA Medical Center, Undersecretary Robert Petzel referred to the concerns dismissively as "kerfuffles[11]" and in a subsequent follow up visit to that site by American Legion System Worth Saving Task Force members, the facility director was hampered from cooperating with the local veterans and American Legion by VA Central Office restrictions. During the January 2014 visit, facility director Joe Battle was unable to provide the action plan the facility was using to address problems with patient deaths. Director Battle stated he could not release the report because it had not been cleared by VACO. Repeated follow up requests for information to VACO officials by American Legion staff have been met with the response that VHA cannot release this information to The American Legion.

The American Legion believes there must be corrective measures taken. There are several improvements VA could begin implementing to start addressing these issues.

As we are now over a decade into the 21st century, The American Legion believes that VA should also begin implementing 21st century solutions to its problems. In 1998, GAO released a report that highlighted the excessive wait times experienced by veterans trying to schedule appointments, and recommended that VA replace its VISTA scheduling system.[12] To address the scheduling problem, the Veteran's Health Administration (VHA) solicited internal proposals from within VA to study and replace the VISTA Scheduling System, with a Commercial Off-the-Shelf (COTS) software program. VA selected a system, and about 14 months into the project they significantly changed the scope of the project from a COTS solution to an in-house build of a scheduling application. After that, VHA ended up determining that it would not be able to implement any of the planned system's capabilities, and after spending an estimated $127 million over 9 years, The American Legion learned that VHA ended the entire Scheduling Replacement Project in September 2009.[13] We be-

[11] http://www.cnbc.com/id/101187855 "There have been some public kerfuffles in the paper that don't in my mind reflect the Jackson VA facility."

[12] U.S. Medicine Magazine, *VA Leadership Lacks Confidence in New $145M Patient Scheduling System,* May 2009

[13] GAO–10–579, *Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System,* May 2010

lieve that this haphazard approach of fits and starts is crippling any hope of progress.

It has now been over three years since VHA canceled the Replacement Scheduling Application project, and as of today, The American Legion understands that there is still no workable solution to fixing VA's outdated and inefficient scheduling system. In 2012 The American Legion passed Resolution number 42 that asked the VA to implement a system "To allow VA patients to be able to make appointments online by choosing the day, time and provider and that VA sends a confirmation within 24 hours." Last December, VA published an opportunity for companies to provide adjustments to the VISTA system through the *Federal Register*—all submissions are due by June 2013. While this is a laudable attempt to address the problem, it hardly seems sufficiently proactive given that the problem has been identified for over fifteen years, and excessive wait times are still being experienced by many veterans across the Nation.

The American Legion recognizes that over the past decade, VA has taken some steps aimed at improving its scheduling and access to care; we believe that there is still much to be done. In order to adequately address the problems of veterans, The American Legion believes VA should adopt the following steps toward a solution:

1. Devote full effort toward filling all empty staff positions. The problems with mental health scheduling clearly indicate how a lack of available medical personnel can be a large contributing factor to long wait times for treatment. Despite VA's efforts to hire 1,600 new staff, as recently as last month VA was noting only two thirds of those positions had been filled. This does not even address the previous 1,500 vacancies, and stakeholder veterans' groups are left to wonder if VA is adequately staffed to meet the needs of veterans.

We believe they are not.

If VA needs more resources to address these staffing needs, The American Legion hopes they will be forthright and open about their needs, and ask for the resources they need to get the job done. The Veteran Service Organizations and Congress have been extremely responsive to get VA the resources they need to fulfill their mission, but VA must be transparent about what their real needs are.

2. Develop a better plan to address appointments outside traditional business hours. With the growing numbers of women veterans who need to balance family obligations and other commitments, our veterans' abilities to meet appointments during regular business hours is greatly hampered. The American Legion believes VA can better address the community's needs with more evening and weekend appointment times. American Legion Resolution number 40 calls on the VA to provide more extended hour options, and believes VA should recruit and hire adequate staff to handle the additional weekend and extended hour appointments for both primary and specialty care.

3. Improve the IT solution. Last year The American Legion also passed resolution number 44, which called on the VA to create a records system that both VBA and VHA could share to better facilitate information exchange. A common system could even synchronize care visits in conjunction with compensation and pension examinations. We had hoped such a system might be included in the improvements brought by the Virtual Lifetime Electronic Record; however VA and DOD appear to be content to pursue individual legacy systems for that project, so veterans must continue to contend with VBA and VHA systems that do not communicate as well as they should. In any case, as VA looks outward for a solution to their scheduling program, all can agree that the current system is not serving the needs of veterans and needs to be updated.

4. The American Legion urges Congress to enact legislation that provides the Secretary of Veterans Affairs the authority to remove any individual from the senior executive service if the Secretary determines the performance of the individual warrants such removal, or transfer the individual to a General Schedule position at any grade of the General Schedule the Secretary determines appropriate.

5. The American Legion supports legislation and congressional oversight to improve future Department of Veterans Affairs (VA) construction programs, and urges VA to consider all available options, both within the agency and externally, to include, but not limited to the Army Corps of Engineers, to ensure major construction programs are completed on time and within budget.

There is still room for VA to improve their triage processes. The current consult management program needs work to ensure it is providing better triage for veterans in need of life saving procedures. Primary Care Providers have relayed to American Legion System Worth Saving Task Force members concerns that the current triage

process has bureaucratic hurdles which make the process frustrating and presents a challenge to retaining top quality Primary Care Providers.

Furthermore, regarding VA's current 14 day wait policy, review of this policy is necessary to determine whether the enforcement is causing problems. The goal to see veterans in a timely manner is crucial; however, care must be taken to see how the regional facilities are viewing the policy. If they are reluctant to report longer wait times up to VACO because of fears of being "put on a Bad List" as relayed in the Cheyenne email,[14] then a reassessment of the culture that breeds this attitude is warranted. The observance by VACO of lengthy wait times at a facility should trigger questions to VACO about whether the facility is adequately staffed and resourced to meet the needs of the community. VISNs struggling to meet timeliness standards need to be assessed to determine if they have the tools to treat the veterans in their communities.

Finally, revision of these standards is only as good as the integrity of staff you hire and accountability and transparency for those who break the rules should be disclosed. VA should put a map on their Web site of hospitals that had issues and what corrective actions were taken to include disciplinary actions such as transfers or reprimands. Veterans ought to be able to see there is a top down and bottom up culture of accountability. That is how to restore trust in the system to the veterans' community.

The American Legion thanks this Committee again for their commitment to seeking answers about the troubling trends emerging in VA. The commitment of all parties to ensuring veterans receive quality healthcare in a safe environment is a sacred duty. Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861–2700, or lcelli@legion.org.

ADDENDUM A

HIGHLIGHTS FROM THE AMERICAN LEGION'S RECENT SYSTEM WORTH SAVING TASK FORCE VISITS

2013

Pittsburgh, Pennsylvania (Site Visit Nov. 5–6)

- After persistent management failures led to a deadly Legionnaires' disease outbreak in the VA Pittsburgh Healthcare System, VA Pittsburgh director Terry Gerigk Wolf received a perfect performance review and regional director Michael Moreland, who oversees VA Pittsburgh, collected a $63,000 bonus.

Nashville, TN (SWS Visit Nov 13–15)

- Tennessee Valley Healthcare System struggles to fill critical leadership positions across multiple departments. These gaps could cause communication breakdowns between medical center leadership and staff that work in these departments.

El Paso, TX (SWS Visit Nov. 18–20)

- The current situation with the future of William Beaumont Army Medical Center is uncertain and troubling for veterans in the area, and veterans need to know where they will be able to receive their health care.

Huntington, WV (SWS Visit Dec. 9/11)

- Huntington VAMC has found it difficult to recruit talent (surgeons/physicians) due to pay freezes, a lack of bonuses/retention incentives, and the geographical location of the hospital.

Leavenworth, KS (SWS Visit Dec. 9/11)

- Due to the age of the Leavenworth campus (83 years-old), space is an issue. Additionally, because the Kansas Historical Society has designated the Leavenworth campus as a historical site, there are limitations on what infrastructure changes can be made.

2014

Roseburg, Oregon (Site Visit Jan.9–10)

- An active Legionnaire from American Legion Post 61 in Junction City, went to the Roseburg VA Medical Center this past June for what should have been a routine hernia operation. After the surgery, Roseburg VA Medical Center staff told the veteran's daughter, that her father's blood pressure had "dropped suddenly and he was having difficulty breathing." Since the Roseburg VA Medical Center does not have

[14] http://www.cbsnews.com/news/email-reveals-effort-by-va-hospital-to-hide-long-patient-waits/

an Intensive Care Unit, the veteran was taken to PeaceHealth Sacred Heart Medical Center at Riverbend in Springfield, Oregon. Unfortunately, the veteran passed away en route PeaceHealth Sacred Heart Medical Center due to "intra-dominal bleeding, shock, hyperkalemia, acidosis, respiratory failure and recent ventral hernia surgery."

- The American Legion is not comfortable with the current status of the medical center following the closure of their Intensive Care Unit. The American Legion recommends that VARHS consider one of the three alternatives: fully reinstating the Intensive Care Unit, standing down all surgical procedures, or strengthening their Memorandum of Understanding with Mercy Medical Center to ensure that an Intensive Care Unit bed will be available in case of emergency, which includes remaining without an ICU and continue to perform ambulatory procedures that meet the strict criteria established by the VA as appropriate for facilities without an ICU.

Jackson, Mississippi (Site Visit Jan. 21–22)

- At the G. V. Sonny Montgomery VA Medical Center in Jackson, MS, multiple whistleblower complaints have been raised by employees who were losing confidence in the medical center's ability to treat veterans. The complaints ranged from improper sterilization of instruments to missed diagnoses of fatal illnesses, as well as hospital management policies.

Butler, Pennsylvania (Site Visit Jan. 8–9)

- An attorney for the prime contractor of a Department of Veterans Affairs outpatient center being built in Butler County declined to comment Friday, July 12, 2013 about the VA's investigation of the contractor that led the agency to stop work on the $75 million project.
- The VA Butler Healthcare Center was scheduled to open in 2015, but the termination of the lease left its future in doubt. The VA broke ground on the center in April 2013. The Department of Veterans Affairs yanked its lease with an Ohio company that was building a $75 million health center for vets in Butler, accusing the firm of "false and misleading representations" during bidding. The VA ordered work halted in June when it began to uncover problems with the project.
- The Department of Veterans Affairs failed to properly check the qualifications of the former developer of an outpatient center in Butler County, according to a highly critical report by the VA's Office of Inspector General released Monday. The report says the VA improperly calculated that a 20-year lease with Westar Development Co., valued at $157 million, would be cheaper than the VA building and owning the $75 million outpatient center on its own.

Atlanta, Georgia (Site Visit Jan. 28)

- Despite four preventable patient deaths, three of which VA's inspector general linked to widespread mismanagement, former Atlanta VA Medical Center Director James Clark received $65,000 in bonuses over four years. Additionally, the facility's current director, Leslie Wiggins, maintains that no employees responsible for the mismanagement linked to the deaths should be fired.

Orlando, Florida/Denver, Colorado (Orlando SWS Visit-Feb.11–12, 2014) (Denver SWS Visit-May 13–14)

- Costs substantially increased and schedules were delayed for Department of Veterans Affairs' (VA) largest medical-center construction projects in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida. As of November 2012, the cost increases for these projects ranged from 59 percent to 144 percent, with a total cost increase of nearly $1.5 billion and an average increase of approximately $366 million. The delays for these projects range from 14 to 74 months, resulting in an average delay of 35 months per project. In commenting on a draft of this report, VA contends that using the initial completion date from the construction contract would be more accurate than using the initial completion date provided to Congress; however, using this date would not account for how VA managed these projects prior to the award of the construction contract. Several factors, including changes to veterans' health care needs and site-acquisition issues contributed to increased costs and schedule delays at these sites.

Dallas, Texas (SWS Visit Feb 4–5)

- Dallas VA Medical Center Director Jeff Milligan and regional director Lawrence Biro have received a combined $50,000 in bonuses since 2011 despite a series of allegations from VA workers, patients and family members regarding poor care at the facility as well as more than 30 certification agency complaints against the medical center in the last three years.

Hot Springs, SD (SWS Visit Feb 17–19)

- The VA Black Hills Healthcare System (VABHHS) is going under a reconfiguration proposal which is opposed by the local community. The issue is whether relocating services from the Hot Springs VA Medical Center to the Fort Meade VA Medical Center and the domiciliary to Rapid City are in the best interest of veterans. This would require veterans to travel further to receive their health care.

Augusta, Georgia (Site Visit Mar. 11–12)

- CNVAMC leadership first learned of delays in providing gastrointestinal (GI) services to veterans on August 30, 2012. Of the 4,580 delayed GI consults, a quality management review team determined 81 cases for physician case review. Seven of the 81 cases may have been adversely affected by delays in care. Six of seven institutional disclosures were completed and three cancer-related deaths may have been affected by delays in diagnosis. Factors contributing to the 4,580 patient backlogs included an explosion of baby boomers turning 50 and requiring screening, the medical center's non-anticipation of a spike in GI consult demand, lack of an integrated database for tracking GI procedures, and GI physician recruitment challenges.

Columbia, South Carolina (SWS Visit April 15, 16)

- In September 2013, six deaths were linked to delayed screenings for colorectal cancer at the veterans medical center in Columbia, S.C., the Veterans Affairs Department reported. The VA's inspector general determined that the William Jennings Bryan Dorn VA Medical Center fell behind with its screenings because critical nursing positions went unfilled for months. It also found that only about $275,000 of $1 million provided to the hospital to alleviate the backlog had been used over the course of a year.

ADDENDUM B

RECENT DEVELOPMENTS

- Former employee, Dr. Sam Foote, claimed the Phoenix system is afflicted by "gross mismanagement of VA resources and criminal misconduct "that produced "systemic patient safety issues and possible wrongful deaths."
- Foote and other employees alleged a variety of other institutional breakdowns in Arizona's VA, including:

- Medical recordkeeping so backed up the system is 250,000 pages behind, and millions of records reportedly are missing.
- A compromised mental-health system where patient suicides doubled in the past few years, while staff suicides also emerged as a serious concern.
- A swamped emergency room that becomes the last resort for veterans who cannot get appointments with primary-care doctors or specialists. In some cases, VA health system employees have told the newspaper, vets with life-threatening conditions have waited hours without diagnosis or treatment because nurses are overworked and undertrained.
- Discrimination, cronyism and security breakdowns in the VA police department that endanger the safety of patients and employees.
- Hostile working conditions that caused an exodus of quality doctors and nurses, producing backlogs in specialty areas such as urology, where bladder cancer and other serious diseases are detected. Patients reportedly are referred to out-of-state VA centers or private physicians for treatment.
- On Sunday, April 27, 2014, a second whistleblower, Dr. Katherine Mitchell reported that "patient appointment records in the Phoenix VA Health Care System were in danger of being destroyed."
- On Sunday, May 4, 2014, a whistleblower reported that clerks at the Department of Veterans Affairs clinic in Fort Collins, Colorado were instructed in 2013 how to falsify appointment records so it appeared the small staff of doctors was seeing patients within the agency's goal of 14 days.
- The VA's official policy is that all patients should be able to see a doctor, dentist or some other medical professional within 14 days of their requested/preferred date. Any wait longer than two weeks is supposed to documented.

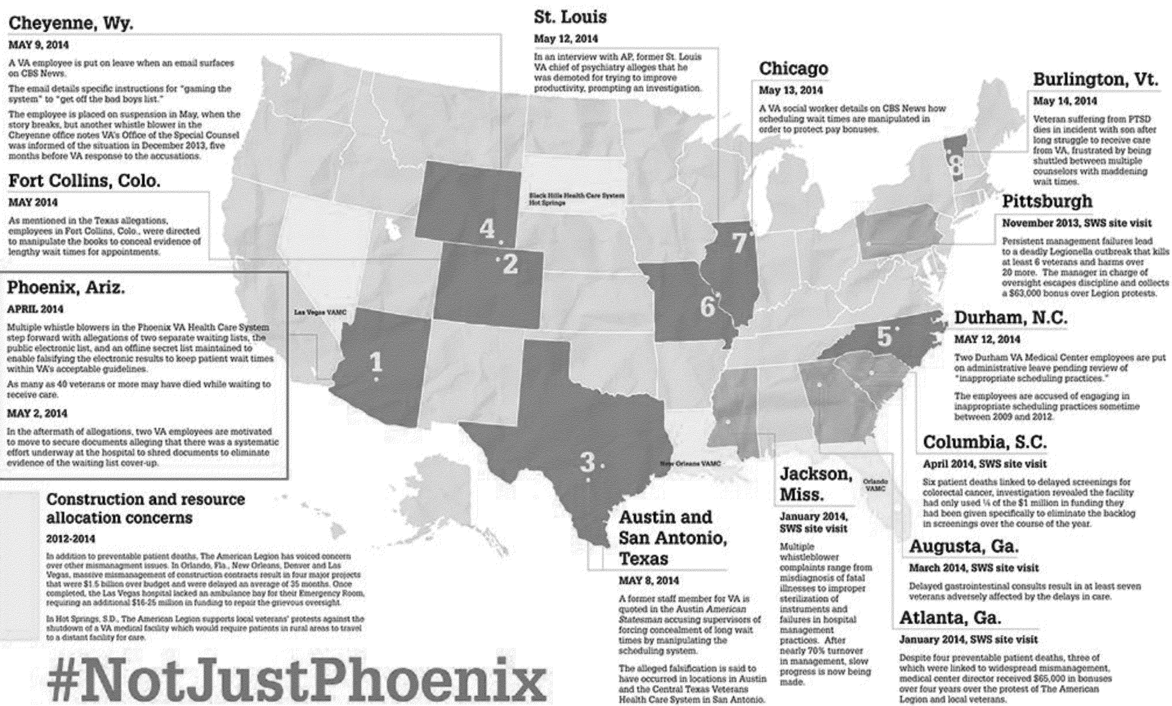
Yet on Friday, May 9, 2014 Brian Turner, a Veterans Affairs scheduling clerk based in San Antonio, said that some who called to make appointments at his facility did end up waiting longer, yet such delays were never reported.

For example, he said, they might be told the next available appointment wasn't for several months. It would be scheduled for then, but marked in official files as if the patient had put off their appointment until then by choice.

"What we've been instructed was that—they are not saying fudged, there is no secret wait list—but what they've done is come out and just say 'zero out that date,'" Turner said. The "zero," in this case, suggests the patient didn't have to wait at all.

"It could be three months and look like no days [wait]," he added. "It looked like they had scheduled the appointment and got exactly what they wanted."

ADDENDUM C



Addendum "C" to The American Legion Testimony "The State Of VA Health Care" May 15th 2014 Committee On Veterans' Affairs, United States Senate

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO THE AMERICAN LEGION

Question. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response.

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

Chairman SANDERS. Thank you very much, Commander Dellinger.

Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. 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.

DAV remains deeply concerned about allegations that VA employees or management took actions that obscure the true picture of access problems at some VA facilities. We fully support the ongoing investigation by the Inspector General and will demand full accountability for anyone found to have violated the law or failed to follow and enforce VA rules and regulations.

We also support Secretary Shinseki's initiative to audit all VA facilities to determine whether similar problems are occurring. However, we strongly recommend the VA include outside third-party experts to increase its objectivity and credibility and help regain the full trust of veterans and the American people.

Mr. Chairman, 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 high-quality medical care. While it may be weeks or months before the investigations and audits are completed, 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 and working with stakeholders to correct them.

Mr. Chairman, 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 any other model of care. The real challenge facing VA and the root cause of the problems being reported today have to do with access to care rather than the quality of care delivered.

For the past decade, DAV and our partners in the *Independent Budget* (IB) have pointed out funding shortfalls in VA's medical care and construction budgets. In the prior ten VA budgets, funding for medical care provided by Congress was more than $5.5 billion less than the *IB* recommended. For fiscal year 2015, the *IB* recommends 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 fiscal year 2015, but based on available information today, it

appears your Senate colleagues will not significantly increase the administration's inadequate request, just as the House already failed to do.

Similarly, over the past decade, funding requested by VA for construction and the amount appropriated by Congress has been more than $9 billion less than the *IB* recommendations. For fiscal year 2015, the VA budget request is $2.5 billion less than the *IB* recommendation, which was based upon VA's own analysis. We agree with your views and estimate letters for the past 2 years, Mr. Chairman, where you stated that the administration's budget request for construction has been, "clearly insufficient to meet the identified needs," but unfortunately, Congress took no action to increase construction funding.

Finally, VA needs to better utilize its purchased care authority. 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. However, since 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, VA must provide accurate estimates of the additional funding required and Congress must appropriate those dollars.

Even with sufficient funding, how will non-VA care be coordinated with VA care? Are there even sufficient qualified providers available in each community? 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.

Mr. Chairman, looking at VA today and putting it into proper perspective against the entire American system of health care, we continue to have confidence that veterans are well served by seeking their care from VA. We remain confident that VA and Secretary Shinseki, working with stakeholders and Congress, can, will, and must address these challenges. American veterans deserve nothing less.

Thank you.

[The prepared statement of Mr. Violante follows:]

PREPARED STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

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 wheth-

er 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 to 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.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO DISABLED AMERICAN VETERANS

Question. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response.

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

Chairman SANDERS. Thank you very much, Mr. Violante.

Mr. Tarantino.

STATEMENT OF TOM TARANTINO, CHIEF POLICY OFFICER, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. TARANTINO. Chairman Sanders, Ranking Member Burr, and distinguished Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America, I thank you for this opportunity to share our views and recommendations regarding the current state of health care with VA.

For nearly a decade, IAVA has been a tireless leader, working on behalf of veterans and their families to ensure that VA meets 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, clearly, far too many remain.

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. Disturbingly, long wait times are alleged to be the result of 40 deaths, 40 veterans who perished while waiting for care at the Phoenix VA medical facility alone, and since Phoenix, more allegations of misconduct at other facilities from coast to coast are painting a similar picture. Unfortunately, these types of incidents are not new, nor are they apparently unique.

It is time for bold reform and new measures of accountability and oversight. Our members are outraged and expect substantive and meaningful evidence that longstanding inefficiencies are being appropriately addressed and appropriate VA personnel are being held accountable. Veterans must be assured that VA can deliver quality care in a timely manner, and veterans are tired of business as usual.

IAVA also expects VA to fully comply with the subpoena issued by the House Committee on Veterans' Affairs. Full and swift compliance with this subpoena will be a good first step in not only figuring out what happened in Phoenix, but demonstrating how allegations of misconduct will be addressed at other VA facilities.

And, just like the Secretary, we are also awaiting the results of the Inspector General's investigation of alleged misconduct in Phoenix, but we cannot sit around idle while the investigation is underway. We applaud the full audit of all 1,700 points of care at VA. However, we expect results and action in weeks, not months. Additionally, we support and encourage concurrent investigations that are completely independent of VA.

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 the Secretary cannot do it, 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 incidence of mismanaged care would indicate that such a thing is missing from all 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 most pervasive problems causing veterans to lose faith in this system. VA has a long way to go to earn back the confidence of millions of veterans shaken by this growing controversy.

Although recently exposed by whistleblowers, allegations of long wait times at VA are actually nothing new. The GAO has conducted numerous studies over the last decade touching on scheduling inefficiencies at VA and their findings continue to center

around lack of oversight, inadequate training, ambiguous policies and procedures; in other words, weak leadership.

Now, long wait times are one thing. Essentially, they are a management and process problem. They can be solved with a combination of people and time and resources, and more effective business practices. They are solvable as long as good leaders have the tools and information they need to fix it. That does not seem to be the case here. Instead of leaders coming forward to fix the system, they appear to be fixing the books. This is indicative of a culture of failed oversight and no accountability.

Now, reasons for highlighting VA mismanagement and bureaucratic flaws are not taken lightly, nor should they be. The worst thing that can happen in our community is a sense that VA is so inefficient and terrible at administrating care that veterans lose faith in the system designed to take care of their needs. Now, the right answer to this is not to cover up problems in VA, but to solve them or keep them from happening in the first place.

And this is not just a matter of communication, it is 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 care 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 Act and the VA Management Accountability Act should be enacted into law immediately. Our membership and the veterans community as a whole need to be reassured by VA and the Congress that, despite these issues, 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 at the VA system. This is why IAVA is proud to work with the Project on Government Oversight 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. We look forward to continuing to work with you, your Committee, your staff, and VA to improve the lives of veterans and their families. Thank you for your time and attention.

[The prepared statement of Mr. Tarantino follows:]

PREPARED STATEMENT OF IRAQ & AFGHANISTAN VETERANS OF AMERICA

Statement of Tom Tarantino
Chief Policy Officer, Iraq & Afghanistan Veterans Of America
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.

Statement of Iraq & Afghanistan Veterans of America
Senate Committee on Veterans' Affairs
May 15th, 2014

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

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO IRAQ & AFGHANISTAN VETERANS OF AMERICA (IAVA)

IRAQ & AFGHANISTAN VETERANS OF AMERICA,
June 30, 2014

Hon. JON TESTER,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR SENATOR TESTER: Iraq & Afghanistan Veterans of America is pleased to provide the following answers to the question for the record you sent to us following the May 15 hearing entitled "The State of VA Health Care" before the Senate Committee on Veterans Affairs:

Question 1. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response. There are currently over 22.4 million veterans living in the United States, but only 8.9 million are currently enrolled in the Veteran Health Administration according to VA. VHA currently uses multiple platforms and strategies to conduct outreach to veterans, but the fact that less than half of eligible veterans are connected with VHA raises concerns that current outreach efforts are not enough.

Congress has directed VHA to provide outreach to specific veteran populations such as homeless veterans, elderly veterans, woman veterans and eligible dependents of veterans via legislation. VHA also uses staff to directly contact veterans using telephone and mailers to provide information on benefits however, these methods are inefficient. Additionally, VHA also disseminates information to veterans via press releases and social media, including on platforms like Twitter (44,300 followers) and Facebook (124,500 likes). While VHA's use of social media to reach out to its target audience is commendable, the combined total of just over 168,000 social media followers is far below what the outreach goals of VHA should be.

VHA is on the right track by expanding its outreach efforts into the social media sphere, but the department can certainly do more to grow and expand its social media presence. In addition to using these web 2.0 platforms, VHA should also bring in more Iraq and Afghanistan-era veterans who understand the target outreach audience. Finally, VHA should partner with both traditional veteran service organizations and newer, hybrid veteran advocacy groups to help vouch for and spread the word about VA benefits and services.

If you have any additional questions, please don't hesitate to reach out to me or to our Legislative Director, Alexander Nicholson.

Thank you again for giving IAVA the opportunity to offer our analysis and the views of our members as the Committee continues to consider and debate this very important issue for the military and veteran community.

Respectfully,

THOMAS A. TARANTINO,
Chief Policy Officer.

Chairman SANDERS. Thank you, Mr. Tarantino.

Carl Blake is the National Legislative Director, Paralyzed Veterans of America. Mr. Blake.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Chairman Sanders, Ranking Member Burr, and Members of the Committee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today on the state of health care delivered by the Department of Veterans Affairs and the spinal cord injury system of care. No group of veterans understands the full scope of care provided by VA better than PVA's members, veterans who have incurred a spi-

nal cord injury or a dysfunction. PVA members are the highest percentage users of VA health care.

Let me begin by saying that PVA is deeply disappointed by the number of reports from around the country that suggest that veterans' health care is being compromised. There are undoubtedly serious access problems in the VA.

I would like to associate myself with the comments made by Senator Isakson and Senator Begich regarding gaming the system, and for all intents and purposes, cheating the standard. If that is going on, and when cases are found when that is going on, serious and appropriate action should be taken. If that means people have to be fired, so be it. That is what has to happen.

However, we believe that a thorough analysis to understand the depth of the situation across the system should be completed before any final decisions about VA leadership are made. At this time, PVA fully stands behind Secretary Shinseki. We believe he is committed to fixing these problems and he should be afforded the opportunity to get it right.

I would like to emphasize, however, that the narrative that has been created by the media does not necessarily reflect what is happening inside the walls of the VA Health Care System. If the Committee really wants to gauge what is going on and how the quality of care is being delivered, I would ask you to spend a day walking around inside a local VA hospital talking to veterans and discussing their health care experiences, not sitting in front of a prescreened, pre-selected panel of veterans to support sweeping generalizations and to stoke public outrage.

The fact is that VA health care services, by and large, are excellent. Patient satisfaction surveys of VA support that assertion.

The primary complaint that we hear all of the time from veterans is how long they had to wait to be seen for an initial appointment or to receive care. At its core, this is an access problem, not a quality of care problem. These are not the same thing.

And, to be clear, sending veterans outside of the VA to get private care is not the solution to this problem. It might be part of a solution. It is not the solution, particularly for veterans who rely on VA's specialized services. The fact is that there are not comparable services in the private sector to VA's SCI service, blinded care, amputee care, and the wide variety of specialized care that the VA provides.

Our written statement provides a snapshot of VA's spinal cord injury system of care. We have clearly identified serious staffing shortages that exist in the SCI service, particularly on the nurse staffing side. The site visits that we have conducted with our medical services teams for nearly three decades provide us the unique authority to affirm those problems. Unfortunately, those staffing shortages severely limit access to the system while also placing the health care delivery for veterans at risk.

Insufficient staffing, and by extension insufficient capacity, is ultimately a reflection of insufficient resources that this administration and previous administrations have requested for health care and insufficient resources that Congress has ultimately provided. The *Independent Budget*, co-authored by PVA, AMVETS, DAV, and the VFW, has made recommendations to adequately fund VA

health care for 28 years. For the last several years, Congress has essentially ignored our recommendations. And now, here we are discussing, how could this have all happened?

I would agree with Senator Johanns, who indicated, you know, what the heck is going on, when he looks at this and considers the budgets that have been requested.

I would suggest that the great irony of this hearing today is the discussion about whether the OIG adequately funded to do these investigations. Is the VA Health Care System adequately funded to deliver timely, quality care? I would suggest the answer to that question is no. Until the Congress and the Administration commit to providing truly sufficient resources to hire adequate staff and establish real capacity, the problems being reported around the country will only get worse.

The Administration and Congress both bear the responsibility of these problems. Veterans pay the costs, sometimes with their lives, of inaction resulting from partisan bickering and political gridlock. Political interests do not come before the needs of the men and women who have served and sacrificed for this country.

We call on this Committee, Congress as a whole, and the Administration to redouble your efforts to ensure that veterans get the absolute best health care provided when they need it, not when it is convenient. PVA members and all veterans will not stand for anything less.

I thank you again, Mr. Chairman. I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ACTING ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the current state of health care provided by the Department of Veterans Affairs (VA) and the spinal cord injury and disorder (SCI/D) system of care. No group of veterans understands the full scope of care provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or dysfunction. PVA members are the highest percentage of users among the veteran population. They are also the most vulnerable when access to health care and other challenges impact quality of care. I will first offer PVA's thoughts on the specialized services provided by the VA, particularly in the area of SCI/D care, and then I will focus my remarks on the VA health care system in general.

THE VA SPINAL CORD INJURY/DISORDER SYSTEM OF CARE

The SCI/D system of care is one of the crown jewels of the VA health care system. Spinal cord injury care is provided use the "hub-and-spoke" model. This model establishes the 24 spinal cord injury centers that exist with the VA system as the hubs of care. All other major medical facilities in the system serve as outpatient clinics (spokes) that direct and refer care back to the hubs. This model has proven to be very successful in meeting the complex needs of PVA's members. In fact, this model system of care has been so successful that the VA used the same model to establish the poly-trauma system of care.

Unfortunately, the ability of the SCI/D centers to function properly is dictated by the numbers of qualified SCI/D trained staff that are employed within the system. As a result of frequent staff turnover and a general lack of education and training in outlying "spoke" facilities, not all SCI/D patients have the advantage of referrals, consults, and annual evaluations in an SCI/D center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS). Some SCI/D centers treat these patients, while others deny admission. We recognize that there is an ongoing effort to create a continuum of care model for MS, and this model

should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. Ultimately, we believe admission to an SCI/D center is the most appropriate setting for treatment for all SCI/D veterans.

In December 2009, VA developed and published *Veterans Health Administration Handbook 1011.06, Multiple Sclerosis System of Care Procedures*, which clearly identifies a model of care and health care protocols for meeting the individual treatment needs of SCI/D veterans. However, VA has yet to develop and publish a Veterans Health Administration (VHA) directive to enforce the aforementioned handbook. Without a directive, the continuity and quality of care for both SCI/D veterans and veterans with MS could be compromised. The issuance of a VHA directive for the handbook is essential to ensuring that all local VA medical centers are aware of and are meeting the health care needs of SCI/D veterans. Additionally, and perhaps most importantly, no dedicated funding has been provided to VA medical centers to implement the guidelines in the handbook. However, we believe that the current SCI/C system can appropriately handle all SCI/D veterans if properly resourced.

Additionally, historical data has shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for an SCI/D veteran is physically demanding and requires nursing staff to provide hands-on care that involves bending, lifting, and stooping in order to transfer patients, prevent bed sores, and deliver care to individuals who are completely reliant on another individual for functions and activities that most people take for granted. These repetitive movements and heavy lifting often lead to work related injuries, even with the advent of patient lifts and other innovations. Also, veterans with SCI/D often have complex psychological issues and other hidden health dangers as a result of their injury/disorder. Special skills, knowledge, and dedication, which call for a set of competencies that can prove extremely esoteric even for the most skilled non-SCI/D providers, are required in order for nursing staff to care for SCI/D veterans.

Recruitment and retention bonuses have proven effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans as well as in the morale of the nursing staff. Unfortunately, facilities are faced with local budget challenges that result in the deprioritization of recruitment and retention bonuses. The funding necessary to support this effort is taken from local facility budgets, essentially forcing a choice between maximizing care for the most vulnerable versus providing care for the greatest number. A consistent national policy of salary enhancement should be implemented across the country to ensure that qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budgets.

Moreover, the VA has a system of classifying patients according to the hours of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of care required during hospitalization, amount of time spent with the patient, technical expertise, and clinical needs of each patient. Acuity category III has been used to define the national average acuity/patient classification for the SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time equivalent employees (FTEE) needed for continuous coverage.

However, the emphasis of this classification system is based on bedside nursing care that may work in non-SCI/D systems of care, but that are not necessarily appropriate for SCI/D care. It does not include administrative nurses, non-bedside specialty nurses, or light-duty nursing personnel as these individuals do not, and are not able, to provide full-time, hands-on bedside care for the high acuity veterans patient with SCI/D whose health needs vastly exceed that of an ICU, hospice, or geriatric patient with special needs. Because of this specialized quality, nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.01 and VHA Directive 2008–085 based on VA and PVA's joint assessment of need. It was derived from the basis of 71 FTEEs per 50 staffed beds, based on an average acuity category III SCI/D patient, which reflected a younger average age among veterans with SCI/D. However, this national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than category III due to higher average age and multiple chronic complications that accompany aging with an SCI/D. While VA has recognized our requests in the past that administrative nurses not be included in the nurse staffing numbers for patient classifications, the current nurse staffing numbers still do not reflect and accurate picture of bedside nursing care. VA nurse staffing numbers incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients. When the minimal staffing levels include non-bedside nurses and light-duty nurses, the number of actual nurses available to provide bedside care is

misrepresented in staffing reports. This leads to "floating" SCI/D nurses to other units, understaffing that results in mandatory overtime for existing staff, and other practices that erode quality of care over time. It is well documented in professional medical publications that adverse patient outcomes occur with inadequate nursing staff levels.

VHA Directive 2008–085 mandates 1,504 bedside nurses to provide nursing care for 85 percent of the available beds at the 24 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. Unfortunately, the SCI/D centers recruit only to the mandated minimum nurse staffing required by VHA Directive 2008–085. As of April 2014, the actual number of nursing personnel delivering bedside care was 161.9 FTEEs below the minimum nurse staffing requirement. Factoring in the actual average acuity level, there is a deficit of 746.2 FTEE between nurse staffing needed and the actual number of nurses available. The low percentage of professional RNs providing bedside care and the high acuity level of SCI/D patients put these veterans at increased risk for complications secondary to their injuries. Translated into lay terms that are relevant to why we are here today, the low percentage of professional RNs providing bedside care coupled with the high acuity of SCI/D patients presents us with a completely foreseeable, remarkably costly scenario where the next headline will read "paralyzed veterans suffer secondary complications due to failure to properly staff SCI/D centers," a claim that would be far from hyperbolic. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, development of pressure ulcers, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their conditions. We have steadily maintained, and VA at one point agreed, that a minimum 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

Unfortunately, the nurse shortage has also resulted in VA facilities restricting admissions to SCI/D centers (an issue that we believe mirrors the larger access issues that are being reported around the country). Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D centers and beds are consolidated, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important to ensure adequate staffing to meet the medical needs of veterans; it is also a vital component to ensure that SCI/D centers receive adequate funding. Since SCI/D centers are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans.

As an example of this point, VA's projections for long term care SCI/D beds in VISN 22 (Southern California and Southern Nevada) called for 30 beds per the Capital Asset Realignment for Enhanced Services (CARES) model, which estimated demand for health care services in order to determine capacity of its infrastructure to meet that demand. It seems logical to presume that more aging veterans over time will need extended care services in Southern California, not fewer. However, VA advised us that new, lowered projections based on the Enrollee Health Care Projection Model (EHCPM) dictated a decrease in scope of new construction for the San Diego SCI/D center in VISN 22. This leads to serious concerns about future timely access to specialized care. Moreover, the EHCPM fails to account for suppressed demand that can lead to false assumptions about future utilization. Such situations severely compromise patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs to build capacity.

In order to better track these issues and ensure they are addressed by the VA, PVA developed a memorandum of understanding with the VA more than 30 years ago that authorizes site visit teams managed by our Medical Services Department to conduct annual site visits of all VA SCI/D centers as well as spoke facilities that support the hubs. This opportunity has allowed us to work with VHA over the years to identify concerns, particularly with regards to staffing, and offer recommendations to address these concerns. More importantly, PVA is the only veterans' service organization (VSO) that employs a staff of licenses physicians, registered nurses, and architects to conduct these visits and report on the conditions. Our most recent site visits have yielded the information that is included below. This information reflects the Bed and Staffing Survey as of April 2014 for beds, doctors, nurses, social workers, psychologists, and therapists in the SCI/D system of care.

Physician personnel across the SCI/D system are below the required staffing level by 21.8 FTEEs. Social workers are below the requirement by 15.2 FTEEs. Psychologists are below the required level by 15.4 FTEEs. Finally, therapists are 33.4 FTEEs below the required level. As mentioned previously, the actual number of nursing

personnel delivering bedside care is 161.9 FTEEs below the minimum nurse staffing requirement. The nurse shortages alone resulted in 114.0 SCI/D beds staffed below the minimum required number. Factoring in the actual average facility acuity level, this amount increases to 372.9 SCI/D beds staffed below the requirement. This means that there are currently 281 unavailable SCI/D beds throughout the system. If this number is adjusted based on the actual average facility acuity level, this amount increases to 539.9 unavailable SCI beds throughout the system. This absurdly staggering number has proven easy to dismiss by leaders within VHA who insist that we provide by-name lists of veterans with SCI/D who languish on waiting lists rather than interrogate the merits of our claim and objectively examine their own data.

These facts are simply unacceptable. The statistics reflect the fact that many veterans who might be seeking care in the VA are unable to attain that care. But to be clear, these facts reflect an access problem, not a quality of care problem. Access and quality is not the same thing. Veterans who have incurred a spinal cord injury or disorder and who get regular care at the VA are very satisfied with the care they are receiving. In fact, patient satisfaction surveys bear out this point. Unfortunately, for too long the VA has been provided insufficient resources to properly address the tremendous staffing shortages that exist, not only in the SCI/D system of are, but across the entire system.

Within the VA health care system, the capacity to provide for the unique health care needs of severely disabled veterans—veterans with spinal cord injury/disorder, blindness, amputations, and mental illness—has not been maintained as mandated by Public Law 104–262, the "Veterans Health Care Eligibility Reform Act of 1996." This law requires VA to maintain its capacity to provide for the specialized treatment and rehabilitative needs of catastrophically disabled veterans. As a result of Public Law 104–262, the VA developed policy that required the baseline of capacity for the spinal cord injury/disorder system of care to be measured by the number of staffed beds and the number of full-time equivalent employees assigned to provide care (the basis for PVA's site visits today). This law also required the VA to provide Congress with an annual "capacity" report to ensure that the VA is operating at the mandated levels of "capacity" for health care delivery for all specialized services.

Unfortunately, the requirement for the capacity report expired in 2008. PVA's Legislation staff, in consultation with PVA's Medical Services Department, identified reinstatement of this annual "capacity" report as a legislative priority for 2014. We have worked extensively with our partners in the VSO community as well as with Hill offices to formulate legislation that would reinstate the annual "capacity" report. This report affords the House and Senate Committees on Veterans' Affairs as well as veteran stakeholders the ability to analyze the accessibility of VA specialized care for veterans seeking that care at little to no cost. Currently, legislation is pending in the House Committee on Veterans' Affairs—H.R. 4198, the "Appropriate Care for Disabled Veterans Act"—that would reinstate this report. We urge the Senate Committee on Veterans' Affairs to consider similar legislation as soon as possible.

PROTECTION OF VA SPECIALIZED SERVICES

The simple truth is the VA is the best health care provider for veterans. In fact, the VA's specialized services are incomparable resources that often cannot be duplicated in the private sector. However, these services are often expensive, and are severely threatened by cost-cutting measures and the drive toward achieving management efficiencies. Even with VA's advances as a health care provider, some political leaders and policymakers continue to advocate expanding health care access for veterans by contracting for services in the community. While we recognize that VA must tap into every resource available to ensure that the needs of veterans are being met, such changes to the VHA would move veterans out of the "veteran-specific" care within VA, leading to a diminution of VA health care services, and increased health care costs in the Federal budget.

Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. These services were initially developed to care for the complex and unique health care needs of the most severely disabled veterans. The provision of specialized services is vital to maintaining a viable VA health care system. The fragmentation of these services would lead to the degradation of the larger VA health care mission. With growing pressure to allow veterans to seek care outside of the VA, the VA faces the real possibility that the critical mass of patients needed to keep all services viable could significantly decline. All of the primary care support services are critical to the broader specialized care programs provided to veterans. If primary care services decline, then specialized care is also diminished.

We believe that the VA itself has created conditions that require contract (or privatized) health care as a solution. The Committee needs to look no further than the wholly inadequate budget requests over many years and multiple Administrations for Major and Minor Construction to see this scenario playing out. For example, this year the Administration requested $561 million for Major Construction. This included funding for only four primary projects and secondary construction costs—this despite a backlog of construction projects that requires a minimum of $23 billion over the next 10 years in order to maintain adequate and serviceable infrastructure. If the Administration refuses to properly address this construction funding problem, then Congress should be filling this void. Unfortunately, Congress has punted on this responsibility as well. Ultimately, if VA is not provided sufficient resources to address the critical infrastructure needs throughout the system, then it will have no choice but to seek care options in other settings, particularly the private section. However, calls for using contract care options to alleviate these problems are not the answer for SCI/D veterans because comparable specialized health care options do not really exist in the private sector.

VA HEALTH CARE

PVA believes that the quality of VA health care is excellent, when it is accessible. In fact, as mentioned previously, VA patient satisfaction surveys reflect that more than 85 percent of veterans receiving care directly from the VA rate that care as excellent (a number that surpasses satisfaction in the private sector). The fact is that the most common complaint from veterans who are seeking care or who have already received care in the VA is timely access. PVA cannot deny that there are serious access problems around the country. The broad array of staff shortages that we previously mentioned in our statement naturally lead to the access problems that VA is facing across the Nation. Many of the problems that the media continues to report are really access problems, not quality of care problems. While there are many detractors of the VA who would like to convince veterans and the public at large that the VA is providing poor quality care that is simply not true. If the Committee wants to get the truth about the quality of VA health care, spend a day walking around in a major VA medical facility (not conducting a panel with four preselected veterans' opinions) and ask veterans their impressions of the care. We can guarantee that you will likely hear complaints about how long it took to be seen, but rare is the complaint about the actual quality of care. In fact the complaints of veterans about access often ring true about health care delivery in private hospitals and clinics as well. It is no secret that wait times for appointments for specialty care in the private sector tend to be extremely long.

As we have already testified, access problems are primarily a reflection of insufficient staffing and by extension capacity. While insufficient staffing can be traced in some areas to the VHA inefficiently managing the resources it is provided, limited funding provided over many years has superseded the savings that can be generated from operational efficiencies and increased demand for health care services. We believe many of the access problems facing the VA health care system are the responsibility of Congress and the Administration together. The Administration (and previous Administrations) has requested wholly insufficient resources to meet the evergrowing demand for health care services, while at the same time attempting to fragment the VHA health system framework. Meanwhile, it has committed to operation improvements and management efficiencies that are not adequate enough to fill the gaps in funding. Similarly, Congress has been equally responsible for this problem as it continues to provide insufficient funding through the appropriations process to meet the needs of veterans seeking care.

For many years, the co-authors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—have advocated for sufficient funding for the VA health care system, and the larger VA. In recent years, our recommendations have been largely ignored by Congress. Our recommendations are not "pie-in-the-sky" wish lists based on nothing. They reflect a thorough analysis of health care utilization in the VA and full and sufficient budget recommendations to address current and future utilization. Moreover, our recommendations are not clouded by the politics of fiscal policy. Despite the recommendations of *The Independent Budget* for FY 2015 (released in February of this year), the House just recently approved an appropriations bill for VA that we believe is nearly $2.0 billion short for VA health care in FY 2015 and approximately $500 million short for FY 2016.

While we understand that significant pressure continues to be placed on Federal agencies to hold down spending and Congress has moved more toward fiscal restraint in recent years, the health care of veterans outweighs those priorities. If

Congress refuses to acknowledge that it has not provided sufficient resources for the VA, and that many of these access problems that are being reported around the country are a result of those decisions, then we will. Until Congress and the Administration make a serious commitment to providing sufficient resources so that adequate staffing and capacity can be established in the VA health care system, access will continue to be a problem.

And unfortunately for those clamoring for it, contract health care is not the answer to this problem. Studies have shown that contract health care providers cannot provide the same quality of care as the VA at any less cost, despite claims by some that it can. Similarly, contract care simply is not a viable option for veterans with the most complex and specialized health care needs. A veteran with a cervical spine injury whose autonomic dysreflexia was mistakenly treated as a stroke is not better served at a local outpatient clinic or the local doctor's office closer to his or her home. Sending those individuals outside of the VA actually places their health at significant risk while abrogating VA of the responsibility to ensure timely delivery of high quality health care for our Nation's veterans.

Mr. Chairman and Members of the Committee, we appreciate your commitment to ensuring that veterans receive the best health care available. We also appreciate the fact that this Committee has functioned in a generally bipartisan manner over the years. Unfortunately, even veterans issues are now held hostage to political gridlock and partisan wrangling. It is time for this to stop! Political interests do not come before the needs of the men and women who have served and sacrificed for this country. We call on this Committee, Congress as a whole, and the Administration to redouble your efforts to ensure that veterans get the absolute best health care provided when they need it, not when it is convenient. PVA's members and all veterans will not stand for anything less.

This concludes my statement. I would be happy to answer any questions that you may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO PARALYZED VETERANS OF AMERICA

Question. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response.

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

Chairman SANDERS. Thank you very much, Mr. Blake.

D. Wayne Robinson is the President and CEO of Student Veterans of America. Mr. Robinson.

STATEMENT OF D. WAYNE ROBINSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, STUDENT VETERANS OF AMERICA

Mr. ROBINSON. Chairman Sanders, Ranking Member Burr, and Members of the Committee, thank you for inviting Student Veterans of America to submit our testimony on the state of VA health care. As the premier advocate for student veterans in higher education, it is our privilege to share our on-the-ground perspective with you today.

I would like to begin by addressing the family members of the veterans for whom we are gathered today. We at Student Veterans of America honor the service of your loved ones and stand with you in seeking answers related to their deaths.

Student Veterans of America, or SVA, is a network of over 1,000 chapters on as many campuses across all 50 States and three countries. These chapters are comprised of veterans from multiple eras of service, with the majority having served after 9/11. Paramount

to their success is the ability to remain healthy and utilize the health care system provided by the Department of Veterans Affairs.

In this testimony, we speak on student-level issues of health and well-being, with our main focus being on higher education. As the G.I. Bill makes up a major portion of the benefits administered by VA, we believe it is essential to consider education and the role it plays in the life of veterans who may simultaneously be receiving health care.

As a former Command Sergeant Major in the Army, with service spanning nearly three decades, and as the current leader of a large disparate organization, I understand how difficult it is to be responsible for many locations and workforces. I also understand the position of older and younger veterans, as I have served alongside, have led, and have been taught by both. Many of these friends and former leaders of mine ensure that I remain abreast of the issues they face while accessing care.

Our student veterans are as diverse as our Nation and are progressing toward degrees at varying stages of their lives. Likewise, our members have millions of experiences with VA and other large institutions integral to their success on a daily basis. They rely on VA every day for their livelihood, their health care, and the future success of themselves and their families.

This support system for student veterans may be understood by looking at three levels of support which we term the three pillars. We encourage this Committee to focus on the following three pillars of student veteran well-being individually as well as collectively.

Pillar one, institutions. Institutional support for student veterans is an important aspect of maintaining a strong pipeline of successful veteran graduates.

Pillar two, individuals. Establishing an environment for the student veteran to fluidly interact with the institution and the community is a determining factor of well-being.

Pillar three, communities. An established network across various university offices, academic networks, and career services enables the student veteran to make the transition from the campus to a fulfilling career.

It is the firm belief of SVA that VA has successfully overhauled the education benefits process and that the same level of production should result within all levels of the Department. Over the last 5 years, Secretary Shinseki has led the VA as it brought G.I. Bill processing times down to just 1 week and tripled the number of Vet Success on Campus sites across the country. In that same time, VA has paid out more than $40 billion in tuition and benefits to nearly 1.2 million veterans, servicemembers, and their families since the Post-9/11 G.I. Bill went into effect on August 1, 2009.

We recognize that VA has a long way to go on some of its programs. It is our sincere hope that the Secretary is able to achieve the kind of outcomes across the Department that he has accomplished for student veterans with the implementation of its benefits programs.

SVA believes that Secretary Shinseki is dedicated to America's veterans more than ever. It has been under his leadership that VA

has seen substantial improvements over the years. While the recent allegations are disturbing, indeed, we would encourage the Secretary to take swift and decisive action when the full facts become clear. This action would demonstrate his continued commitment to student veterans who utilize the VA Health Care System and to veterans everywhere.

We thank the Chairman, the Ranking Member, and the Committee Members for your time, attention, and devotion to this cause. As always, we welcome your feedback and your questions.

[The prepared statement of Mr. Robinson follows:]

PREPARED STATEMENT OF MR. D. WAYNE ROBINSON, PRESIDENT & CEO, STUDENT VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr and Members of the Committee: Thank you for inviting Student Veterans of America (SVA) to submit our testimony on "The State of VA Health Care." As the premier advocate for student veterans in higher education, it is our privilege to share our on-the-ground perspective with you today.

I'd like to begin by addressing the family members of the veterans for whom we are gathered today. We at Student Veterans of America honor the service of your loved ones and stand with you in seeking answers related to their deaths.

SVA is a network of over 1,000 chapters on as many campuses across all fifty states and three countries. These chapters are comprised of veterans from multiple eras of service, with the majority having served after 9/11. Our recently released Million Records Project showed that these student veterans are succeeding in higher education. Paramount to that success is the ability to remain healthy and utilize the healthcare system provided by the Department of Veterans Affairs. While our constituents may be younger, they also face very similar issues as the brave men and women who have come before.

OUR APPROACH

As a former Command Sergeant Major in the Army with service spanning nearly three decades, and as the current leader of a large disparate organization, I understand how difficult it is to be responsible for many locations and workforces. I also understand the position of older and younger veterans, as I have served alongside, have led, and have been taught by both. Many of these friends and former leaders of mine ensure that I remain abreast of the issues they face while accessing care. Also in my travels, I speak to our chapter members who are seeking to raise their kids, attend classes, and deal with the effects of serving in a protracted war on two fronts. I am very familiar with the difficulties of developing strategy and tactics simultaneously, especially in a resource constrained environment. It is with this purview that I approach the current VA issues concerning healthcare and those deserving of it.

In this testimony, we touch on student-level issues of health and well-being with our main focus being on higher education, for that is our area of expertise. As the GI Bill makes up a major portion of the benefits administered by the VA, we believe it is essential to consider education and the role it plays in the life of veterans who may simultaneously be receiving healthcare.

Student veterans are as diverse as our Nation, progressing toward degrees at varying stages of their lives. Likewise, our members have millions of experiences with the VA and other large institutions integral to their success on a daily basis. They rely on the VA every day for their livelihood, their healthcare, and the future success of themselves and their families. This support system for student veterans may be understood by looking at three levels of support, which we term the "three pillars."

THE THREE PILLARS OF STUDENT VETERAN WELL-BEING

We encourage this Committee to focus on the following Three Pillars of Student Veteran Well-Being individually as well as collectively:

• *Pillar 1—Institutions:* Institutional support for student veterans is an important aspect of maintaining a strong pipeline of successful veteran graduates. The ability of the VA to connect with and administer care at the university level—for both mental and physical health—is critical. The lack of coordination and communication at this level continues to be a major concern.

• *Pillar 2—Individuals:* Establishing an environment for the student veteran to fluidly interact with the institution and the community is a determining factor in whether or not they will achieve their goals, as those who do not feel welcome may not persist in their studies. Empowering on-campus health systems to meet the needs of student veterans can supplement VA services.

• *Pillar 3—Communities:* An established network across various university offices, academic networks, and career services enables the student veteran to make the transition from the campus to a fulfilling career. Another area of improvement would be to connect student veterans with the various veteran-related points of contact, such as the VA certifying official, the counseling center, and potentially the VetSuccess advisor. The VA could facilitate these connections by making it easier to contact these individuals through a transparent directory available to both university staff and student veterans.

SUCCESSES IN EDUCATION

It is the firm belief of SVA that the VA has successfully overhauled the education benefits process, and that this same level of production should be sought within all components of the Department. Over the last five years, Sec. Shinseki led the VA as it brought GI Bill processing times down to just one week, and tripled the number of VetSuccess On Campus (VSOC) sites across the country. In that same time, the VA has paid out more than $40 billion in tuition and benefits to nearly 1.2 million veterans, servicemembers, and their families, since the Post-9/11 GI Bill went into effect on August 1, 2009.

With programs like VSOC, and support from postsecondary institutions signing onto the Principles of Excellence, veterans are operating in environments where they are prone to excel. The VA's VSOC is intended to, "help Veterans, Servicemembers, and their qualified dependents succeed and thrive through a coordinated delivery of on-campus benefits assistance and counseling, leading to completion of their education and preparing them to enter the labor market in viable careers." We see the VSOC program as a means to further enrich student veteran support across a variety of benefits to include healthcare.

The targeted expansion of this program to a current total of 94 schools continues to show positive outcomes, and we have heard overwhelmingly positive feedback from our members at the campuses where it is in place. We should note that we feel the program is difficult to bring to a university if they have a need or interest due to the selective criteria of having large veteran populations of 800+ and a 25-mile proximity to VA medical centers. As such, some schools in rural areas or with smaller yet just as deserving veteran populations may never be eligible for these services at the present requirements.

WHAT IS BEST FOR STUDENT VETERANS?

With the right tools and resources, SVA sees no limit to the potential of student veterans in higher education and beyond. When empowered and in the right environment, we know veterans lead productive and healthy lives. For student veterans, acting as leaders amongst our peers, balancing multiple competing priorities, and succeeding with limited resources are all natural challenges; indeed they are the very circumstances for which the Department of Defense has so effectively trained them. It is up to our schools, the VA, and the Nation to ensure that those veterans are met half-way with the proper care and benefits that they have earned.

We recognize that the VA has a long way to go on some of its programs. It is our sincere hope that the Secretary is able to achieve the kind of outcomes across the Department that he has accomplished for student veterans with the implementation of its benefits programs. We urge the VA to nominate a candidate for the soon-to-be-vacant Under Secretary of Health position to replace the retiring Dr. Petzel as soon as possible for Senate consideration, so that new leadership can come to VHA to address this issue head on.

SVA believes that Sec. Shinseki is dedicated to America's veterans more than ever; it has been under his leadership that the VA has seen substantial improvements over the years. While the recent allegations are disturbing indeed, we would encourage the Secretary to take swift and decisive action when the full facts become clear. This action will demonstrate his commitment to student veterans who utilize the VA healthcare system, and to veterans everywhere.

We thank the Chairman, Ranking Member, and the Committee members for your time, attention, and devotion to the cause of veterans in higher education. As always, we welcome your feedback and questions, and we look forward to continuing to work with this Committee, and the Congress to ensure the success of all generations of veterans through education.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO STUDENT VETERANS OF AMERICA

Question. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response.

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

Chairman SANDERS. Thank you very much, Mr. Robinson.

Ryan Gallucci is the Deputy Director of the National Legislative Service for VFW. Mr. Gallucci.

STATEMENT OF RYAN GALLUCCI, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. GALLUCCI. Thank you, Mr. Chairman, Ranking Member Burr, and Members of the Committee. I wish I did not have to be here today, but on behalf of the 1.2 million members of the Veterans of Foreign Wars, I want to thank you for the opportunity to share the VFW's concerns on VA health care delivery.

Simply put, VFW members are outraged and I am personally outraged that the health care system that I use may be doing harm to my fellow veterans. What is more frustrating is that nearly a month after some of these allegations came out, we still do not have the facts. We do not know who the veterans are who may have died waiting for care in Phoenix. We do not know where hospitals are cooking the books in appointment scheduling to keep up appearances while veterans wait for care or pay for it out of pocket.

Regardless of what comes out in Phoenix, Wyoming, Atlanta, Chicago, Spokane, or elsewhere, the VFW knows that veterans have died waiting. This is inexcusable. VA is supposed to have protocols in place to make sure this never happens. So, what happened?

The VA tells us the situation is improving, but to the veterans affected, this is not good enough. Over the last month, we see VA may not be living up to its obligation to provide our veterans with the best care our Nation has to offer. Veterans deserve the truth, not vague platitudes about quotas, wait times, and pending investigations. The VFW has been frustrated at the situation, but we have been reticent to condemn individuals without all the facts.

We are here today to say that enough is enough. Whistleblowers first brought problems in Phoenix to the attention of VA and Congress as early as 2010. CNN broke the doors off this story a couple of weeks back. Why are we still waiting? Last week, the VFW grew tired of waiting and told veterans to call our help line, 1–800-VFW–1899, to voice their concerns and connect with some of our service officers to help. While some said they were satisfied, most painted a picture of a VA Health Care System that is overburdened, under-resourced, and many times paranoid.

In Durham, NC, an Iraq veteran told me that he can see his primary care doctor only once a year and that he has sought care elsewhere, out of pocket, after 10 years of misdiagnoses.

What we heard over the last week is only a small sample of the hundreds of concerns we heard from veterans from coast to coast, but the outpouring of concern was alarming and seemingly systemic. So, what is causing this failure? Is it a lack of resources, personnel? Is it leadership?

The VFW also plans to conduct a series of veterans' town hall meetings, talking to veterans face to face. Once we have finalized locations and dates, we will invite this Committee to attend and hear directly from our veterans.

As a veteran who uses VA care, I worry that the recent allegations are causing veterans and their families to lose confidence in the system that is designed to support them and care for their needs. If one veteran is not receiving the care he or she needs, it is one too many. VFW members demand answers and we want those responsible for any wrongdoing held accountable at all levels of leadership and to the fullest extent of the law. With this in mind, the VFW believes it may be time to commission an independent review of VA care.

We hope that VA would never intentionally deny care to veterans, but there have to be reasons why care takes so long to be delivered. The VFW worries that the current culture may be focused on making funding fit at every level, as my colleagues from Paralyzed Veterans of America outlined. If this is the case, the culture must change. Leadership at every level must have the confidence that if they have a need, they can ask for it to be addressed.

We know capacity is an issue. The VFW and our other partners on the *Independent Budget* have for years highlighted the need to increase VA capacity. In 2004, utilization was at 80 percent. In 2010, 122 percent. And, in 2013, down to 119 percent, which is still unacceptably high. This undoubtedly affects VA's ability to deliver care. Plus, when there is a lack of resources, there is a tendency to make tradeoffs, whether through delaying care or gaming the schedule to satisfy quotas.

The VA health care system was commissioned to care for those who served and bled for our Nation. Men and women who are chosen as stewards of this system have been entrusted with a mission that cannot fail. If the system is failing, it is their duty to fix it. It is their duty to hold underperforming employees accountable. Most important, if they are unwilling to perform the mission, it is their duty to either ask for help or step aside.

However, in addressing any failures, we must resist any suggestion that VHA is a fundamental failure and it should be dismantled in favor of an alternative model. This only relieves VA of its responsibility.

Last year, the President met with then-VFW Commander-in-Chief, John Hamilton, and promised that he would not leave VA's problems to his successor. Last week, VFW Commander-in-Chief, Bill Thien, sent a letter to the President reiterating these concerns. We learned last night that the President shares the concerns of the VFW.

Today, we ask not only for the President to live up to his word, but we implore Congress to do the same. We cannot sit on our hands and wait for the system to slowly improve. The situation

that is unfolding across the country demands immediate, decisive action. The mission of VA health care is far too important, and as veterans' advocates and users of the system, we will not allow it to fail.

Mr. Chairman, this concludes my testimony and I am happy to answer any questions you or the Committee may have.

[The prepared statement of Mr. Gallucci follows:]

PREPARED STATEMENT OF RYAN M. GALLUCCI, DEPUTY DIRECTOR, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Sanders, Ranking Member Burr and Members of the Committee: I wish I did not have to be here today, but I want to thank you for the opportunity to share the Veterans of Foreign Wars' concerns on the Department of Veterans Affairs' (VA) health care delivery.

Simply put, the VFW is outraged over the allegations that have surfaced in recent weeks that VA denies care to veterans. What is more frustrating is that nearly a month after these allegations surfaced, we still do not have all the facts. We do not know who the veterans are who died waiting for care in Phoenix. We do not know if other hospitals are cooking the books in appointment scheduling to keep up appearances, while veterans either wait for care, or pay for it out of their own pockets.

Regardless of the forensic facts in Phoenix, Wyoming, Atlanta, Chicago, or Jackson, Mississippi, the VFW knows that veterans have died waiting for care. This in and of itself is inexcusable. VA is supposed to have protocols in place to make sure this never happens. So, what happened?

VA tells us the situation is improving, but to the veterans' community, this is not good enough. VA's obligation is to provide our veterans with the best health care our Nation has to offer. Over the last month, we can clearly see that VA is not living up to this obligation.

Veterans want and deserve the truth, but instead we are fed vague platitudes about quotas, wait times, waiting lists, and ongoing investigations. The VFW has been vocally frustrated at the situation, but we have been reticent to condemn individuals because of these "ongoing investigations." We are here today to say that enough is enough. Whistleblowers first brought the problems in Phoenix to the attention of VA and Congress as early as 2010. CNN broke the doors off this story in April. Why are we still waiting?

Last week, the VFW grew tired of waiting and told veterans to call our help line, 1–800-VFW–1899, to voice their concerns about VA health care, and connect with our service officers for help. While some said they were satisfied, or acknowledged improvements, most veterans painted a picture of a VA health care system that is overburdened, under-resourced, and many times paranoid:

- In Durham, North Carolina, an Iraq veteran told us that he can see his primary care doctor only once a year, and that he has sought care elsewhere after 10 years of misdiagnoses.
- In Denver, a veteran told us that when he moved to the city in 2011, it took a year and a half to book an appointment, and now he cannot get in for treatment of his service-connected conditions.
- In Florida, a veteran who was diagnosed with prostate cancer told us that he had to wait five months to see his primary care doctor.
- In Nevada, a veteran who was diagnosed with skin cancer tells us he is waiting eight months for an appointment after the hospital's dermatologist quit.
- And finally, in Phoenix, a veteran told us that he has been waiting three years for a surgical consult, and was told that if his condition gives him problems, he should just come to the emergency room.

If one veteran is not receiving the care he or she needs, it is one too many. This is only a small sample of the hundreds of concerns we heard from veterans at VA facilities from coast to coast, but the outpouring of concerns was alarming, and seemingly systemic. So, what is causing this failure? Is it a lack of resources? Is it personnel? Is it leadership?

As a result, the VFW will also conduct a series of veterans' Town Hall meetings, talking to veterans face-to-face, allowing them to voice their concerns. Once we have finalized locations and dates, we invite this Committee to attend and observe, hearing directly from the veterans about VA care delivery.

Although we are still waiting for the full reports to be issued on the latest allegations, recent preventable deaths at other VA facilities have already been confirmed. In South Carolina and Georgia, we learned that 23 veterans died due to recent con-

sultation errors. Last year, VA's Inspector General released a report detailing the improper handling of an outbreak of Legionella at the Pittsburgh Veterans Affairs Medical Center (VAMC) which took the lives of at least five veterans. Another report revealed the mismanagement of inpatient mental health care at the Atlanta VAMC, costing at least four veterans their lives. The Jackson, Mississippi VAMC has been plagued by multiple problems which endangered veterans' safety and lead to preventable deaths, including chronic understaffing, failure to sterilize instruments, and thousands of unread radiology images leading to missed diagnoses. Most recently, the VFW learned that as many as 19 veterans died nationwide in 2010 and 2011 due to unacceptably long wait times for routine cancer screening procedures.

In the past three weeks, whistleblowers in Phoenix, Colorado, Wyoming, Texas and North Carolina have alleged that these locations have "gamed" their patient appointment schedules to make it appear these facilities are achieving their appointment wait times. VA's assertion that wait times for primary care appointments in Phoenix have decreased from more than a year to 55 days on average is unacceptable. Mental health access also continues to be an issue. VA has hired more than 1,000 mental health care providers, but they still are not sure how many providers they need to fulfill the current demand.

The lack of timely care for veterans is unacceptable. The VFW certainly hopes that VA would never intentionally deny care to veterans, but there have to be reasons why care takes so long to be delivered. We know capacity is an issue. The VFW, in partnership with the *Independent Budget*, has highlighted for years the need to increase VA medical facility capacity. Even VA's own 10-year Strategic Capital Investment Plan (SCIP) identifies capacity as an issue. In 2004, VA's medical center capacity was 80 percent. It peaked at 122 percent capacity in 2010, and in 2013 capacity remained unacceptably high at 119 percent. Since FY 2010, appropriations for major construction projects have decreased from $1.2 billion annually to an FY 2014 appropriation of less than $350 million for the same account. Access to care can be directly linked to capacity. VA's major lease authority is also placing a burden on capacity, which directly effects access. Since FY 2012, Congress has not authorized VA major medical lease authority. That is 27 facilities in 18 states, most of which should be providing direct care to veterans.

These allegations are causing veterans and their family members to lose faith and confidence in a system that is supposed to care for them. VFW members and their families are outraged. They want answers, and they want those responsible for any substantiated allegations held accountable from the lowest to the highest level of leadership. With this in mind, it may be time to commission an independent review of VA's health care system. We must all work together to ensure that the culture across VA is one of placing veterans' needs first, and when veterans' care suffers because of one of these reasons, those responsible must be held accountable to the fullest extent of the law.

To provide timely access to care, VA must use all available tools, including purchasing non-VA care when necessary. Ideally, VA would have the capacity to provide timely, quality direct care to all those who need it, but it has become apparent to the VFW that they do not. Although we support expanding VA infrastructure and hiring enough health care professionals to meet demand at VA facilities, we recognize that this will not happen overnight. In the meantime, it is absolutely unacceptable for veterans to suffer. Non-VA care must be used as a bridge between full access to direct care and where we are now.

If it appears that certain facilities are not making proper outside referrals due to improper training, lack of standards, or institutional resistance, VA must move swiftly to correct those problems. If VA's new fee basis care model, PC3, is not being used to its full potential due to insufficient funding at the local level, we will call on VA and Congress to give them the resources they need.

When there is a lack of resources, there is a tendency to make tradeoffs, whether it is delaying care or manipulating scheduling systems to satisfy quotas.

It appears that the culture of leadership, management and accountability is focused on making the funding fit at every level. If this is the case, this culture must change. Leadership at every level must have the confidence that if they have a need, they can ask for that need to be addressed. VA, the Administration and Congress must resolve to make the true need the priority, not the need to make budget lines fit.

There is no question that the Veterans Health Administration (VHA) faces significant challenges in efficiently and effectively running the largest health care system in the United States. Successfully executing its four major missions of providing care to veterans, conducting medical and prosthetic research, training this Nation's physicians, and providing medical support to the public during domestic emer-

gencies is a massive undertaking. When failures are identified, it must be the responsibility of VA, Congress, veterans service organizations, and all of America to swiftly correct those problems with better oversight, sufficient funding, and accountability of those responsible.

In doing so, however, we must resist any suggestion that VHA is a fundamental failure which should be dismantled in favor of an alternative model. Such suggestions not only serve to relieve VA of its responsibilities, but fail to take into account the contributions that VHA makes to veterans, their families, and the medical community as a whole.

The VA health care system was commissioned to care for those who served and bled for our Nation. The men and women who are chosen as stewards of the VA health care system have been entrusted with a mission that cannot fail under any circumstances. If the system is failing, it is their duty to fix it. It is their duty to hold underperforming employees accountable. Most importantly, if they are unwilling to perform this mission, it is their duty to either ask for help or step aside.

Last year, when the President met with then-VFW Commander-in-Chief John Hamilton at the White House, he promised that he would not leave the problems within VA for his successor to deal with. Today we ask not only the President to live up to his word, but we implore Congress to do the same.

We absolutely cannot sit on our hands and wait for the system to slowly improve. Every day we hear of new allegations in another VA facility. The situation that is unfolding in VA facilities across the country demands immediate, decisive action. The mission of the VA health care system is far too important, and as a society that cares for the men and women who volunteer to defend our way of life, we cannot allow it to fail.

Mr. Chairman, this concludes my testimony, and I am prepared to take any questions you or the Committee members may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO VETERANS OF FOREIGN WARS OF THE UNITED STATES (VFW)

Question. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response from VFW: Senator, as you will recall, DAV was a strong proponent of VA's establishing an Office of Rural Health (ORH) in Public Law 109–461, and of Congress providing that office access to funds outside the regular allocation system used in VHA, so that ORH could sponsor rural health initiatives and innovations to account for health shortages in rural and highly rural areas. Over the past several years, using a special $250 million annual appropriation, the ORH has done a remarkable job in not only outreaching to rural veterans, but ensuring they can gain access to care in some communities and regions that are hundreds of miles from the nearest VA facilities. The ORH is also the co-managing office of Project ARCH, a pilot program authorized in Public Law 110–387, that provides veterans in four geographic areas access to managed care, but monitored closely by VA. While we have not seen VA's report to Congress on this pilot project, from all appearances and from our contacts with ORH and the Rural Veterans Advisory Committee, we believe this pilot has been very successful and well-received.

We are grateful to Congress for providing this partitioned health care funding for rural health initiatives by ORH, but we note that all those funds are now obligated and committed to a series of distinct initiatives, and the amount of funds has not been adjusted by Congress since the first authorizing year. In order for ORH to continue expanding health care options and outreach to new rural veterans and rural areas, additional funding will be needed in that account.

In terms of the general waiting problem now confronting VA that suddenly has been so much in the news, we know of no special initiatives VA may be conducting to assuage that situation in terms of outreach, and we defer to VA for that response to you. VA is required by law, however, to periodically and routinely report to Congress on outreach efforts.

Our public statements on the current situation in VA are a matter of record. We demand that any VA official or personnel who orchestrated or participated in covering up or hiding waiting lists be held accountable. However, DAV has long held that VA's ability to meet its own standards and policies for waiting time could not be met given the funding levels requested for health care by Administrations during recent years, or those insufficient funding levels that were approved by Congress.

Encouraged by Congress and the veterans service organization (VSO) community, strong outreach by VA in the 1990s to enroll more veterans in VA health care, combined with the onrush of patients enrolling after serving in Iraq and Afghanistan more recently, have caused demand for VA health care to exceed available resources. Additional outreach by VA in this environment would seem foolish without an infusion of significant new health resources and facilities to deal with the outcome of VA outreach. However, as a part of the military discharge process, VA and VSO counselors do brief veterans in transition about the nature, scope and variety of VA programs available to them, and do encourage new veterans to explore VA, for health, education, compensation and other benefits and services to which they are entitled. Given the continual rise in demand being seen in VA, we believe these efforts are effective.

Chairman SANDERS. Thank you, Mr. Gallucci.

Rick Weidman is the Executive Director for Policy and Government Affairs of Vietnam Veterans of America. Mr. Weidman.

STATEMENT OF RICHARD WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. WEIDMAN. Thank you, Mr. Chairman and the panel for the opportunity to be here today.

Let me just share one thing that has troubled us for a long time, and that is the lack of truthfulness on the part of some people in senior grades at VA, both in shading the truth in hearings on the Hill, but also in reporting up. And there is something else that baffles all of us from the VSOs. If I lie to our National President, John Rowan, I am toast. I am out of here. I am fired, as in, you are gone, pal. And, I would agree with that decision. You cannot run an organization, certainly not a medical organization, where people do not tell the truth to their superiors, because otherwise, if they do not have good information, they cannot manage properly.

I will say that it is our firm contention that the majority of people who use VA get good-to-excellent care. The problem has to do with access and with poor quality assurance. It is very uneven.

The plain fact is that there are not enough clinicians. It is very much analogous to Walter Reed MC, which I think many of you remember, in 2006. It is a question of too many clinical needs chasing too few clinicians, and what happens is distortion in the system and breakdown of the sequencing of care, and that was what was wrong with their care. That is what is wrong with the care at VA. There are not enough clinicians and it is the getting people to care exactly when they need it that is not happening.

The question is, are there enough resources for the Veterans Health Administration? We have to say we do not know. What we have been saying for 5 years is, when the budgets started to go up—the largest increase in the health care budget for VA since the end of World War II—that too many middle-management positions were being created. Congress gave that huge increase to VA to hire more direct service providers—more doctors, more nurse practitioners, more clinicians and counselors, et cetera—but it ended up that, in some places, the resources are deployed all wrong.

It may be that there has to be a supplemental, but we would urge that the review that goes on be a position-by-position and facility-by-facility review with everybody who is not directly involved in patient care. You have to justify that position and why and how

it adds to the overall enterprise of delivering quality care to veterans in a timely manner in a place where they can access it.

Part of that problem with resources is—we have said it ever since they started using it at VA—the Millman formula is a civilian formula. It does not take into account—that is what they use to estimate the amount of resources that they would need. We have exposures to things that, from my lips to God's ear, the civilian population of the United States will never be exposed to, and not just hostile fire, but chemicals, and on and on.

What it means is that when—at VA hospitals, the average presentations or things wrong with an individual is five to seven per individual. The Millman formula was built on middle-class PPOs and HMOs and they had one to three average presentations or things that were wrong with them. What that means is the burn rate of resources at VA is much higher. That is particularly true as us old guys from Vietnam age and become even more aged, plus our uncles from Korea and our fathers from World War II, but it is also true of the young people coming home today. The presentations per individual of OIF, OEF, and OND veterans is over a dozen for each individual who comes through.

So, the point is, we need to reprogram some money. We need to have picked up the Management Accountability Act on this side of the Hill and pass that; then reprogram money and, frankly, go for a supplemental, if it turns out it is needed.

In the meantime, we would urge everybody, every hospital—something we have been urging is to screen everybody at the hospital for the five major killers. The Lung Cancer Alliance, VVA has worked with for the last couple of years. VA has yet to do one of these screenings on a mass basis, and do it for the five major killers: lung cancer, prostate cancer, colorectal cancer, bladder cancer, and for heart conditions. If you screen everybody, then it is not—you do not have the kind of situation that developed in Phoenix.

I thank you very much, Mr. Chairman.

[The prepared statement of Mr. Weidman follows:]

PREPARED STATEMENT OF VIETNAM VETERANS OF AMERICA SUBMITTED BY RICHARD WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. Chairman, Ranking Member Burr, and other distinguish members of the Senate Veterans' Affairs Committee, thank you for allowing us to appear here today. We appreciate you giving Vietnam Veterans of America (VVA) the opportunity to express our views in regard to the State of VA Health Care.

As we did for the 112th Congress, VVA stressed again in our annual statements for the 113th Congress to the Committees on Veterans Affairs that we again wanted to make it clear: "Funding is not the primary issue" when it comes to timely adjudication of claims and of appeals at VA.

Similarly, VVA stressed that Funding is not the primary issue when it comes to the delivery of timely, quality medical care to veterans at the Veterans Health Administration facilities.

We are aware that some have called for Secretary Shinseki to step down in the wake of press reports of significant problems with timely access to medical care at many VA medical centers. Some of those so speaking out are our own members. With all due respect, the departure of Shinseki would not change nor "fix" anything, as these problems with timely access, proper use of tools to assist in the delivery of medical care, and being honest in portrayal of the status of wait times by VA clinics (both for primary care and for specialty care) did not begin with the tenure of Secretary Shinseki, but rather long before he left active duty in the Army.

The crux of the problem is that VA does not have enough clinical care deliverers who actually see patients for care. The reasons for this are basically that the Vet-

erans Health Administration (VHA) has spent the enormous increases from FY 2007 to date on hiring way too many "middle" people, often at salaries higher than the front line clinicians, who do not see veteran patients, and whose contribution to the overall enterprise is dubious at best.

VVA has voiced this directly to the Undersecretary of Health and to the Deputy Undersecretary for Health and others in the VHA hierarchy for the last six years at least. We have also spoken directly to the VISN Directors en masse about this problem virtually every chance we have been given. VVA has also noted that having two management lines up and down the chain of command, one for policy and one for operations, is just too many people in management, VVA has phrased this in such a way that the while most of the world's medical and other enterprises are going toward fewer levels of management between the CEO/COO and the actual workers (in this case clinicians) (or a wide fairly flat pyramid, the VHA was becoming a steeper pyramid, with way too many VISN staff and others in slots that can best be characterized as administrative overhead. Much of this has been done is such a way as to mask this fact, both internally and externally. Whether this is intended to be less than honest is for others to decide. We do believe that this is the fact, however.

There have been some remarkable Americans who have tried to make dramatic changes to the VA, and all of them have tried to improve the corporate culture and effective service to veterans. All have succeed somewhat, and failed somewhat. From Max Cleland to Harry Walters to Jesse Brown to Tony Principi to Eric Shinseki they have all striven mightily to improve the quality of the VA services from adjudication of claims to improving access to health care, as well as improving the quality of health care.

And the fact of the matter is that while there was always some great clinical work going on at VA medical facilities, the quality assurance was lacking. VA had always tried to be prescr4iptive as to what to do and how with its clinicians, and shifted in 1994 to say to local VA medical centers "just take care of veterans in the best way you know how." And that worked to some degree, but what it did not account for was the need for specialized services that were relatively rare outside of VA, such as Spinal Cord Injuries, PTSD, and prosthetics of every sort, Blind Rehabilitation Centers, and the like. What this VISN run healthcare did not do also was given a true account of the need.

All of the funding models that VHA have in place consistently underestimate the number of clinicians needed to optimally run this system. VVA has not altered our position that they are systematically underestimating needs of VAMC because VHA is using is still using a variation of the Millman formula, which is a civilian needs estimation tool designed for use by private Health Maintenance Organizations (HMO) and PPOs who have middle-class patients.

That formula estimates needs for resources based on an average of one to three presentations (things wrong with you that need to be medically addressed). Among veterans it was averaging three to five presentations per individual before the recently fought wars. Even with after VHA made adjustments for additional mental health and some specialized services, the formula continues to underestimate the "burn rate" of resources for every veteran seeking care.

Among IOF/OEF/OND/Global War on Terror veterans the presentations per individual are even higher than for earlier generations. Further, the needs of older veterans only increase as we get older. Additionally, the formula does not take into account the wounds, maladies, injuries, illnesses and adverse medical conditions that stem from military service, depending on what branch , what MOS, where, and when one served, all of which could and should be taken into account.

By and large these are not taken into account because the clinicians have not been trained what to look for, never mind the interns and residents on which VA depends so heavily.

There has been much talk about "secret lists," but the basic information that should be known by all service providers is one of the best kept secrets in VHA. Efforts to put this into the VistA electronic health care record at VA could be accomplished without any major re-programming, but VHA always has ostensible reasons and excuses about why they cannot do it, or not do it now.

For a rundown of many of these conditions, please see: http://www.va.gov/oaa/pocketcard/military-health-history-card-for-print.pdf and http://www.publichealth.va.gov/vethealthinitiative/

For reforms to truly succeed there must be far better oversight of and by Managers who are paid very well (not counting bonuses) to administer a system that is all too obviously not functioning as it ought to.

Management audits and assessments must be a component of annual performance reviews that are clear, specific, and success-oriented. There must also be focused

and hard-hitting oversight by the Veterans' Affairs Committees in both the House and Senate, as well as in the Appropriations and Budget Committees. VVA has suggested joint hearings of the authorizers with the appropriators.

Such hearings have taken place in this Congress yet we are still shy of our common objective of real accountability in the management of the Veterans Health Administration.

With Advance Appropriations now law for VHA's medical accounts, there can be no excuses as to why a VA medical center fails to hire the nurses it needs as it enters a new fiscal year, or does not purchase the new MRI machine that its radiologists insist they must have, or give the go-ahead for several of the small yet pivotal construction projects that in the past would have been put off pending passage of the budget for the next fiscal year.

VVA maintains that measures to ensure accountability must be essential elements in funding the VA. Key to achieving this is to significantly overhaul the system of bonuses for Senior Executive Staff to reward only those who have taken that extra measure, who have walked that extra mile, to ensure that what they are responsible for has been done well, on time and within budget; and for those who innovate and improve the systems and projects under their auspices. Bonuses should be withheld from those who just do their job—that is, after all, why they are handsomely paid. Those who perform poorly need to be removed or reassigned; and any manager or supervisor who gets caught lying to a veteran, to their supervisor, or to a Member of Congress should be dismissed. And bonuses should be given with a caveat attached: If you accept the bonus, you promise to stay with the VA for a given period of time, and not just take the money and run (retire) the very next year.

VVA believes that it will take several things to get a grip on fixing the VHA.

1. A thorough review of all positions that do not involve direct patient care, from the Central Office to the VISN offices, to each VAMC and other remote locations.
2. Since all of the games with scheduling appointments basically stem from not enough clinical direct care providers, there needs to be a thorough re-assessment of the number needed in each discipline at each VAMC. The increase of the numbers of clinicians can flow from a re-allocation of funds from middle-middle positions to actual care delivery.
3. A facility by facility review to ensure that unfilled cr4itical specialties are o0ffering enough money to at least be reasonably competitive with the private sector and other sources of clinician employment.
4. Where needed ask for the money needed to adequately staff each service delivery point as appropriate.
5. Speed up the efforts for a "Grow Our Own" clinical training program within VA up to scale within the next 24 months.
6. Force VHA to start to legitimately reach out to the veterans' community at every level, to involve us as major stakeholders and beneficiaries. Among other things, this will result in better decisions, and will also hold those within the system honest, and grounded in what veterans seeking services actually see.
7. A complete re-thinking of a scheduling program that obviously does not work as intended. Once again, if they do not involve veteran stakeholders, then this effort will prove fruitless.

There are further enhancements that we believe would be helpful in making VHA into a "veterans' health care system" that delivers quality, timely care with systems in place to ensure quality for every veteran. There are many tens upon tens of thousands of veterans who get high quality health care every year at VA. However, we must make sure that there are enough clinicians to do the job at each location.

As to the situation at hand, VVA restates our position that there are people who should leave VA immediately, but that does not include Secretary Shinseki. Just as we did not think that firing then-Secretary Principi when there were judge scandals at VHA, we do not think starting over with anew Secretary is necessary. VVA would remind all; however, tin the above cited instance, the Undersecretary for Health and others did depart.

Thank you for this opportunity to share our position, I will be pleased to answer any questions.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO VIETNAM VETERANS OF AMERICA

Question. When we talk about access to health care, it's not only about reducing waiting times for veterans seeking a medical appointment. It's also about reaching

the population of veterans that may not be aware of the benefits or care to which they are entitled. What is the VHA doing to provide outreach to this population of veterans? Is it enough?

Response.

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

Chairman SANDERS. Thank you, Mr. Weidman, and thank you all very much for your excellent testimony.

Let me start off with a fairly simple question. In general, we all are aware—and no one here disputes—that there are serious problems and serious allegations. But, some of you have said the quality of care that your members are receiving at VA is good to excellent. Do you agree with that? Is the quality of care your members receive adequate? Is it good care, or is it not? We all know there are exceptions out there, but let me hear that answer, briefly, if I could.

Commander Dellinger.

Mr. DELLINGER. We would agree with your assessment, Mr. Chairman. The overall quality of care, after they get into the system and actually get into the hospitals and the clinics, is very good.

Chairman SANDERS. OK. Mr. Violante.

Mr. VIOLANTE. Yes, Mr. Chairman. Our members believe the same thing. The quality of care they receive when they get in is excellent.

Chairman SANDERS. Mr. Tarantino.

Mr. TARANTINO. Mr. Chairman, we survey our members. We find that their experience with VA, while a bit negative, their actual individual care is incredibly positive.

Chairman SANDERS. Incredibly positive?

Mr. TARANTINO. But, that is also including the use of their G.I. Bill and——

Chairman SANDERS. Right.

Mr. TARANTINO [continuing]. Home loans and medical care, yes.

Chairman SANDERS. OK. Mr. Blake.

Mr. BLAKE. My comments spoke for themself [sic], Senator.

Chairman SANDERS. Mr. Robinson.

Mr. ROBINSON. Yes, I would agree with my colleagues, that once the system has been accessed, the quality is good.

Chairman SANDERS. Mr. Gallucci.

Mr. GALLUCCI. I would agree that the issue lies within access. To expand on that a little, one of things that I wanted to point out is I said I use VA, and I do. I was there last week. But, what happens is sometimes the person you get on the other end of the phone may not understand policies, may not understand proper procedures. When I see my clinicians, they offer me top-notch care, and that is a lot of what we heard from our veterans who responded to our inquiry last week.

Chairman SANDERS. Mr. Weidman.

Mr. WEIDMAN. It is generally good to excellent. The problem has to do with case management and access to the system.

Chairman SANDERS. OK. Let me ask another question. We all recognize, that anybody who is lying within VA, anybody who is cooking the books in the VA, is absolutely unacceptable. We demand accountability. People lying should be fired. I do not think

there is much debate. We do not have to go into that at great length.

But, I want to ask, what seems to be a problem, not all over the country but in many parts and all of you basically referred to it, is access. What I am hearing you say is once people get into the system, the quality of care is pretty good. The problem is access. We have heard Mr. Blake talk about the *Independent Budget*, which is the budget done by a number of the veterans service organizations assessing what they believe the needs of the VA are. I support that budget.

The bottom line is, and I will start with Commander Dellinger, do you believe VA needs more funding in order to deal with the access issue, make sure that people all over the country can get into the system in a timely manner?

Commander.

Mr. DELLINGER. I do believe it is underfunded, but I also believe that there should be reallocation of funds within the system.

Chairman SANDERS. Good point, and others can speak to that, as well.

Mr. Violante.

Mr. VIOLANTE. Yes, Mr. Chairman. I think, clearly, the problem rests with a log of the management efficiencies that the administrations have tried to put into the budget. A recent GAO report in February 2012 indicated VA reduced their budget by $2.5 billion based on management efficiencies, which were not realized and which are impacting the resources. So, this has gone on in previous administrations——

Chairman SANDERS. Right.

Mr. VIOLANTE [continuing]. And that needs to be stopped. That is like gaming the system.

Chairman SANDERS. Right.

Mr. Tarantino.

Mr. TARANTINO. The VA is underfunded, but throwing money at the problem does not help unless you have clear lines of accountability and reform for the things that are not working.

Chairman SANDERS. Mr. Blake.

Mr. BLAKE. I would agree with Mr. Tarantino. I mean, you cannot just throw money at the problem if it is not done smartly. Mr. Weidman pointed out that there were a lot of people hired and they were not necessarily hired where the need is. Our own written testimony points out serious staffing shortages in the entire SCI Service. So, clearly, people are not being hired there, where there is a demonstrated need. So, you could do reallocation of resources, but we believe, by extension, there is even more need for additional resources.

Chairman SANDERS. Mr. Robinson.

Mr. ROBINSON. I will agree with my two colleagues to my right that, yes, VA is underfunded. However, I would say, first, there should be infrastructure and systemic reviews and issues addressed. After that, after we are intelligent on where the funds will be allocated, then they should be funded. Thank you.

Chairman SANDERS. Mr. Gallucci.

Mr. GALLUCCI. I would agree with our *Independent Budget* partners that we support the *IB*'s numbers and we believe that VA, in its current form, is underfunded.

Chairman SANDERS. You guys are part of the *Independent Budget*, are you not?

Mr. GALLUCCI. Yes.

Chairman SANDERS. Yes. Right.

Mr. GALLUCCI. And, I would echo the concerns of everyone at the table about resource utilization and proper distribution of resources. And in my written testimony spoke about VA's capacity: what this has to do with is construction and facilities, a little to what my colleague, Wayne, was talking about. If we do not have the space, where are these clinicians supposed to practice? We have seen that problem with mental health hiring. They are able to hire more mental health practitioners, but where are they going to see their patients?

Chairman SANDERS. Mr. Weidman.

Mr. WEIDMAN. Part of it is the allocation of resources, but in addition, I would associate particularly not the major construction, but remodeling and adding to existing facilities. You have got to have a place to actually deliver the care. But, we are underfunded and do not have enough clinicians. That is why they game the system, not because they are bad people. They are under pressure not to admit there are not enough doctors.

Chairman SANDERS. OK. I am going to take a little bit more time; and Sen. Isakson, I will give you an equal amount of time. I just wanted to ask one brief question, which is important.

When you deal with a public system like VA, every problem, in a sense, sometimes makes the front pages. I mentioned earlier that there are studies out there, 200,000 or 300,000 people are dying from medical errors in private hospitals. You usually do not have hearings like this with TV cameras talking about it. On the other hand, the advantage of a public system is that, as citizens of the country and as representatives of millions of veterans, which you guys do, you have input into the process.

Let me ask you this question. I do not know what the answer is. My understanding is that the Secretary meets with representatives of organizations like ours fairly frequently, that he wants to hear your input. Is that true, Mr. Commander?

Mr. DELLINGER. Yes, it is, Mr. Chairman. We have a sit-down breakfast with him approximately once a month——

Chairman SANDERS. Once a month——

Mr. DELLINGER [continuing]. To discuss the issues.

Chairman SANDERS. OK. And, I assume everybody thinks that that is a sensible idea, yes?

Mr. DELLINGER. Yes. Input from the veterans' organizations, of course.

Chairman SANDERS. Right. And, Mr. Violante.

Mr. VIOLANTE. Yes. Our Executive Director meets with both the Secretary and the Under Secretaries on a regular basis.

Chairman SANDERS. Mr. Tarantino.

Mr. TARANTINO. That is not true for IAVA. We had our first meeting with the Secretary at VA Headquarters last week, and that was the first time since he was——

Chairman SANDERS. OK. So, you have not been meeting on a regular basis?

Mr. TARANTINO. No.

Chairman SANDERS. OK. Mr. Blake?

Mr. BLAKE. Our situation is the same as the DAV. Our Executive Director meets with him on a monthly basis.

Chairman SANDERS. Mr. Robinson.

Mr. ROBINSON. Yes. We meet with the Secretary on a regular basis.

Chairman SANDERS. Mr. Gallucci.

Mr. WEIDMAN. We meet with the Secretary——

Chairman SANDERS. Mr. Gallucci first.

Mr. WEIDMAN. I am sorry.

Mr. GALLUCCI. Thank you, Mr. Chairman. The VFW's executive leadership does meet with the Secretary on a regular basis, and our front-line leaders meet with his deputies on a regular basis, as well.

Chairman SANDERS. OK. Mr. Weidman.

Mr. WEIDMAN. VVA meets on a regular basis at the national level. Where it is not on that basis is programmatic things. The only place in VA that is sticking to the President's Executive Order on consultation of stakeholders before decisions are made is the Under Secretary for Benefits, because it does not happen in many other areas, and if it did, the decisions would be better.

Chairman SANDERS. Sen. Isakson, I have gone way over my time. You will have equal time.

Senator ISAKSON. Thank you, Mr. Chairman. That is the prerogative of the Chair, too, I might add, so——

[Laughter.]

Chairman SANDERS. But it is going to be the prerogative of the Acting Ranking Member. You will have that time.

Senator ISAKSON. Following up on the tone of the discussion, it needs to—I am going to make a statement and I would like each one of you to tell me whether you agree with this statement or not. The question before us today is not the quality of health care delivered to veterans by VA. The question is access to the quality of care. Would you agree with that, Commander?

Mr. DELLINGER. Senator, we do agree with that, but there are also pockets within it, like a cancer, like a skin cancer. If you get the small pockets out, the overall system will live. But, eventually, if you do not take care of that, the system will die.

Senator ISAKSON. OK.

Mr. Violante.

Mr. VIOLANTE. Yes, DAV certainly agrees with that. And I would like to point out a task that President Bush force back in 2003 established to look at health care, pointed out at that time that there was a mismatch of funding and demand, and if something was not done about that, access was going to be affected, which is what we are seeing now.

Senator ISAKSON. That is going to be my next point, but go ahead, Mr. Tarantino.

Mr. TARANTINO. We would agree with that statement, Senator.

Senator ISAKSON. Mr. Blake.

Mr. BLAKE. Yes, sir, Senator. It is definitely access.

Senator ISAKSON. Mr. Robinson.

Mr. ROBINSON. Our concern certainly would be the access, especially in rural areas.

Senator ISAKSON. Right.

Mr. Gallucci.

Mr. GALLUCCI. Senator Isakson, we would agree with that, but with access, that can leach into care delivery. One of the concerns that we received from a veteran in Nevada was that he was diagnosed with skin cancer, a proper diagnosis. But, because a dermatologist had left the VA medical center, they were not going to be able to schedule him for a proper consultation until that person was replaced.

Senator ISAKSON. Which is somewhat an access problem in and of itself.

Mr. GALLUCCI. It is an access problem, but that is where access leaches into the quality of care that can be delivered.

Senator ISAKSON. Well, capacity is one of the problems for access.

Mr. GALLUCCI. Exactly.

Senator ISAKSON. Mr. Weidman.

Mr. WEIDMAN. It is primarily access, and an additional thing is that VA still is not systematically in the medical system addressing the wounds, maladies, and injuries of war and taking a military history and using it in the diagnosis and treatment modalities.

Senator ISAKSON. The reason I am taking this track is I do not want us to leave this hearing with a mixed message. If there is any problem with VA quality of health care, we need to talk about that. But, if there is not, except for isolated cases, and the dermatology case is a good example, we need to talk about what the problem is, which is access to that health care, which is a capacity problem, number 1, but it also appears to be an attitudinal problem within the VA where there is more of a motivation to make the numbers look good than give access to the care to make the veteran well. Am I stating it fairly? Does anybody disagree with that statement?

Mr. BLAKE. No, Senator, I think you are right. I mean, I think there have been concerns raised that maybe the performance accountability system promotes something like that, and so access is controlled in order to make performance look better.

Senator ISAKSON. And, capacity is a function of appropriations, I understand that, but it is also a function of the management of the system internally within the VA. I do not ever recall—and I could be wrong, Mr. Chairman—us receiving a report from the Veterans Administration on any study it has done to improve its access to capacity, or improve its capacity so we improve access. What we always tend to talk about is the time it takes to get a determination for a disability, or how long it takes to get into a VA center, or some other isolated case like that, when it seems like we ought to have a very thorough examination of the capacity situation in terms of the VA.

And then we have got to take a look at the issues that you addressed, Mr. Blake. I know you are not for any private delivery of service. You want the veterans' hospitals to operate. And I know, Commander, that is the same for you. But, the option of having that access could help solve the capacity problem, particularly on a selected specialty, like dermatology, like melanoma, like most

surgery or something like that. So, is that an idea that—not replacing the VA Health Care System, but having veterans have options to access the private health care system. Would that work, Mr. Blake?

Mr. BLAKE. Senator, I think veterans have options, even now——

Senator ISAKSON. They do.

Mr. BLAKE [continuing]. And I think they are improving on it. The PCCC is an example of how they are trying to improve upon that. We certainly believe that if they are going to move some in that direction, there needs to be coordinated care. My point was that that does not particularly work, though, for veterans with specialized care needs, like SCI or blinded care or amputation, because those types of services do not really exist——

Senator ISAKSON. In the private sector.

Mr. BLAKE [continuing]. In the private sector; at least not in the way that our members have come to expect it. But, we certainly could see where privatized care plays a role in it, or contracted for services with coordinated care plays a role.

One thing I would suggest, though, is that as a solution suggests that that is what veterans want. But, I think some of the problem that we see right now validates that veterans want into VA. So, why would we create an option where they necessarily where they would go somewhere else? They want into VA. They cannot get into VA. So, we are not sure that allowing them to go outside is addressing what their immediate desire is.

Senator ISAKSON. Except that wants and needs are two different things, and the need is the most important. If it gets them the service they need in a timely manner, even though it might not be in a VA hospital because of the particular problem, it is better than having them wait so long to have a life-threatening condition come about.

Mr. BLAKE. I would agree with that point, Senator.

Senator ISAKSON. All of your testimony was outstanding, by the way. I appreciate all of it very much. And, I am going to leave this hearing with a clear message for the veterans of Georgia. We need to solve the access and the scheduling problem and we need to do it now, and we need—VA needs to go internally—which Secretary Shinseki and I talked about this—have an accountability mechanism all the way down, because I think the senior leadership is disserving the American veteran. I think we have known what the problems are for some period of time and I think we know what the needs are. I hope we will take this hearing and move forward to solve those problems, hold everybody appropriately accountable, and have an attitude toward solving problems rather than masking problems.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Isakson.

Senator Begich, I think, is next.

Senator BEGICH. Mr. Chairman, thank you.

I am going to follow up on Senator Isakson's comments. You know, we had a similar problem. I first want to thank many of you because you had concerns about what I am about to talk about but you came—and, Carl, you are one of them, and you were really good in helping us figure this out—and that is, we have a huge

Alaska Native veteran population, American Indian population, in Alaska: 150,000-plus. We have an Indian Health Service system which was not very good, to be frank, many, many years ago. Now, in Alaska, the tribes took it over and now deliver, we consider, the best health care in this country, in my opinion and I think many others' opinion. As a matter of fact, CMS has said it is some of the best health care in the country.

So, because we do not have a veterans' hospital, and many of us had these conversations over the last few years, we were trying to figure out a system to create better care—access is really what it is about. If you live in Nome, AK, and you want to come into Anchorage to the clinic, you could spend $1,500, $2,000 from one of the outer villages going to Nome and then coming to—very expensive for our veterans. We have 800 veterans living in Nome, AK, that are both native and non-native. We built a brand new hospital there with stimulus money, which I am very proud of—a $170 million facility for Indian Health Services, which is actually run by our tribal consortium. Indian Health Services does not run health care in Alaska. It gives a check to the tribal consortium who then delivers health care for our tribes.

Because of the work you all did with our office, we now have access for our veterans. Those 800 veterans have a choice now. They can go to Indian Health Care Services, get that health care anywhere near their home, their village. I can tell you story after story about how that system has now come to be very valuable. Or, they can go to the clinic or go to Seattle to the hospital, because it was an access issue. The care that VA offers, and I think you all said it, we have great professionals there. They work hard. I think they are overworked for the amount of time they have. They have not enough staffing, and we can go through all those lists.

But, the moral is, we found a solution, protecting the importance of VA health care, which is veterans want to be part of the VA Health Care System. They want to be—that is their—they earned it. They fought for it. It is a benefit of theirs.

But, in Alaska, we had an access issue. We could not afford to have a veteran sitting out in rural Alaska waiting to catch the next plane when there is a hospital right next door. So, we figured this out. We have a model called Nuka, which, when you walk into the Indian Health Care Services, the odds of you getting a same-day appointment is probably 75 percent or better.

And, when you come in—the question you brought up is the amount of ailments that someone comes in with is different than the model that VA has been designed for years ago. The Nuka Model, same situation and problem: too many ailments per one individual. So, now when you come in, you get a mental health provider, eye doctor, dentist, full health care. They meet with you as a team. So, they resolve the issues collectively rather than individually, and the care quality is superb.

You know, we have been pushing on VA to look at the Nuka Model, because that is how we have got to deal with multiple ailments of an individual, and also same-day access. To be able to schedule a routine appointment and have to wait weeks or months is outrageous. And so maybe it is more of a statement, but I would be interested in—and again, I know many of you worked with us,

and I point Carl out because he and I had some good debates on this, but I think it is working. I have veterans now who call me and say thank you; not that they are not going to always go to VA. They are going to go to VA. But now, in a situation where they are living in a village or a small community, they can go across the street and there it is. They have a choice.

So, I guess I would like your—you have heard kind of my comments here. I would be interested in any comments folks have. And, again, the Nuka Model—N-u-k-a—is a very unique delivery system. It is all about access. Any comments from folks?

Mr. DELLINGER. Senator, Dan Dellinger. Thank you for that question, because it just so happens, I was in Alaska last month, and I was in Kenai, and——

Senator BEGICH. A beautiful new hospital down there.

Mr. DELLINGER [continuing]. And they want to expand what they are doing in that area, and they are in a strip mall with the CBOC there——

Senator BEGICH. That is right.

Mr. DELLINGER. But, they are also are looking for additional space. VA spent 3 years trying to get a lease worked up and they are frustrated. They want to do additional things. But, I agree with your assessment as far as accessibility, especially out West. The East Coast is something different——

Senator BEGICH. I agree.

Mr. DELLINGER [continuing]. But, as I travel through the Western States, I see more——

Senator BEGICH. Like ours.

Mr. DELLINGER [continuing]. Services—exactly. And, I think it is something we should build upon in——

Senator BEGICH. Kenai has a brand new, it is a Kenaitze Tribe hospital, a beautiful hospital that will partner, actually, with that CBOC——

Mr. DELLINGER. Exactly.

Senator BEGICH [continuing]. Which is unbelievable care. Thank you for that.

Any other comments on that? And, I know my time is almost up here, so——

Mr. VIOLANTE. The only thing I would like to say, Senator, is right now we have 27 points of access that are on hold because we cannot get the funding, and it is important that we move forward on that. I mean, going back to the Clinton administration, when they put a lot of construction on hold under CARES to determine where they wanted to build. I mean, VA has been underfunded in construction since the Clinton administration.

Senator BEGICH. Good point.

Mr. VIOLANTE. So, we need to do something about that, also.

Senator BEGICH. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Begich.

Senator Moran.

Senator MORAN. Mr. Chairman, thank you very much, and Secretary Shinseki, thank you for remaining for the testimony. I appreciate you being here.

Let me raise a topic about the assessment that is now going on, the face-to-face review across our country. One of my Congressional

colleagues had a conversation with VA personnel in Jackson, MI, after the assessment presumably took place, and this is a bit of a paraphrase of his or her report back from what they heard about this assessment.

We asked about their face-to-face review. They stated that the team came in on Monday, interviewed some clerks and some supervisors, and they did not find any evidence of scheduling issues. No veterans were interviewed. What struck this person was the apparent superficiality of this so-called audit. A day, at most, visit that did not comb through the electronic system or actually audit any reports is not indicative of a thorough review.

And so what I tried to raise in my opening statement is we are going to have one more review that is to be completed within 2 weeks. We have 1,700 facilities across the country. And so, in part, my concern is the quality of the review. It appears to me that this is more of damage control. It is what people do when there are allegations of mismanagement, improper conduct. You have another review planned. And so my concern is how credible will the review be based upon the amount of time and resources that is being devoted to it.

But, perhaps more troubling to me is how many reports, allegations, IG, GAO, Congressional hearings do we have to have before there is a different approach or attitude at VA to solve the problem. And so, I guess I do not disagree with an audit across the country but what is this really going to accomplish? Will we be here 6 months from now in which VA has a plan in place to transform itself so that these access issues that you all described are not the same ones that we heard today, we heard last week, we heard last month, we heard last year?

The Phoenix situation seems to have brought national attention to this problem, but I cannot imagine that there is anyone at the table who believes that the Phoenix situation is really what the—is the problem. It is a symptom of a much broader problem that has been ignored for a long time.

So, Commander—and here, let me add this. I understand that the testimony of the Secretary this morning in response to the Senator from North Carolina in which the Senator, outlined a long list of audits and reviews, GAO reports, Inspector General audits, and the Secretary indicated that he was unaware of those audits and reports and, therefore, had not been used in any conclusions that I assume would be made at VA.

There was an IG report that is included in that list that said the unexpected death report could be avoided if the VA focused on its core mission, to deliver quality health care. Because no two VA medical centers are alike, it is difficult to implement VHA directives when there are no standard position descriptions or organizational structures. The IG believes it is time to review the organizational structure and business rules of VHA.

How can that be an IG report that a Secretary of Veterans Affairs would be unaware of? It is directly related to the management and organization of the Department of Veterans Affairs.

So, my question, if there is one in my commentary, is what assurance can we have, or what assurance do you have, that when this face-to-face review is done, that something will be different in

the direction that VA is taking in regard to creating higher quality care for veterans and making certain that they have access?

Commander.

Mr. DELLINGER. Senator, that is quite a task. With the IG audit, yes. In the findings, once they come out, I think this Committee needs to establish, along with VA, milestones so as to rectify these issues as they go through. But, as you noted in your comments, each hospital is different, and even when a director changes, a hospital that was doing excellent then could possibly slip below the standard. So, it is going to be an ongoing challenge; and we would hope that the Secretary and VA would move forward as soon as possible with the changes necessary to give us the quality health care that all veterans deserve.

Senator MORAN. My time is soon to expire, and I do not know whether the Chairman is intending to allow you to answer my question, but I would add that you all—almost all—indicated that you have, or your senior staff have, ongoing conversations with the Secretary or high-level individuals at the Department of Veterans Affairs. But, the question that I would ask is, does that result in a change in approach, style, management, or attitude at VA that actually results in higher quality care for our veterans?

Mr. Chairman, thank you for the opportunity to issue a statement and to ask the questions.

Chairman SANDERS. Thank you, Senator Moran.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, and I want to thank this panel for their testimony, their perspective, and their vision.

I also want to thank Secretary Shinseki for staying here for this part of the hearing and to express my apologies. I got tied up in the Banking Committee and votes on the floor, but we will follow up with you in private.

It is good to be asking questions about fifth or sixth down the list because I think we have all agreed that access is the issue. And, we have had everything talked about from dollars, to allocation, to construction, to milestones, to manpower, to all sorts of stuff, which it all is good and it all is helpful.

I am going to ask each one of you folks—because you represent veterans in this country that are being served by the VA, I think you have an understanding of what the challenges are out there, so, you are not Secretary of VA, you are not President of the United States, you are above all them. You tell me what you would do first to fix the VA and what you would do second. And, I assuming there would be three or four or five more down the line, but is it money? Is it the resources they have need to be allocated different? Is it we need to put a focus on hiring professionals? And you cannot say, do all of them, because we want to hold folks accountable. So, if you could give me your priorities for what we need to do, I think it could be helpful.

Mr. DELLINGER. Senator, assessment, I think, is the first thing that needs to happen, because as we have heard VA speak about they have enough money, but they do not have the accurate numbers. If they are gaming the system, how many actual visits are they going to have a year? Instead of having 85 million, is it going to be 150 million? So, you cannot assess a money value to that

until you can make the assessment as to what exactly the problem is.

Senator TESTER. OK. And so, then, I assume that once you get the assessment, you follow that assessment as a blueprint to fixing VA.

Does anybody else have anything they would like to add to that? Go ahead, Mr. Gallucci.

Mr. GALLUCCI. Senator, thank you for asking that question. I actually have a list of four things——

Senator TESTER. Perfect.

Mr. GALLUCCI [continuing]. That I would really want to talk about. First is resources, as the VFW and our *Independent Budget* partners have talked about. And, it may not be a numbers game. It may be allocation of resources.

Second——

Senator TESTER. So, what are you telling us to do?

Mr. GALLUCCI. We would recommend taking the *IB*'s recommendations on how to properly fund VA and things like capital infrastructure and VHA's baseline budget.

Senator TESTER. Continue.

Mr. GALLUCCI. Second would be training and outreach for your gatekeepers, the people who man the call centers at VA facilities.

Senator TESTER. OK.

Mr. GALLUCCI [continuing]. On outreach to veterans so they know what to expect when they call VA.

Senator TESTER. OK.

Mr. GALLUCCI. Consistency across the board, so that your experience at one VA center is very similar to your experience at another VA center.

And, finally, one that I have been chomping at the bit to talk about is accountability. We have had a lot of talk about accountability. The Secretary said that 3,000 employees were sanctioned in some way, whether that was termination, retirement, transfer, or demotion, what have you.

There is a problem—in having conversations over recent weeks about this internally with VFW, with some of our advocates and veterans, there are two things that we know. First of all, reprimanding or firing an employee in the Federal Government is a difficult process, a difficult legal process with significant EEO and other legal protections. It can take a long time to take punitive action against an employee.

Second, when there is a vacancy in the Federal Government—this is, again, not VA exclusive—it can take between 6 months and 1 year to fill it. So, if you have an underperforming employee——

Senator TESTER. Yes.

Mr. GALLUCCI [continuing]. You have to then make—and I am really asking the question here—do you make the tradeoff decision. So, I have an underperforming employee. Is it better to keep them on the books at least serving some veterans or terminate them and have that vacuum of care for 6 months to a year, or possibly longer?

Senator TESTER. I appreciate that, and that might, Mr. Chairman, bring us around to another discussion about how we can work with the Department—and, by the way, this could apply to all

agencies in government—to reduce the red tape for hiring, because it takes far too long to get that done.

I want to just ask a little bit about the accountability portion, because accountability is really, from my perspective, really easy to talk about, but sometimes very difficult to put your finger on where the problem is, who is the problem, and, quite frankly, how you deal with it. Any ideas on—I mean, for example, the argument could be made that because we have hired all these middle-management folks—and I think you guys made a very good point on that; this is crazy, we should not be doing that. These should be on-the-ground folks. But, we have hired these middle-management folks to make sure the folks on the ground are actually doing the job. Now, how do you deal with accountability? Do you contract it out? Do oversight? What do you do? Or, does it strictly fall at the Secretary's feet and everybody else is held harmless? Go ahead, Mr. Weidman.

Mr. WEIDMAN. I think that the bill introduced by Mr. Miller on the House side is a good start—and people said, do you favor that bill—which strips SES people at VA of any protections whatsoever. But, there is a reasonable point in between Mr. Miller's bill as it currently is and what we have now, because they cannot fire SES people. They say they can, but they cannot. I mean, I remember the lady from Kansas City a few years ago. They removed her as a VISN Director——

Senator TESTER. Yes.

Mr. WEIDMAN [continuing]. But, every Monday morning, flew her to Washington, kept her here at government expense, and flew her back for 3 years, paying her $180,000. So, they need flexibility.

Senator TESTER. Thank you, and thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Tester.

Senator Johanns.

Senator JOHANNS. Thank you, Mr. Chairman, and to everybody who is here. This has been extremely helpful.

I think we are going to find that the access issue, which you all consistently say is the problem, is going to be easier to identify than to solve. You know, I think about, let us say, a VA hospital needs five specialists. They are probably going to recruit from the area around and they are going to compete with private doctors' practices, they are going to compete with hospitals, and on and on, and that is true whether it is the doctor or the nurse or the medical technician, whatever it is. So, building that capacity, even with lots of money, would be a challenge, and I think we all agree to that.

So, let me ask you a question, because I also agree—we are waiting for a hospital in Omaha. I am beginning to wonder if it will happen during my lifetime, and I am a fairly young man. I am, you know, not too old. And even if we could get all the money all at once, which would be very hard to accomplish, how much construction can you get up and going, and on and on.

So, let me ask you a question about access. Let us say that we are thinking about this and we have got all this population that is needing more access, not less—us Vietnam-era people. It is a whole group of people, and we are aging. We are the Baby Boomers and we need more access, not less.

Would your members be open to an idea that said something like this: They call, they say, I need to see a health care professional because I have got a spot on my leg that does not look right. I think it might be cancer. And they say, well, we want to see you just as quick as we can, but that will be 4 months, or 6 months, or whatever. Would your members be open to an idea that says, look, if you cannot get in within 2 weeks, or 3 weeks, or whatever the appropriate timeline is, you can seek private care. You can go to your local doctor or a specialist or whatever. The government will pay the cost of that and we will cover that, because we do not want you to wait and we believe that that is the best way to deal with access, the quickest way, the most effective way.

And the other thing I would mention in asking you this question is, in States like mine—we are a Western State, the State of Nebraska—access for rural veterans is especially difficult and it is especially difficult in some areas like mental health and specialized care.

Commander, what is your thought about that?

Mr. DELLINGER. Well, you know, VA right now utilizes telemedicine, so if they are at a CBOC, and even though there is only a nurse there, they can, by utilizing telehealth, be seen at a hospital——

Senator JOHANNS. Yes, I appreciate that, but how would your members react if I said, look, we are just not going to make you wait anymore. If VA cannot meet your needs within a certain period of time, then we will allow you, if you choose, to seek private care. If you want to wait, it is a free country. You can wait, too.

Mr. DELLINGER. I understand that. We would not be opposed to that, because we want the best health care as fast as possible. But, we also have to put a caveat on that that it cannot happen exceedingly, because then there goes the entire budget as fee-based, which is going to be higher in the private sector versus the ability in the VA.

Senator JOHANNS. Well, I get that, but we are all saying we want——

Mr. DELLINGER. I understand.

Senator JOHANNS [continuing]. The best care. Yes, sir.

Mr. VIOLANTE. Senator, I mean, that is the exact point; if you are not willing to give VA the resources it needs to allow for access in their facilities, you are going to need to give them more resources by sending veterans out into the community. Now, VA has the authority—I do not think they use it enough—for purchased care. And, again, as I pointed out, if a veteran cannot be seen in a certain timeframe, they should be able to get that care by a private doctor, but VA needs to coordinate that care.

We need to be careful that we do not start increasing the money going out to private doctors and taking away from VA's ability to hire internally, because all we are doing is robbing Peter to pay Paul, and if they do not have the money to do it now, they are going to have less money to do it with the private sector.

Senator JOHANNS. I am out of time on a complex issue, but here is my point, again. If it results in better care, is that not what we are trying to achieve? And, boy, I hope some day I can have a discussion with all of you.

Thank you, Mr. Chairman.

Mr. BLAKE. Senator, could I address that real quick?

Senator JOHANNS. Sure.

Mr. BLAKE. It is my understanding that the PCCC, which is Patient Centered Coordinated Care, is sort of envisioned to address part of what the problem is that you outlined specifically, and that is what we want. We want coordinated care, because the key is the continuity of care and ensuring that VA is ultimately responsible for that veteran, so they know the spectrum of what that veteran is receiving. So, I think maybe PCCC is moving in the direction of addressing the kind of concerns that you are raising.

Senator JOHANNS. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman.

I want to thank all of the leaders here for your presence today, but also your tireless and relentless work on behalf of the veterans of America. And, truly, your leadership has made a big difference, not only in the performance and outcomes from the Veterans Administration, but in countless communities and other areas across the country. So, my thanks to you.

My questions are very simple. All of you, I believe, would agree with me that the investigation should be as hard hitting, aggressive, thorough, and prompt as possible, and that if that requires the resources of other investigative agencies, they ought to be called upon, as well. Would you agree?

Mr. DELLINGER. I do, sir—Senator.

Senator BLUMENTHAL. And, second——

Mr. WEIDMAN. We not only——

Senator BLUMENTHAL. I am sorry, Mr. Weidman.

Mr. WEIDMAN. We not only agree, but our National President, John Rowan, wrote to the Attorney General of Arizona last week and to the U.S. Attorney for the District of Arizona, asking each of them to launch criminal investigations into reckless endangerment, possibly resulting in loss of life.

Senator BLUMENTHAL. Well, if you were not here earlier, let me just tell you that I urged the Secretary of VA, Secretary Shinseki, to strongly consider—in fact, I recommended that he involve the Department of Justice because there is ample evidence—and, I emphasize, evidence, not just allegations—of criminal wrongdoing, including destruction of documents and falsification of statements—to warrant the FBI to review this situation, as they do commonly when there are allegations of this kind, and determine, in fact, whether there is a basis for that investigation.

The reason is, quite simply, not only the evidence of possible criminal wrongdoing, but also the Inspector General lacks the jurisdiction and authority, the resources, and the expertise to do a prompt and effective criminal investigation. Only the FBI can provide the resources, expertise, and authority, and the Department of Justice includes the U.S. Attorney in Arizona and every U.S. Attorney in every State that may be affected here.

So, I think what we share is a determination—and I believe that the Secretary of VA shares it, as well—to get to the bottom, to remedy the wrongdoing, to provide relief to anyone denied access; and

I think that is a determination that unites us in this room and that accountability means changing the team, if necessary, at VA. I believe that there may, at some point, be a need to consider those changes, as well.

So, again, thanks for being here. My time is limited. I thank the Chairman.

Chairman SANDERS. Thank you very much, Senator Blumenthal. Senator Hirono.

Senator HIRONO. Thank you very much.

I do apologize if this question has already been asked, but Senator Murray had asked earlier of, I believe, Secretary Shinseki, as to what a face-to-face audit should involve; and I would like to ask you—perhaps we can start with Mr. Dellinger—what needs to happen in a face-to-face audit to truly elicit the kind of information we need to address the challenges and the problems at VA hospitals and clinics.

Mr. DELLINGER. Thank you, Senator, for that question. I feel it has to start with IT first. They have to look at the process of the books as far as what actually occurs there. They also have to go through the administration, through the physicians, the employees, and also get input from the stakeholders in this, including the veterans.

Senator HIRONO. Did that happen the last time? Apparently, there have been audits before, and when those audits were conducted, were the stakeholders, i.e., the veterans' organizations, included?

Mr. DELLINGER. I do not have that information.

Senator HIRONO. Do the rest of you have any information that will help us? Yes.

Mr. WEIDMAN. Often, we are not included. Actually, even more important than the organizations at the local level is to talk to veterans at the local level who are not hand-picked and ask, what is happening here? If you ask the veterans, they are smart. We got hurt. We got wounded. We did not get dumb. The veterans will tell you how to fix the facility.

Senator HIRONO. So, would you all agree that any face-to-face audit should include—probably, this is a rhetorical question, but—input from the veterans' organizations as well as veterans at the particular facility?

Mr. WEIDMAN. Yes.

Mr. VIOLANTE. Senator, I would agree with that. I would also, as we pointed out in our testimony, recommend that there be an independent third-party expert involved. It would alleviate a lot of the questions that Senator Moran raised about the audit and I think it would help everyone be assured that these audits were being done properly and everything was being looked at.

Senator HIRONO. What do you mean by an independent third party——

Mr. VIOLANTE. Someone who is—I mean, I do not have the expertise——

Senator HIRONO. Like whom?

Mr. VIOLANTE. I do not have the expertise to determine, you know, are the people cooking the books, are the veterans getting timely care, are they spending sufficient time or too much time

with the doctor. There needs to be someone who is an expert in time management, in accessing medical care, that can be there to make a determination if they are asking the right questions and are the answers sufficient to address this problem.

Mr. BLAKE. Senator, I would suggest, also, if they are going to do a thorough audit, it would take more than a couple weeks, certainly, because a thorough audit would be an examination of what the entire capacity of the system currently is. That might involve clinicians, nurses, whatever it may be.

I will suggest that if the audit that is going on right now is what Senator Moran suggested is happening, that is pretty damn disheartening, because that is not going to solve any problems as far as we are concerned. It is going to take a more thorough analysis, for sure, than a couple of hours out of 1 day in a week to sit down and figure out what is happening. It might get to the bottom of a problem, a shallow-depth problem at a local facility, but I am not sure that is going to solve the deeper-rooted problems.

Senator HIRONO. I would envision that any kind of an assessment of the entire VA health care system would involve not just this process that Secretary Shinseki has described to us, but that it will be an ongoing kind of an assessment, which I hope will be the case. The Secretary is still here and I am sure that he is taking to heart the suggestions and comments that you are now providing.

I had asked the Secretary, in view of all that we are asking the VA with regard to education issues, housing issues, homelessness, all of that, whether he thinks that this is taking away from VA's core mission of providing health care for the veterans. Does anybody care to respond to that?

Mr. WEIDMAN. There is no such thing as a homeless veteran. There are veterans whose problems have become so acute and have not been addressed that they have ended up without a home. So, it is not a whole different class of veterans, if you will. And, if the other services come through, then people do not end up on the street. Each one is a failure. It does not mean that people set out to fail, but somehow, we have failed those folks coming home.

Mr. GALLUCCI. Senator, I would like to add to that the VFW believes that the resources and services the VA can provide should never come at a tradeoff. VA's obligation is to provide holistic services to the veteran. That can come in the form of education benefits, employment assistance—like the resource that they launched a couple of weeks ago through e-Benefits—but, health care has to remain a cornerstone of that.

When veterans transition off of active duty, there are a litany of transitional resources that need to be made available to them. The VA has the primary mission in delivering most of those, except for possibly what the Department of Labor, Veterans Employment and Training Service, has.

So, we would never want to see tradeoffs made on how we deliver other benefits, because if we start injecting resources into health care, will G.I. Bill administration suffer, or will other benefits administration suffer?

Senator HIRONO. Thank you for that perspective.

Thank you, Mr. Chairman.

Chairman SANDERS. Senator Burr.

Senator BURR. Mr. Chairman, just 1 second, because in my absence, Senator Moran did talk specifically about the audits and he read a statement. I just wanted the witnesses to know, that was the assessment of Chairman Miller from the House Committee. He actually was at Jackson, and I am not sure how many facilities he is covering, but that was his assessment of the audit process.

Not that I do not love you guys, but we are going to try to get the next panel in before we get into a series of votes that will bring a finality to this, so thank you.

Chairman SANDERS. Thank you, Senator Burr.

First of all, thank you for what you do every day representing veterans, and thanks for being here. More importantly, I think we all know we are not going to create the great health care system we need in the VA without your active participation. We need you. So, thank you very much for being here and keep up the good work. [Pause.]

And, if we could bring up the third panel. [Pause.]

OK. Let me introduce our third panel of the day. Representing VA's independent Inspector General's Office is its Acting Inspector General, Richard Griffin; he is accompanied by Dr. John D. Daigh, Assistant Inspector General for Healthcare Inspections.

From the National Association of State Directors of Veterans Affairs, we have its President, Retired Rear Admiral W. Clyde Marsh.

From the Government Accountability Office, the GAO, we have their Director of Health Care, Debra Draper.

Finally, joining us today is Phillip Longman, Senior Research Fellow at the New America Foundation.

Thank you all very much for being here.

Mr. Griffin, you may begin.

STATEMENT OF RICHARD GRIFFIN, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS

Mr. GRIFFIN. Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to provide testimony at this hearing. I would like to provide an overview of our ongoing review at the Phoenix Health Care System.

The OIG has assembled a multi-disciplinary team comprised of auditors, health care inspectors, board-certified physicians, and criminal investigators from across the country to address these allegations. I have directed our team to focus on two questions. Number 1, whether the facility's electronic wait list purposely omitted the names of veterans waiting for care, and if so, at whose direction. And, number 2, whether the deaths of any of these veterans were related to delays in care.

To get to the bottom of these allegations, the OIG has an exhaustive review underway that includes seven components:

> Number 1, interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers, management staff, and whistleblowers who have stepped forward to report allegations of wrongdoing.

Number 2, collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.

Number 3, reviewing medical records of patients whose deaths may be related to days in care.

Number 4, reviewing performance ratings and awards of senior facility staff.

Number 5, reviewing past and newly received complaints to the OIG Hotline on delays in care, as well as those complaints shared with us by members of Congress and by the media.

Number 6, reviewing other prior reports relevant to these allegations, including Administrative Board of Investigations or reports from Veterans Health Administration Office of the Medical Inspector.

Finally, number 7, reviewing massive amounts of e-mail and other documentation pertinent to this review.

To facilitate our work, on May 1, I asked Secretary Shinseki to place the Phoenix Director, Associate Director, and another individual on administrative leave. This was done because of the gravity of the allegations and to ensure cooperation by Phoenix staff, some of whom expressed concern about talking to the OIG team. Secretary Shinseki immediately agreed to my request.

I am confident that we have the resources and talent to complete a thorough review of these allegations at Phoenix. We are using our top audit experts, who have reviewed VA scheduling over the years, to examine all of the scheduling-related records.

Dr. Daigh's board-certified physicians from our Office of Healthcare Inspections will be reviewing medical records, treatment, and harm that may have resulted from delays in care.

OIG criminal investigators, including IT forensic experts, are also assisting the team. We are working with Federal prosecutors from the U.S. Attorney's Office for the District of Arizona and the Public Integrity Section of the Department of Justice here in Washington so that we can determine any conduct that we discover that merits criminal prosecution.

Since the Phoenix story broke in the national media, we have received additional reports of manipulated waiting times at other VHA facilities, either through the OIG Hotline, members of Congress, or the media. In response, we have opened simultaneous reviews at several other VHA facilities. These reviews are being conducted by other OIG staff to enable the team working on the Phoenix review to focus their efforts on completing their project. We expect that these reviews will give us insight into the extent to which these scheduling issues are present at other VHA facilities.

My staff is working diligently to determine the facts of what happened at Phoenix and who is accountable. While much has been done, much more remains ahead. Be assured, however, this review is the OIG's top priority and that maximum resources are dedicated to bring about its timely conclusion.

We intend to brief you and other members of the Congress once we have reached final findings of facts and are ready to publish our report. We project finishing the project and publishing a report in August of this year.

Thanks again for holding this hearing. Dr. Daigh and I will be pleased to answer any questions.

[The prepared statement of Mr. Griffin follows:]

PREPARED STATEMENT OF RICHARD J. GRIFFIN, ACTING INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

Chairman Sanders and Members of the Committee, thank you for the opportunity to testify today to discuss the quality of health care provided to veterans at Department of Veterans Affairs (VA) medical facilities. The VA Office of Inspector General (OIG) has issued many reports that have addressed the care at VA medical centers (VAMC). I am accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections. For the purposes of this statement, I will focus on seven recent reports that I believe are indicative of issues facing VA in providing quality health care.[1]

BACKGROUND

The VA provides medical care to 6.5 million veterans through a system of medical facilities including 151 Medical Centers, 300 Vet Centers, and 820 Community Based Outpatient Clinics (CBOC). The Veterans Health Administration (VHA) Central Office provides leadership and policy guidance to the nationwide system of care. Hospitals, clinics, and related medical facilities are grouped into 21 Veterans Integrated Service Networks (VISN). VISNs and their related hospitals' organization and business practices have evolved at different paces and have been significantly influenced by local preferences since their creation, resulting in 21 different VISN organizations, each charged with the same mission.

COLON CANCER SCREENING

Colon cancer has long been recognized as a silent killer in that the cancer is often able to grow within the intestine to significant size before being discovered. Patients may be screened for this cancer by a variety of tests, some of which focus upon the presence of blood within stool or the physical presence of a mass within the intestine. Examinations that test stool for the presence of blood or other chemicals or visualize the intestine are common diagnostic tests used to discover the presence of this silent killer.

In 2006, the OIG published a review, *Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (February 2, 2006), of aspects of VHA's performance in the delivery of colon cancer screening and management of positive screening tests. This review found that the time between having a positive screening test for colon cancer and the provision of the next test to diagnose a tumor took several months. VA agreed that this delay in action was not acceptable. When colon cancer was diagnosed, surgeons and oncologists responded quickly with treatment, yet the lag between the identification of a specific risk and the determination that there was or was not colon cancer was not timely.

In that report, the Under Secretary for Health concurred with the findings and recommendations we made to more efficiently and more timely address the lag between the positive screening test and the diagnostic test for colon cancer. The Under Secretary for Health indicated in the response to this report that timelines would be established to monitor the timeliness of colon rectal cancer diagnosis after a positive screening test and that a directive would be issued to establish national standards for the management of this process. This was accomplished with the issuance of VHA Directive 2007–004, "Colorectal Cancer Screening," in January 2007.

In September 2013, the OIG reported a disturbing set of events at the William Jennings Bryan Dorn VAMC in Columbia, South Carolina, that led to thousands of delayed gastroenterology (GI) consults for colon cancer screening and the determination that over 50 veterans had a delayed diagnosis of colon cancer, some of whom

[1] *Healthcare Inspection—Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina* (9/6/2013); *Healthcare Inspection—Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013); *Healthcare Inspection—Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida* (3/27/2014); *Healthcare Inspection—Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013); *Healthcare Inspection—Emergency Department Patient Deaths Memphis VAMC, Memphis, Tennessee* (10/23/2013); *Healthcare Inspection—Inappropriate Use of Insulin Pens, VA Western New York Healthcare System, Buffalo, New York* (5/9/2013); *Healthcare Inspection—Review of VHA Follow-Up on Inappropriate Use of Insulin Pens at Medical Facilities* (8/1/2013).

died from colon cancer.[2] After patients are screened positive for possible colon cancer or require a GI procedure, a consult to GI is usually sent by the primary care provider. Network and facility leaders became aware of the GI consult backlog at Columbia in July 2011 involving 2,500 delayed consults, 700 of them deemed "critical" by VA physicians. Additional funds were requested by the facility upon determining the need for a large number of GI procedures, and the VISN awarded the facility $1.02M for Fee-Basis colonoscopies in September 2011.[3] However, facility leaders did not ensure that a structure for tracking and accounting was in place and by December 2011, the backlog stood at 3,800 delayed GI consults. The facility developed an action plan in January 2012 but had difficulty making progress in reducing the backlog. The delayed diagnosis of a patient with cancer in May 2012 prompted facility leaders to re-evaluate the GI situation, and facility, network, and VHA leaders aggressively pursued elimination of the backlog. This was essentially accomplished by late October 2012. However, during the review "look-back" period, 280 patients were diagnosed with GI malignancies, 52 of whom were associated with a delay in diagnosis and treatment. The facility completed at least 19 institutional disclosures providing patients and their family members with specific details of the adverse event or delay of care and their right to file a claim.

A confluence of factors contributed to the GI delays and hampered efforts to improve the condition. Specifically, the facility's Planning Council did not have a supportive structure; Nursing Service did not hire GI nurses timely; the availability of Fee Basis care had been reduced; low-risk patients were being referred for screening colonoscopies, thus increasing demand; staff members did not consistently and correctly use the consult management reporting and tracking systems; critical network and facility leadership positions were filled by a series of managers who often had collateral duties and differing priorities; and Quality Management staff was not included in discussions about the GI backlogs.

In its response to the report, VHA indicated that national VHA leadership considered delays in consult responsiveness to be of significant concern. VHA Central Office leadership took specific steps to address these issues in Columbia as well as system-wide. In January 2013, VHA undertook a national review of open consults to gain a better perspective on nationwide demand for consultative services. In May 2013, VHA launched an initiative to standardize use of the clinical consultation software package in the electronic health record.

The appropriate management of patients who are at risk for colon cancer is standard medical practice. This issue has been discussed by VHA for years, and yet veterans were not timely diagnosed with colon cancer at this academic VA medical center.

MENTAL HEALTH POLICIES AND PROCEDURES

The OIG has issued two reports recently on veterans who died of narcotic drug overdoses while in VA facilities for mental health care.[4] In both cases, the hospital staff failed to ensure that veterans, who by their prior behavior were known to be at risk of abusing narcotic medication, were placed in environments that were secure from those drugs.

At the Miami VA Healthcare System, in Miami, Florida, we found that a patient died in his room in the substance abuse residential rehabilitation treatment program (SARRTP), and autopsy results indicated the patient died from cocaine and heroin toxicity. This veteran had a history of multiple positive urine drug screens while in the SARRTP. We found that the SARRTP security surveillance camera was not working at the time of the patient's death, was still not working at the time of our site visit, and no alternative arrangements were made to monitor patients in the absence of an operational camera. Moreover, we found that evening, night, and weekend SARRTP staff often sat in a backroom where they had an extremely limited view of the unit and no view of the unit's entrance and exits. We also found that staff were not consistent in their methods of contraband searches and did not monitor patient whereabouts or unit visitors as required.

In our report on the Atlanta VA Medical Center in Decatur, Georgia, we received allegations that the VA did not protect a veteran from illicit drugs while an inpa-

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[2] *Healthcare Inspection—Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina* (9/6/2013).

[3] Fee basis care is non-VA/private sector care paid for by VA when the service is not available in a timely manner within VHA due to capability, capacity, or accessibility.

[4] *Healthcare Inspection—Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013); *Healthcare Inspection—Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida* (3/27/2014).

tient on the locked mental health unit and that he died of an overdose. We substantiated that the facility did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. We found inadequate program oversight including a lack of timely follow up actions by leadership in response to patient incidents.

At both Miami and Atlanta, as the reports indicate, standard steps to ensure veterans were kept safe while under VA control were not taken and two veterans died. In each instance, VA managers did not ensure that hospital staff performed their jobs.

The OIG reported on poor management of contracted mental health care at the Atlanta VAMC, where between 4,000–5,000 veterans who were referred for non-VA mental health care at a public non-profit Community Service Board (CSB), were not followed or managed.[5] In a sample of 85 cases, 21 percent of the referred veterans did not receive mental health care and, outside of the sample, several veterans were found to have died with a history of inadequate mental health care support from VA or non-VA sources. Mental Health Service Line managers did not adequately oversee or monitor contracted patient care services to ensure safe and effective treatment. This lack of effective patient care management and program oversight by the facility contributed to problems with access to mental health care and as a VA employee told the OIG "may have contributed to patients falling through the cracks." The facility's contract program lacked an integrated and effective Quality Assurance (QA) program and did not have a CSB QA process. For example, VA facility program managers did not track and trend patient complaints or conduct oversight visits to the CSB sites, as required by VA directives and the contract.

Our review also confirmed that facility managers did not provide adequate staff, training, resources, support, or guidance for effective oversight of the contracted mental health program. Managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety. Furthermore, other administrative issues contributed to the delay because the facility managers did not pay invoices promptly. These delays affected the CSBs' ability to accept new patients and plan their patient census.

The Atlanta VAMC was overwhelmed by the demand for mental health services over a multiyear period. VA leadership's response to this crisis was fragmented, ineffective, and resulted in poor care, and may have contributed to the death of some of the veterans among the 4,000 to 5,000 patients referred for non-VA care.

EMERGENCY DEPARTMENT ISSUES

In October 2013, we issued a report detailing three deaths in the Emergency Department (ED) at the Memphis VAMC in Memphis, Tennessee.[6] We received allegations that three patients died subsequent to care they received in the Memphis VAMC ED. We found the following:

- A patient was administered a medication in spite of a documented drug allergy and had a fatal reaction. Handwritten orders for this patient did not comply with the facility's requirement that all provider orders and patient care be documented in the electronic medical record. Since the orders were not entered into the electronic medical record, systems in place to notify the provider of a drug allergy conflict with ordered medications were bypassed. The patient died of a reaction to a medication allergy that was identified in the electronic medical record.
- Another patient was found unresponsive after being administered multiple sedating medications without being properly observed.
- A third patient had a critically high blood pressure that was not aggressively monitored and experienced bleeding in the brain.

The facility did complete protected peer reviews of the care for all three patients. Two of the deaths were also evaluated through root cause analyses (RCA), which are quality reviews designed to identify and correct systemic factors and conditions that may pose a threat to patient safety. However, we found that the implementation of the RCA action plan was delayed and incomplete. Additionally, the RCA documentation we reviewed contained several errors of fact, such as how long Patient 1 was monitored in the emergency room before discharge and the number of intravenous medications given to Patient 2.

Decisions were made which permitted the electronic medical record and its safeguards to be bypassed and to have patients on multiple sedating medications to be

[5] *Healthcare Inspection—Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013).

[6] *Healthcare Inspection—Emergency Department Patient Deaths Memphis VAMC, Memphis, Tennessee* (10/23/2013).

located in places difficult to monitor. Furthermore, when issues were identified through the RCA process, actions to prevent a recurrence were not taken seriously.

INTRODUCTION OF NEW TECHNOLOGY

Several VAMCs including the medical centers in Buffalo, New York, and Salisbury, North Carolina, failed to introduce new technology properly into the hospital environment.[7] This resulted in 700 patients at Buffalo and 260 patients at Salisbury being exposed to the risk of blood borne viral infections when insulin pens, designed to be used with one pen per patient, were instead used improperly such that one pen was used on multiple patients.

In late October 2012, the Buffalo Chief of Pharmacy discovered three insulin pens, which were designed for single-patient use only, with no patient labels in a supply drawer of a medication cart. Facility officials subsequently found three more pens without patient labels in medication carts on three other inpatient units, and, when queried, several nurses reportedly acknowledged using the pens on multiple patients. Inappropriately using single-patient use insulin pens on multiple patients may potentially expose patients to blood borne pathogens.

We identified six factors that contributed to the misuse of insulin pens at Buffalo. We also found that misuse of the insulin pens went undetected for 2 years because even though facility staff often observed pens with no patient labels on the medication carts, they did not report it because they either did not fully comprehend the clinical risks of sharing pens, or they accepted the unlabeled pens as standard practice believing they were both multi-dose and multi-patient devices. We found that VHA did not notify Members of Congress or at-risk patients until January 2013 because of the time required for multiple levels of coordination between VA and VHA and inefficiencies in VHA's internal review process for large-scale adverse event disclosures.

In addition to the Buffalo incident, nurses at two other facilities were found to have inappropriately used insulin pens on multiple patients. In January 2013, the Salisbury VAMC reported that two nurses had inappropriately used insulin pens on multiple patients. VHA instituted a large-scale adverse event disclosure to notify 266 at-risk patients. At another facility, a nurse acknowledged using a pen on two patients on one occasion. We identified two contributing factors to explain why some nurses misused the insulin pens:

- Facilities did not fully evaluate the risks of using insulin pens on inpatient units, specifically in regards to the impact on nursing procedures.
- Facilities did not provide comprehensive nurse education on the pens.

We found that VHA has processes in place to identify important patient safety alerts, including product recalls, and disseminate this information to facility managers. VHA's National Center for Patient Safety and Pharmacy Benefits Management Service lead VHA's efforts to collect patient safety information and share this information with facilities. At the facility level, patient safety managers are responsible for disseminating alerts to appropriate administrative and clinical staff and tracking the facility's response through a national database. VHA has followed up and tested for evidence of infection in the patients identified in this report.

The use of these insulin pens in this fashion violates the core principles of infection control. Multiple personnel in several hospitals over an extended period of time failed to comprehend the impact of the decision to introduce pens of this nature onto inpatient wards. The decision to introduce new technology into hospital use is one that occurs routinely and to be done safely requires facility leaders to coordinate their actions and understand the implications of their decisions. Facilities with a singular focus on delivering high quality medical care should have recognized the risk these devices bring to the inpatient environment and taken appropriate actions to mitigate that risk.

LACK OF ACCURATE QUALITY MANAGEMENT DATA AND STAFFING STANDARDS

The OIG and Government Accountability Office have been reporting for nearly a decade that VHA managers needed to improve efforts for collecting, trending, and analyzing quality management data. We have reported that inaccuracies in some of VHA's data sources hinder the usability of VHA decisionmakers to fully assess their current capacity, optimal resource distribution, productivity across the system, or to establish staffing and productivity standards. Since July 2005, we have reported on

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[7] *Healthcare Inspection—Inappropriate Use of Insulin Pens, VA Western New York Healthcare System, Buffalo, New York* (5/9/2013); *Healthcare Inspection—Review of VHA Follow-Up on Inappropriate Use of Insulin Pens at Medical Facilities* (8/1/2013).

inaccurate wait times and lists, and expect to report on the results of multiple reviews that are underway to the Committee later this summer.[8] As recently as December 2012, we identified the continuing need for VHA to improve their staffing methodology by implementing productivity standards for specialty care services.[9] We determined VHA had not established productivity standards for 31 or 33 specialty care services reviewed, and had not developed staffing plans that addressed facilities' mission, structure, workforce, recruitment, and retention issues to meet current or projected patient outcomes, clinical effectiveness, and efficiency. VA agreed to put staffing standards for specialty care in place by FY 2015.

OBSERVATIONS

OIG work routinely reports on clinical outcomes or performance that did not meet expectations. We routinely determine that there were opportunities by people and systems to prevent untoward outcomes. In addition to local issues at the facility, there are several organizational issues that impede the efficient and effective operation of VHA and place patients at risk of unexpected outcomes.

Although health care delivery may be the first priority of many within the system, others are focused on research, training the next generation of health care providers, disaster preparedness, homelessness, support for compensation evaluation requirements, and other related missions. This lack of focus on health care delivery as priority one can be seen by the process commonly used at hospitals to fill vacant positions. A resource board reviews open positions and then determines which should be filled. Thus the position recently occupied by a nurse in the GI clinic, who is essential to the delivery of required care, may not be filled while a position that is important to the research or teaching community is filled. The decision by this board, to not fill a clinic position, may have far reaching consequences. The clinic that does not have the nurse may not function properly. The leadership of the clinic is left believing that hospital "leadership" does not understand or does not care about the care provided in that clinic. All a provider can do is ask for clinical positions to be filled, and if they are not filled, either leave VA or agree to work in an environment that provides less than satisfactory care. There is no national process to establish a set of positions that are deemed "essential" to the delivery of health care and thus are priority one for the hospital administration to resource.[10] The establishment of "essential positions" in the context of a standard hospital structure would enhance the delivery of quality patient care.

VA hospitals and clinics do not have a standard organizational chart. Some hospitals have a chief of surgery and a chief of anesthesia; others have a chief of the surgical care line. The lack of a common organizational chart for medical facilities results in confusion in assigning local responsibility for actions required by national directives. Variation in staff organization also creates difficulty in comparing the performance of clinical groups between hospitals and clinics.

Leadership, teamwork, communication, and technical competence are among the most important factors in providing quality health care. However, organization, assignment of clear responsibility, and efficiency of operation all make important contributions to the process of improving the quality of health care delivered.

CONCLUSION

The unexpected deaths that the OIG continues to report on at VA facilities could be avoided if VA would focus first on its core mission to deliver quality health care. Its efforts would also be aided by discussion of the best organizational structure to consistently provide quality care. The network system of organization and the accompanying motto, 'all health care is local,' served the VA well over the last several decades but does not standardize the organization of medical centers. It is difficult to implement national directives when there are no standard position descriptions or areas of responsibility across the system. VA has embraced the "aircraft checklist" approach to improve the chances that preventable medical errors will not occur in the operating room, but has taken the opposite approach to the assignment of duties and responsibilities in medical centers, where no two hospitals are alike. We believe it is time to review the organizational structure and business rules of VHA

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[8] *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures* (7/8/2005); *Audit of the Veterans Health Administration's Outpatient Waiting Times* (9/10/2007); *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3* (5/19/2008); *Review of Veterans' Access to Mental Health Care* (4/23/2012).

[9] *Audit of VHA's Physician Staffing Levels for Specialty Care Services* (12/27/2012).

[10] *Healthcare Inspection—Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California* (7/24/2007).

to determine if there are changes that would make the delivery of care the priority mission.

Mr. Chairman, that concludes my statement and we would be pleased to answer any questions that you or other Members of the Committee may have.

Chairman SANDERS. Thank you very much, Mr. Griffin.

Admiral Marsh.

STATEMENT OF REAR ADMIRAL W. CLYDE MARSH, USN (RETIRED), PRESIDENT, NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Admiral MARSH. Chairman Sanders, Ranking Member Burr, and distinguished Members of the Committee, my name is Clyde Marsh and I am the President of the National Association of State Directors of Veterans Affairs. I am honored to present the views of the State Directors from all 50 States, the District of Columbia, and five Territories.

As State governmental agencies, we are charged with the duties to include assisting the processing of claims for disability compensation and pension, burial services in our State veterans' cemeteries, survivor benefits, coordinate access to health care, and provide over half of all VA-authorized long-term care in our State nursing homes.

From the NASDVA perspective, the state of VA health care is strong. The VA has medical centers located in the majority of major cities in America. The VA has expanded their community-based outpatient clinics in recent years to many of the smaller cities and rural areas in our States. The VHA has moved out of the box, taken advantage of technology to provide telehealth, telemedicine, and rural consults in rural areas. They have also taken steps to provide transportation for those veterans in extremely rural areas to make their CBOC appointments.

VA customer satisfaction has been trending higher in accordance with the American Consumer Satisfaction Index. The VA may not get everything perfectly every time. However, on a national level, VA has and still is one of the leading health care providers in the country in providing good, quality health care.

Those of us in the health delivery business for VA, we constantly strive to get it right and we work on that every single day. In our experience, VBA, VHA, and NCA are on the same page.

NASDVA does not endorse, nor do we agree with calling for Secretary Shinseki's resignation, along with his top VA administration officials. These leaders are crucial, not only to continuing to transform our Nation's second-largest Federal agency, but they will be needed to lead following actions to swiftly address or correct any health care or procedural issues that may be identified. It is premature to point fingers or rush to judgment, and it certainly is not in the best interests of our Nation's 22 million veterans to make premature decisions based on allegations before the IG investigations are concluded and the facts are determined.

Under Secretary Shinseki's leadership, the U.S. Department of Veterans Affairs is transforming a pre-World War II antiquated claims process into a paperless claims system that has reduced compensation and pension claims backlog by 44 percent, has reduced veterans' homelessness by 24 percent, and has enrolled more

than two million veterans in the health care system since 2009, receiving some of the highest quality care ratings in decades.

NASDVA is committed to supporting VHA in caring for over eight million veterans enrolled in the health care system. At the local level, State Directors are in constant coordination with medical center directors concerning the delivery of health care.

To assist VA, NASDVA asks that the Senate gives full attention to confirming those individuals that have been nominated to fill VA key vacant leadership positions that VA could then become fully manned.

NASDVA strongly emphasizes, again, that it is imperative that VA, and specifically VHA, receive the necessary support that is required to adequately care not only for the eight million veterans enrolled today, but the anticipated one million more veterans over the next several years that will require medical assistance, and those folks will be coming as a result of the war and military drawdown. The bottom line is that VA may require more in terms of the budgets. They may need more doctors, nurses, technicians, clinicians, and possibly even facility expansions or operations.

As the IG inspection results are made available and VA implements corrective measures of improved procedures in the VA health care system, NASDVA looks forward to participating as copartners or facilitators.

In conclusion, NASDVA can help veterans become more informed about their benefits as well as how to be enrolled and receive the care that they have earned and need.

Mr. Chairman and distinguished Members of the Committee, the State Directors of Veterans Affairs remain dedicated and committed to doing our part. We have the utmost confidence in Secretary Shinseki and firmly believe that he and his VA leaders will transform VA into a technology-based, more service-oriented and veteran-friendly 21st century agency. Thank you for including NASDVA in this very important hearing.

[The prepared statement of Admiral Marsh follows:]

PREPARED STATEMENT OF REAR ADMIRAL W. CLYDE MARSH, USN (RET.), PRESIDENT, NATIONAL ASSOCIATION STATE DIRECTORS OF VETERANS AFFAIRS AND COMMISSIONER, ALABAMA DEPARTMENT OF VETERANS AFFAIRS

INTRODUCTION

Chairman Sanders and distinguished members of the Senate Veterans' Affairs Committee, my name is Clyde Marsh, President of the National Association of State Directors of Veterans Affairs (NASDVA) and Director of the Alabama Department of Veterans Affairs. I am honored to present the collective views of the State Directors of Veterans Affairs for all 50 states, the District of Columbia, and five U.S. Territories.

As state governmental agencies, our Governors, State Boards and/or Commissions task their respective State Departments of Veterans Affairs (SDVA) with the responsibility of addressing the needs of our veterans and their families particularly in our role as advocates. We are charged with a plethora of duties that include processing veterans' claims for disability compensation and pensions, burial services in state veterans cemeteries, survivor benefits, coordinate access to "healthcare," and provide over half of all VA authorized long term care in state veterans nursing homes.

THE STATE OF VA HEALTHCARE

From a NASDVA prospective, the state of VA Healthcare in our nation is strong. The VA has Medical Centers located in the majority of major cities in America. They have expanded their Community-Based Outpatient Clinics (CBOCs) over the past

several years to many of the smaller cities and rural areas in our states. VHA has moved "out of the box" taking advantage of technology to provide Tele-health and Tele-medicine consults in rural areas. They have also taken steps to provide transportation for those veterans in extremely rural areas in order to make CBOC appointments.

VA customer satisfaction has been trending higher. VA does not do everything perfectly nor do they have everything they need. However, on a national level, VA has and still is one of the leading health care providers in the country in providing top quality health care. Those of us involved in the delivery of VA benefits and services strive to get it right and constantly work toward making conditions better. In our experience, VHA, VBA and NCA are on the same page. Overall, VA provides good quality care and services to our Nation's veterans and their families.

NASDVA, does not endorse, nor do we agree with those calling for Secretary Shinseki's resignation along with his top VA officials, Under Secretary for Health Honorable Robert Petzel and Under Secretary for Benefits Honorable Allison Hickey. These leaders are crucial not only for the continuing transformation of the Nation's second largest Federal agency. They will need to lead the follow-on actions to swiftly address or correct any health care or process issues that may be identified. It is premature to point fingers, rush to judgment and is certainly not in the best interest of the majority of veterans before the IG investigations are concluded.

Under Secretary Shinseki's leadership, the U.S. Department of Veterans Affairs in transforming from a pre-WWII antiquated VA claims process into a paperless claims system that has reduced the compensation and pension claims backlog by 44 percent; has reduced veterans homelessness by 24 percent; and has enrolled more than 2 million veterans in the health care system since 2009 receiving some of the highest quality of care ratings in decades.

ITEMS CRITICAL TO SUCCESS OF VA HEALTHCARE

NASDVA and its individual states appreciate and are committed to supporting the VHA in caring for the over 8 million veterans enrolled in the healthcare system. The States are also actively engaged in referring veterans to the VAMCs and CBOCs and we daily assist veterans in completing applications for medical care. At the local level, State Directors are in constant coordination with the VISN and VAMC Directors concerning the delivery of healthcare. Issues that arrive are handled personally with the leaders. We also conduct outreach events such as health-fares and "stand downs" to inform veterans about VA medical benefits and help them in obtaining them. To assist VA, we ask that the Senate give attention to confirming those individuals that have been nominated to fill key leadership positions.

I would like to emphasize again that it is imperative that VA, and specifically VHA, receive the necessary support that is required to adequately care not only for the veterans enrolled today but also the anticipated million more veterans in the next year or two that will also require medical assistance. The bottom line is VA may require an increase in budget for more doctors, nurses, therapist, technicians and possibly facility expansion.

Some outsourcing may be possible and or encouraged; however, we should not bank on sending veterans to outside doctors and facilities as the magic answer or cure. If overdone, we will be sending veterans out of a compassionate veteran centric environment and placing them in the "for profit" corporate medical system. Any outside provider would come with its own set of problems with not guarantees of significant appointment time reduction or better quality of care.

As the IG inspection results are made available and VA recommends or implements corrective measures of improved procedures in the VA Health Care system, NASDVA looks forward to participating as co-partners or facilitators. We can help veterans become more informed about their benefits as well as how to be enrolled and receive the care they have earned and need.

CONCLUSION

Mr. Chairman and distinguished Members of the VA Committee the State Directors of Veterans Affairs remain dedicated to doing our part. Thank you for including NASDVA in this very important hearing.

Chairman SANDERS. Admiral, thank you very much.

We now have from the Government Accountability Office their Director of Health Care, Debra Draper. Thank you.

STATEMENT OF DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DRAPER. Chairman Sanders, Ranking Member Burr, and Members of the Committee, I appreciate the opportunity today to discuss access to care problems in VA that may delay needed medical care for our Nation's veterans.

For over a decade, GAO and others, including VA's Inspector General, have reported that VA medical centers do not always provide timely care. In some cases, these delays have resulted in harm to veterans.

Across our work on access to VA health care, several common themes have emerged: weak and ambiguous policies and processes, which are often subject to interpretation, resulting in significant variation and confusion at the local level; antiquated software system that do not facilitate good practices; inadequate training; unclear staffing needs and staffing allocation priorities; and inadequate oversight that relies largely on facility self-certification and use of unreliable data for monitoring.

In 2012, we reported that VA's wait times were unreliable because scheduling staff did not always correctly record the required appointment desired date, the date on which the veteran or provider wants the veteran to be seen. This is due, in part, to lack of clarity in the scheduling policy on how to determine and record the desired date, a situation made worse by the large number of staff who can schedule appointments, more than 50,000 people at the time of our review.

During our site visits to four medical centers, we found that more than half of the schedulers we observed did not record the desired date correctly, which may have resulted in reported wait times shorter than what veterans actually experience. Some staff also told us they changed appointment desired dates so that the wait times aligned with VA's related performance goals.

We also identified other problems in how the scheduling policy was implemented. For example, we found follow-up appointments being scheduled without ever talking to the veteran, who would then receive notification of their appointment through the mail. In addition, we found that the scheduling system's electronic wait list was not always used to track new patients, putting these patients at risk for delayed care or not receiving care at all. We also found that the completion of required training was not always done, although officials stressed its importance.

Additionally, we found a number of other factors that negatively impacted the scheduling process. For example, officials described the VISTA software system used for scheduling as antiquated, cumbersome, and error-prone. We also found shortages and turnover of scheduling staff, provider staffing shortages, and high telephone call volumes without sufficient staff dedicated to answering these calls.

We recommended VA take actions to improve the reliability of its medical appointment wait time measures, ensure the consistent implementation of its scheduling policy, allocate scheduling resources based on needs, and improve telephone access for medical appointments. VA concurred with our recommendations and told us they are taking steps to address them. We are pleased that actions

are being taken, but substantially more progress is needed to ensure timely access to care.

We are currently conducting work examining VA's management of specialty care consults, which is a type of medical appointment. Our preliminary work has identified a number of problems, including delays in care or care not being provided at all at each of the five medical centers included in our review, unreliable specialty care consult data, and systemwide closure of 1.5 million consults older than 90 days with no documentation as to why they were closed. We expect to publish our findings related to this work this summer.

As the demand for VA health care continues to escalate, it is imperative that VA address its access to care problems. Since 2005, the number of patients served by VA has increased nearly 20 percent, and the number of annual outpatient medical appointments has increased by approximately 45 percent. In light of this, the failure of VA to address its access to care problems, including the accurate tracking and reporting of wait times at specialty care consults, will considerably worsen an already untenable situation.

Mr. Chairman, this concludes my opening remarks. I am happy to answer any questions.

[The prepared statement of Ms. Draper follows:]

PREPARED STATEMENT OF DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

VA Lacks Accurate Information about Outpatient Medical Appointment Wait Times, Including Specialty Care Consults

Statement of Debra A. Draper
Director, Health Care

GAO-14-620T

May 15, 2014

VA HEALTH CARE

VA Lacks Accurate Information about Outpatient Medical Appointment Wait Times, Including Specialty Care Consults

GAO Highlights

Highlights of GAO-14-620T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, these delays have resulted in harm to patients.

In December 2012, GAO reported that improvements were needed in the reliability of VHA's reported medical appointment wait times, as well as oversight of the appointment scheduling process. Also in 2012, VHA found that systemwide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. In May 2013, VHA launched the Consult Management Business Rules Initiative with the aim of standardizing aspects of the consults process.

This statement highlights (1) preliminary observations GAO made in an April 9, 2014, testimony statement regarding VHA's management of outpatient specialty care consults, and (2) concerns GAO raised in its December 2012 report regarding VHA's outpatient medical appointment scheduling, and progress made implementing GAO's recommendations. To conduct this work, GAO reviewed documents and interviewed officials from VHA's central office. Additionally, GAO interviewed officials from five VAMCs for the consults work and four VAMCs for the scheduling work that varied based on size, complexity, and location.

View GAO-14-620T. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

As GAO previously reported in its testimony on April 9, 2014, its preliminary work examining the Department of Veterans Affairs' (VA), Veterans Health Administration's (VHA) management of outpatient specialty care consults identified examples of delays in veterans receiving outpatient specialty care, as well as limitations in the implementation of new consult business rules designed to standardize aspects of the clinical consult process. For example, for 4 of the 10 physical therapy consults GAO reviewed for one VA medical center (VAMC), between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's guideline of completing consults within 90 days of being requested. GAO's preliminary work also identified variation in how the five VAMCs reviewed have implemented key aspects of VHA's business rules, such as strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days. Such variation may limit the usefulness of VHA's data in monitoring and overseeing consults systemwide. Furthermore, oversight of the implementation of the business rules has been limited and has not included independent verification of VAMC actions. Because of the preliminary nature of this work, GAO is not making recommendations on VHA's consult process at this time.

In its December 2012 report, GAO found that VHA's outpatient medical appointment wait times were unreliable. The reliability of reported wait time performance measures was dependent in part on the consistency with which schedulers recorded desired date—defined as the date on which the patient or health care provider wants the patient to be seen—in the scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. GAO also found that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely medical appointments. For example, GAO identified clinics that did not use the electronic wait list to track new patients in need of medical appointments as required by VHA policy, putting these patients at risk for not receiving timely care. VA concurred with the four recommendations included in the report and, in April 2014, reported continued actions to address them. For example, in response to GAO's recommendation for VA to take actions to improve the reliability of its medical appointment wait time measures, officials stated the department has implemented new patient wait time measures that no longer rely on desired date recorded by a scheduler. VHA officials stated that the department also is continuing to address GAO's three additional recommendations. Although VA has initiated actions to address GAO's recommendations, continued work is needed to ensure these actions are fully implemented in a timely fashion. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

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

I am pleased to be here today as you examine issues related to challenges the Department of Veterans Affairs (VA) faces in providing health care to our nation's veterans. In recent years, VA's Veterans Health Administration (VHA) has faced a growing demand for providing outpatient medical appointments. From fiscal years 2005 through 2012, the number of annual outpatient medical appointments VHA provided increased by approximately 45 percent, from 58 million to 84 million.[1] VHA provided this care through its primary and specialty care clinics, which are managed by VA medical centers (VAMC).[2] Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, problems with VHA's scheduling and management of outpatient medical appointments may contribute to delays in care, or care not being provided at all. Over the past few years there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, the delays have resulted in harm to patients.[3] Nonetheless, VHA has reported continued improvements in achieving timely patient access to medical appointments. For example, in fiscal year 2011, VA reported that VHA completed 89 percent of medical appointments for new patients within its goal; in fiscal year 2012, VA reported that VHA completed 90 percent of primary and specialty care new patient appointments within the goal.[4] However, in December 2012, we reported that VHA's medical

[1]In addition, the number of patients VHA served increased from fiscal years 2005 to 2012 by approximately 19 percent, from 5.3 million to 6.3 million patients.

[2]Outpatient clinics offer services to patients that do not require a hospital stay. Primary care addresses patients' routine health needs, and specialty care is focused on a specific specialty service such as cardiology or gastroenterology.

[3]See, for example, Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina*, Report No. 12-04631-313. (Washington, D.C.: September 6, 2013), and Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Consultation Mismanagement and Care Delays Spokane VA Medical Center Spokane, Washington*, Report No. 12-01731-284. (Washington, D.C.: September 25, 2012).

[4]In fiscal year 2012, VHA's appointment wait time goal for primary and specialty care appointments was 14 days from the patient's or provider's desired appointment date. According to VHA's scheduling policy, the desired appointment date, referred to as the "desired date," is the date on which the patient or provider wants the patient to be seen.

appointment wait times were unreliable and VHA's inadequate oversight of the outpatient medical appointment scheduling processes contributed to VHA's problems with scheduling timely medical appointments.[5]

When a physician or other provider determines that a veteran needs outpatient specialty care, the provider refers the veteran to a specialist for a clinical consult—a request for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure such as a colonoscopy. VAMCs request and manage outpatient consults through an electronic system that retains information about each consult request and is part of VHA's Veterans Health Information Systems and Technology Architecture (VistA).[6] Ideally, the consult system would contain timely and reliable information on the status and outcomes of consults, and would provide VHA information it needs to help effectively manage the process. In 2012, however, VHA found that systemwide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. As a result, in May 2013, VHA launched an initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs.

Appointments resulting from outpatient consults, like other outpatient medical appointments, are subject to VHA's scheduling policy.[7] This policy is designed to help VAMCs meet their commitment to scheduling medical appointments with no undue waits or delays for patients. It establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. Additionally, it includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement. For example, the policy requires

[5]GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012).

[6]VistA is the single integrated health information system used throughout VHA in all of its health care settings. It contains patients' electronic health records.

[7]VHA medical appointment scheduling policy is documented in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010). We refer to the directive as "VHA's scheduling policy" from this point forward.

schedulers to record appointments in VHA's VistA medical appointment scheduling system.

My statement today will draw from information we provided in a testimony given on April 9, 2014, regarding VHA's management of outpatient specialty care consult processes at five selected VAMCs, and our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times data and scheduling oversight.[8] In particular, this statement highlights (1) preliminary observations included in our April 9, 2014, testimony statement, and (2) key findings and recommendations from our December 2012 report, as well as the progress VHA has made in implementing those recommendations.

For our April 9, 2014, testimony statement addressing VHA's management of outpatient specialty care consults,[9] we reviewed documents and interviewed VHA central office officials about VHA's policies and guidance for VAMCs to send, receive, and complete consults, and VHA's procedures for VAMCs to schedule outpatient medical appointments, which include those for specialty care. We also reviewed documents and interviewed VHA central office officials about their efforts to oversee VAMCs' implementation of VHA's consult policies, including VHA's Consult Management Business Rules Initiative, launched in May 2013. Additionally, we interviewed officials from five VAMCs selected for variation in volume of outpatient consults, complexity,[10] and location. These five VAMCs were located in Augusta, Maine; Denver, Colorado; Gainesville, Florida; Oklahoma City, Oklahoma; and Palo Alto, California. For each VAMC included in our review, we interviewed leadership about how VHA's consult policies and any local policies or procedures for managing consults are implemented at their facility. We also interviewed specialty care service chiefs, administrative staff, and

[8]See GAO, *VA Health Care: Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans*, GAO-14-509T (Washington, D.C.: Apr. 9, 2014) and GAO-13-130.

[9]The scope of our work is limited to outpatient consults; however, providers may also request consults for inpatient care and administrative needs, among other things.

[10]VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

providers of three high-volume specialty services—cardiology, gastroenterology, and physical therapy. Additionally, for each of the five medical centers, we reviewed the history of actions taken on a random sample of 30 outpatient consults (10 from each of the three specialties included in our review) that were requested during the period April 1, 2013, through September 30, 2013, that either took more than 90 days to complete or had been in process for more than 90 days. The results of our review of outpatient consults are not generalizable across all VAMCs.

For our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times and scheduling oversight,[11] we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times and interviewed VHA central office officials responsible for developing them.[12] We also visited 23 high-volume outpatient clinics at four VAMCs selected for variation in size, complexity, and location; these four VAMCs were located in Dayton, Ohio; Fort Harrison, Montana; Los Angeles, California; and Washington, D.C. At each VAMC we interviewed leadership and other officials about how they manage and improve medical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with scheduling policy, and problems staff experience in scheduling timely medical appointments. We examined each VAMC's and clinic's implementation of elements of VHA's scheduling policy and obtained documentation of scheduler training completion. In addition, we interviewed schedulers from 19 of the 23 clinics visited, and also reviewed patient complaints about telephone responsiveness, which is integral to timely medical appointment scheduling. We interviewed the directors and relevant staff of the four regional Veterans Integrated Service Networks (VISN) for the VAMCs we visited.[13] We also interviewed VHA central office officials and officials at the VAMCs we visited about selected initiatives to improve veterans' access to timely medical appointments. Additionally, in April 2014, we reviewed documentation and interviewed officials from VHA's central office about the extent to which they have addressed the recommendations we made in the 2012 report.

[11]GAO-13-130.

[12]We did not include mental health appointments in the scope of our work, because this issue was already being reviewed by VA's Office of Inspector General.

[13]VHA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area.

Our work for this statement, and the products on which it was based, was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

When providers at VAMCs determine that a veteran needs outpatient specialty care, they request and manage consults using VHA's clinical consult process. Clinical consults include requests by physicians or other providers for both clinical consultations and procedures. A clinical consultation is a request seeking an opinion, advice, or expertise regarding evaluation or management of a patient's specific clinical concern, whereas a procedure is a request for a specialty procedure such as a colonoscopy. Clinical consults are typically requested by a veteran's primary care provider using VHA's electronic consult system. Once a provider sends a request, VHA requires specialty care providers to review it within 7 days and determine whether to accept the consult. If the specialty care provider accepts the consult—determines the consult is needed and is appropriate—an appointment is made for the patient to receive the consultation or procedure.[14] In some cases, a provider may discontinue a consult for several reasons, including that the care is not needed, the patient refuses care, or the patient is deceased.[15] In other cases the specialty care provider may determine that additional information is needed, and will send the consult back to the requesting provider, who can resubmit the consult with the needed information. Once the appointment is held, VHA's policy requires the specialty care provider to appropriately document the results of the consult, which would then close out the consult as completed in the electronic system.[16] VHA's current guideline is that consults should be completed within 90 days of

[14]Some consults, referred to as "e-consults," do not require an in-person appointment with the patient and may be addressed electronically through the consult system.

[15]When a provider discontinues a consult, action on the consult is stopped, and a new consult request must be initiated by the requesting provider for the veteran to obtain the specialty care—whether that care is for a clinical consultation or procedure.

[16]The results of consults are documented in the consult system and are contained in the patient's electronic health record.

the request.[17] If an appointment is not held, staff are to document why they were unable to complete the consult.

In 2012, VHA created a database to capture all consults systemwide and, after reviewing these data, determined that the data were inadequate for monitoring consults. One issue identified was the lack of standard processes and uses of the electronic consult system across VHA. For example, in addition to requesting consults for clinical concerns, the system was also being used to request and manage a variety of administrative tasks, such as requesting patient travel to appointments. Additionally, VHA could not accurately determine whether patients actually received the care they needed or if they received the care in a timely fashion. According to VHA officials, approximately 2 million consults (both clinical and administrative consults) were unresolved for more than 90 days. Subsequently, VA's Under Secretary for Health convened a task force to address these and other issues regarding VHA's consult system, among other things. In response to task force recommendations, in May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs. This initiative requires VAMCs to complete four specific tasks between July 1, 2013, and May 1, 2014:

- Review and properly assign codes to consistently record consult requests in the consult system;[18]
- Assign distinct identifiers in the electronic consult system to differentiate between clinical and administrative consults;

[17]VHA officials noted that although VHA's guideline is for consults to be completed within 90 days, consults for urgent needs are completed sooner.

[18]These codes identify the type of care requested in the consult (e.g., dermatology or cardiology) and are used by VHA to run reports that assist with managing its services.

- Develop and implement strategies for requesting and managing requests for consults that are not needed within 90 days—known as "future care" consults;[19] and
- Conduct a clinical review as warranted, and as appropriate, close all unresolved consults—those open more than 90 days.

At the time of our December 2012 review, VHA measured outpatient medical appointment wait times as the number of days elapsed from the patient's or provider's desired date, as recorded in the VistA scheduling system by VAMCs' schedulers. In fiscal year 2012, VHA had a goal of completing new and established patient specialty care appointments within 14 days of the desired date. VHA established this goal based on its performance reported in previous years.[20] To facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance measures—in its VISN directors' and VAMC directors' performance contracts, and VA includes measures in its budget submissions and performance reports to Congress and stakeholders.[21] The performance measures, like wait time goals, have changed over time.

Officials at VHA's central office, VISNs, and VAMCs all have oversight responsibilities for the implementation of VHA's scheduling policy. For example, each VAMC director, or designee, is responsible for ensuring

[19]According to VHA guidance, the consult system should only be used for services needed within 90 days. VAMCs were given the option to track future care consults either by developing markers so they could be identified in the consult system, or using existing mechanisms outside of the consult system such as electronic wait lists. The electronic wait list is a type of computer software application designed for recording, tracking, and reporting veterans waiting for medical appointments.

[20]In 1995, VHA established a goal of scheduling primary and specialty care medical appointments within 30 days to ensure veterans' timely access to care. VA's reported wait times for fiscal year 2010 showed that nearly all primary and specialty care medical appointments were scheduled within 30 days of the desired date. In fiscal year 2011, VHA shortened the wait time goal to 14 days for both primary and specialty care medical appointments.

[21]VA prepares a congressional budget justification that provides details supporting the policy and funding decisions in the President's budget request submitted to Congress prior to the beginning of each fiscal year. The budget justification articulates what VA plans to achieve with the resources requested; it includes performance measures by program area. VA also publishes an annual performance report—the performance and accountability report—which contains performance targets and results achieved compared with those targets in the previous year.

that clinics' scheduling of medical appointments complies with VHA's scheduling policy and for ensuring that any staff who can schedule medical appointments in the VistA scheduling system have completed the required VHA scheduler training.[22] In addition to the scheduling policy, VHA has a separate directive that establishes policy on the provision of telephone service related to clinical care, including facilitating telephone access for medical appointment management.

GAO's Preliminary Work Identified Examples of Delays in Specialty Care, and Limitations in VHA's Implementation of Its Business Rules Impede Its Ability to Assess Delays

As we reported in our April 9, 2014, testimony statement, our preliminary work identified examples of delays in veterans receiving requested outpatient specialty care at the five VAMCs we reviewed.[23] VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments, among the factors that hinder their ability to meet VHA's guideline for completing consults within 90 days. Specifically, several VAMC officials discussed a growing demand for both gastroenterology procedures, such as colonoscopies, as well as consultations for physical therapy evaluations. Additionally, officials noted that due to difficulty in hiring and retaining specialists for these two clinical areas, they have developed periodic backlogs in providing services. Officials at these facilities indicated that they try to mitigate backlogs by referring veterans for care with non-VA providers. However, this strategy does not always prevent delays in veterans receiving timely care. For example, officials from two VAMCs told us that non-VA providers are not always available. Examples of consults that were not completed in 90 days include:

- For 3 of 10 gastroenterology consults we reviewed for one VAMC, we found that between 140 and 210 days elapsed from the dates the consults were requested to when the patient received care. For the consult that took 210 days, an appointment was not available and the patient was placed on a waiting list before having a screening colonoscopy.

[22]Specifically, VAMCs are required to maintain a list of all staff who can schedule medical appointments in the VistA scheduling system and VAMC directors are required to ensure successful completion of required training by all staff on the list. Schedulers are not to be allowed to schedule medical appointments in the VistA scheduling system without proof of their successful completion of this training.

[23]GAO-14-509T.

- For 4 of the 10 physical therapy consults we reviewed for one VAMC, we found that between 108 and 152 days elapsed, with no apparent actions taken to schedule an appointment for the veteran. The patients' files indicated that due to resource constraints, the clinic was not accepting consults for non-service-connected physical therapy evaluations.[24] In 1 of these cases, several months passed before the veteran was referred to non-VA care, and he was seen 252 days after the initial consult request. In the other 3 cases, the physical therapy clinic sent the consults back to the requesting provider, and the veterans did not receive care for that consult.
- For all 10 of the cardiology consults we reviewed for one VAMC, we found that staff initially scheduled patients for appointments between 33 and 90 days after the request, but medical files indicated that patients either cancelled or did not show for their initial appointments. In several instances patients cancelled multiple times. In 4 of the cases VAMC staff closed the consults without the patients being seen; in the other 6 cases VAMC staff rescheduled the appointments for times that exceeded the 90-day timeframe.[25]

As we also reported, our preliminary work identified variation in how the five VAMCs we reviewed have implemented key aspects of VHA's business rules, which limits the usefulness of the data in monitoring and overseeing consults systemwide. As previously noted, VHA's business rules were designed to standardize aspects of the consult process, thus creating consistency in VAMCs' management of consults. However, VAMCs have reported variation in how they are implementing certain tasks required by the business rules. For example, VAMCs have developed different strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days.

- At one VAMC, officials reported that specialty care providers have been instructed to discontinue consults for appointments that are not needed within 90 days and requesting providers are to track these

[24]A non-service-connected disability is an injury or illness that was not incurred or aggravated during active military service.

[25]According to VHA consult policy, when a patient fails to keep a scheduled appointment, the specialty care provider must reassess the need for service and either reschedule the appointment or cancel the consult request, as appropriate. VHA Directive 2008-056, *VHA Consult Policy* (Sept. 16, 2008).

consults outside of the electronic consult system and resubmit them closer to the date the appointment is needed. These consults would not appear in VHA's systemwide data once they have been discontinued.

- At another VAMC, officials stated that appointments for specialty care consults are scheduled regardless of whether the appointments are needed beyond 90 days. These future care consults would appear in VHA consult data and would eventually appear on a timeliness report as consults open greater than 90 days. Officials from this VAMC stated that they continually have to explain to VISN officials who monitor the VAMC's consult timeliness that these open consults do not necessarily mean that care has been delayed.
- Officials from another VAMC reported piloting a strategy in its gastroenterology clinic where future care consults are entered in an electronic system separate from the consult and appointment scheduling systems. Approximately 30 to 60 days before the care is needed the requesting provider is notified to enter the consult request in the electronic consult system for the specialty care provider to complete.

In addition, oversight of the implementation of VHA's business rules has been limited and has not included independent verification of VAMC actions. VAMCs were required to self-certify completion of each of the four tasks outlined in the business rules. VISNs were not required to independently verify that VAMCs appropriately completed the tasks. Without independent verification, VHA cannot be assured that VAMCs implemented the tasks correctly.

Furthermore, VHA did not require that VAMCs document how they addressed unresolved consults that were open greater than 90 days, and none of the five VAMCs in our review were able to provide us with specific documentation in this regard. VHA officials estimated that as of April 2014, about 450,000 of the approximately 2 million consults (both clinical and administrative consults) remained unresolved systemwide. VAMC officials noted several reasons that consults were either completed or discontinued in this process of addressing unresolved consults, including improper recording of consult notes, patient cancellations, and patient deaths. At one of the VAMCs we reviewed, a specialty care clinic discontinued 18 consults the same day that a task for addressing unresolved consults was due. Three of these 18 consults were part of our random sample, and our review found no indication that a clinical review was conducted prior to the consults being discontinued. Ultimately, the

lack of independent verification and documentation of how VAMCs addressed these unresolved consults may have resulted in VHA consult data that inaccurately reflected whether patients received the care needed or received it in a timely manner.

Although VHA's business rules were intended to create consistency in VAMCs' consult data, our preliminary work identified variation in managing key aspects of consult management that are not addressed by the business rules. For example, there are no detailed systemwide VHA policies on how to handle patient no-shows and cancelled appointments, particularly when patients repeatedly miss appointments, which may make VAMCs' consult data difficult to assess.[26] For example, if a patient cancels multiple specialty care appointments, the associated consult would remain open and could inappropriately suggest delays in care. To manage this type of situation, one VAMC developed a local consult policy referred to as the "1-1-30" rule. The rule states that a patient must receive at least 1 letter and 1 phone call, and be granted 30 days to contact the VAMC to schedule a specialty care appointment.[27] If the patient fails to do so within this time frame, the specialty care provider may discontinue the consult. According to VAMC officials, several of the consults we reviewed would have been discontinued before reaching the 90-day threshold if the 1-1-30 rule had been in place at the time.[28] Three VAMCs included in our review also noted some type of policy addressing patient no-shows and cancelled appointments, each of which varied in its requirements.[29] Without a standard policy across VHA addressing patient no-shows and cancelled appointments, VHA consult data may reflect numerous variations of how VAMCs handle patient no-shows and cancelled appointments.

[26]As we previously reported, scheduling practices at some VAMCs could result in miscommunication with patients and cause them not to make medical appointments. In addition, outdated or incorrect patient contact information may also affect patient no-shows and cancelled appointments. See GAO-13-130.

[27]According to VAMC officials, the 1-1-30 rule provides a minimum standard for specialty care providers to follow in scheduling patient appointments.

[28]The VAMC issued its updated consult policy, which included the 1-1-30 rule, in December 2013 after our request for consults data.

[29]One of the VAMCs allowed for a maximum number of two no-shows for all specialty appointments, with consideration given to the patient's medical needs. The other two VAMCs policies stated that specialty providers should reassess the patient's needs after one no-show and may or may not reschedule the appointment.

Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, and VA Has Initiated Actions to Address Related GAO Recommendations

In December 2012, we reported that VHA's reported outpatient medical appointment wait times were unreliable and that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely outpatient medical appointments. Specifically, we found that VHA's reported wait times were unreliable because of problems with recording the appointment desired date in the scheduling system. Since, at the time of our review, VHA measured medical appointment wait times as the number of days elapsed from the desired date, the reliability of reported wait time performance was dependent on the consistency with which VAMC schedulers recorded the desired date in the VistA scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. Some schedulers at VAMCs that we visited did not record the desired date correctly. For example, the desired date was recorded based on appointment availability, which would have resulted in a reported wait time that was shorter than the patient actually experienced.

At each of the four VAMCs we visited, we also found inconsistent implementation of VHA's scheduling policy, which impeded scheduling of timely medical appointments. For example, we found the electronic wait list was not always used to track new patients that needed medical appointments as required by VHA scheduling policy, putting these patients at risk for delays in care. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. VAMCs also described other problems with scheduling timely medical appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler and provider staffing, and issues with telephone access. For example, officials at all VAMCs we visited reported that high call volumes and a lack of staff dedicated to answering the telephones affected their ability to schedule timely medical appointments.

VA concurred with the four recommendations included in our December 2012 report and reported continuing actions to address them.

- First, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to improve the reliability of its outpatient medical appointment wait time measures. In response, VHA officials stated that they implemented more reliable measures of patient wait times for primary and specialty care. In fiscal years 2013 and 2014, primary and specialty care appointments for new patients

have been measured using time stamps from the VistA scheduling system to report the time elapsed between the date the appointment was created—instead of the desired date—and the date the appointment was completed. VHA officials stated that they made the change from using desired date to creation date based on a study that showed a significant association between new patient wait times using the date the appointment was created and self-reported patient satisfaction with the timeliness of VHA appointments.[30] VA, in its *FY 2013 Performance and Accountability Report*, reported that VHA completed 40 percent of new patient specialty care appointments within 14 days of the date the appointment was created in fiscal year 2013; in contrast, VHA completed 90 percent of new patient specialty care appointments within 14 days of the desired date in fiscal year 2012. VHA also modified its measurement of wait times for established patients, keeping the appointment desired date as the starting point, and using the date of the pending scheduled appointment, instead of the date of the completed appointment, as the end date for both primary and specialty care. VHA officials stated that they decided to use the pending appointment date instead of the completed appointment date because the pending appointment date does not include the time accrued by patient no-shows and cancelled appointments.

- Second, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure VAMCs consistently implement VHA's scheduling policy and ensure that all staff complete required training. In response, VHA officials stated that the department is in the process of revising the VHA scheduling policy to include changes, such as the new methodology for measuring wait times, and improvements and standardization of the use of the electronic wait list. In the interim, VHA distributed guidance, via memo, to VAMCs in March 2013 describing this information and also offered webinars to VHA staff on eight dates in April and May of 2013. To assist VISNs and VAMCs in the task of verifying that all staff have completed required scheduler training, VHA has developed a database that will allow a VAMC to identify all staff who have scheduled appointments and the volume of appointments scheduled

[30]Prentice, Julia C., Michael L. Davies, and Steven D. Pizer, "Which Outpatient Wait-Time Measures Are Related to Patient Satisfaction?" *American Journal of Medical Quality*, (Aug. 12, 2013), accessed April 4, 2014, http://ajm.sagepub.com/content/early/2013/07/31/1062860613494750.abstract.

by each; VAMC staff can then compare this information to the list of staff that have completed the required training. However, VHA officials have not established a target date for when this database would be made available for use by VAMCs.

- Third, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources. VHA officials stated that they are continuing to work on identifying the best methodology to carry out this recommendation, but stated that the database that tracks the volume of appointments scheduled by individual staff also may prove to be a viable tool to assess staffing needs and the allocation of resources. VHA officials stated that they needed to discuss further how VAMCs could use this tool, and that they had not established a targeted completion date for actions to address this recommendation.
- Finally, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure that VAMCs provide oversight of telephone access, and implement best practices to improve telephone access for clinical care. In response, VHA required each VISN director to require VAMCs to assess their current telephone service against the VHA telephone improvement guide and to electronically post an improvement plan with quarterly updates. VAMCs are required to routinely update progress on the improvement plan. VHA officials cited improvement in telephone response and call abandonment rates since VAMCs were required to implement improvement plans. Additionally, VHA officials said that the department has also contracted with an outside vendor to assess VHA's telephone infrastructure and business process. In April 2014, VHA officials stated that they expected to receive the first report in approximately 2 months.

Although VA has initiated actions to address our recommendations, we believe that continued work is needed to ensure these actions are fully implemented in a timely fashion. Furthermore, it is important that VA assess the extent to which these actions are achieving improvements in medical appointment wait times and scheduling oversight as intended. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

Chairman Sanders, Ranking Member Burr, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Key contributors to this statement were Bonnie Anderson, Assistant Director; Janina Austin, Assistant Director; Rebecca Abela; Jennie Apter; Jacquelyn Hamilton; David Lichtenfeld; Brienne Tierney; and Ann Tynan.

Chairman SANDERS. Thank you very much, Ms. Draper.

Phillip Longman is a Senior Research Fellow at the New America Foundation. Mr. Longman, thanks so much for being with us.

STATEMENT OF PHILLIP LONGMAN, SENIOR RESEARCH FELLOW, NEW AMERICA FOUNDATION

Mr. LONGMAN. Thank you, Chairman Sanders and the other Members of the Committee, for giving me this opportunity.

I am a little different from the other panelists you have heard today in that I am not a veteran. I am not affiliated with VA in

any way. I am not affiliated with Veterans Service Organizations. I am here because I wrote a book, now in its third edition, called Best Care Anywhere: Why VA Care Would Be Better for Everyone. I think the title pretty much speaks for itself and I stick by it today.

The inspiration for my book came from losing my wife, Robin, to breast cancer in 1999. Robin was treated in one very prestigious corner of the American health care system right here in Washington, DC. Suffice it to say that what I saw during the 6 months between her diagnosis and demise caused me to become radically interested in the questions of medical quality and safety.

Now, shortly after Robin died, the Institute of Medicine issued a report that has been alluded to here already today showing that up to 98,000 people a year in the American health care system are killed by medical errors. That is equivalent to a jumbo jet falling out of the sky and killing everybody on board every third day. It goes on year in and year out. More recently, the Chairman has alluded to other estimates showing that as many as a quarter-million people a year are killed by various forms of over-treatment, mistreatment, maltreatment, under-treatment in the American health care system, making contact with the U.S. health care system the third leading cause of death in the United States, after all cancers and all heart disease.

So, I set out at some point to find out who is doing a better job, and I was very surprised to find, after reviewing the literature on health care quality and talking to many experts, talking to many veterans and such, that the VA Health Care System, by many, many metrics, outperforms the rest of the U.S. health care system as a whole, and the proceedings today seem to have come to a broad consensus that VA health care in itself has exceptionally high quality. The problems we are dealing with here are access.

So, I will not really belabor the point. I will want to say, though, that I would have welcomed Robin's being treated in a hospital that had an Inspector General. Would that not have been wonderful? Would it not have been wonderful if there had been a committee of Congress, or maybe even two committees of Congress that exercised oversight of that hospital? Would it not have been great if there were various broad-based, effective citizens' organizations akin to the American Legion that have applied scrutiny to that corner of the American health care system? So, we have to bear in mind what the context here is.

I also would want to draw attention to the fact that when we have a problem of someone gaming a metric on wait times or gaming some other metric that VA applies, that is because there is a metric, right. I mean, in the rest of the health care system, by and large, there are no quality metrics that are exercised, let alone wait times. It took me 2½ years to find a primary care physician in Northwest Washington who is still taking patients. Robin waited for a mammogram long enough for her tumor to grow from this size to this size [indicating], right. Many people in the United States today—most people in the United States—live in places where there are acute primary care shortages, right. We have a tremendous problem of access to begin with.

My final point, I will just say, too, is that on the waiting times so much of what we are doing is trying to determine whether somebody has a service-related disability or not, right. Is the reason you are losing your hearing because of the artillery fire that you heard in Vietnam or because of all The Who concerts you went to in the 1960s? We have just a tremendous administrative machine that adjudicates that kind of question, and that is where most of these veterans are getting ground down, waiting to get into the VA. How much smarter would it be if we just opened up VA to all veterans and said, thank you for your service. Come on in.

Thank you very much.

[The prepared statement of Mr. Longman follows:]

PREPARED STATEMENT OF PHILLIP LONGMAN, SENIOR FELLOW, NEW AMERICA FOUNDATION, AUTHOR: *BEST CARE ANYWHERE: WHY VA HEALTH CARE WOULD BE BETTER FOR EVERYONE*

Chairman Sanders, Ranking Member Burr and distinguished Members of the Committee. I greatly appreciate the opportunity to testify in these critical hearings.

I am not a veteran nor a VA employee. I am also not affiliated with any veterans service organization. Instead, the perspective I bring comes from my having written a book about the transformation of the VA health care system. The book, now in its third edition, is called *Best Care Anywhere: Why VA Health Care Would be Better for Everyone*.

The inspiration for the book came from my experience in losing my first wife, Robin, to breast cancer, in 1999.

Robin was treated at a highly renowned cancer center here in Washington DC. I never blamed her doctors for her death. But suffice it to say that what I saw of this one prestigious corner of the American health-care system caused me to become extremely alarmed the problem of medical errors and poorly coordinated care.

Shortly after Robin's death, the Institute of Medicine issued a landmark report in which it estimated that up to 98,000 Americans are killed every year in hospitals as a result of medical errors . That's like three jumbo jets crashing every other day and killing all on board.[1]

Then came another report published in the *Journal of the American Medical Association*, which looked not just at hospitals, but at the American health care system as a whole. It estimated that through a combination of under-treatment, over-treatment, and mistreatment, the U.S. health care system is killing 225,000 Americans per year. To put that in perspective, it means that contact with the U.S. health system is the third-largest cause of death in the United States, following all heart disease and all cancers.[2]

These reports, combined with my personal experience, put me on a quest to find out who had the best workable solutions to America's dysfunctional and dangerous health care delivery system.

The answer that emerged was not one I expected. But as study after after study now confirms, the VA system as a whole outperforms the rest of the health care system on just about every metric that health care quality experts can devise. These include adherence to the protocols of evidence-based medicine, investment in prevention and effective disease management, use of integrated electronic medical records, and, importantly, patient satisfaction.

Just how the VA transformed itself is an inspiring story, involving front-line employees bringing about a revolution from below, as well as courageous leadership at the top, particularly during the period when Dr. Kenneth Kizer headed the Veterans Health Administration.

As I also explain in my book, important structural factors were at work as well. For example, the VA has a nearly lifelong relationship with most of its patients and does not profit from from their illnesses. This gives it incentives to keep its patients well—incentives that are sorely lacking in most of the rest of the health care system. If the VA doesn't teach its patient how to effectively manage their diabetes,

[1] Corrigan J, et al, eds. To Err Is Human: Building a Safer Health System. Washington, DC: Institute of Medicine, the National Academies Press; 2000; and editorial, Preventing fatal medicl errors, New York Times, December 1, 1999, p. 22a.

[2] Starfield B. Is US health really the best in the world? *Journal of the American Medical Association 2000*; 284(4): 483–485.

for example, it becomes liable down the line for the cost of their amputations, renal failures, and all the other long-term complications of the disease.

Now, of course, bad medicine does happen at the VA, and when it does those who may be responsible need to be throughly investigated. But when such breakdowns occur, we should always put them in context by asking: "Compared to what?"

As we've seen, U.S. health care system outside of the VA is exceptionally dangerous. It would have been great,for example, if the private hospital that treated my wife had been been under the scrutiny of an Inspector General, whose full-time job it was to look out for failures in patient care. But of course, private hospitals don't have I.G.s.

Similarly, if a committee of Congress such as this one was specifically focused on the quality of care provided by that hospital, that oversight would have likely helped the institution to become more accountable. Or again, more mistakes would undoubtedly have come to light at that hospital and many others if effective watchdogs group akin the American Legion looked out for the interest of non-VA patients.

But, of course, that kind of scrutiny does not occur. And this asymmetry creates a perverse result. For the average news consumer it can lead to the impression that the VA is limping along from one scandal to the next, even as its patients and health-care quality experts applaud its superior quality, safety, and cost-effectiveness.

Finally, I'll close by pointing out another way in which context is often missing in discussion of VA health care. Overwhelmingly, the failures of the VA in recent years haven't been about the quality of health care for those who get covered. Instead, they've mostly been about the excessive waiting times, and excessive red tape that our vets must go through to establish eligibility.

Here, the Veterans Benefits Administration must accept blame for not doing a better job of streamlining administrative procedures. But in all fairness, it is Congress, and by extension the American people as a whole, who have established the laws that require most vets to prove that they have service-related disabilities before becoming eligible for VA care.

This is the perverse root cause of the waiting time and other problems of access. Who can say if a Vietnam vet is losing his hearing due to expose to too much artillery fire, or exposure to too many Who concerts?

We need to open up the VA and grow it, extending no-questions-asked eligibility not only to all vets but to their family members as well. This not only makes clinical sense, it also makes economic sense. So long as the VA remains one of, if not the most, cost-effective, scientifically driven, integrated health care delivery systems in the country, the more patients it treats, the better for everyone.

Chairman SANDERS. Thank you very much, Mr. Longman.

I thought all the testimony was excellent. Thank you all for the high-quality testimony.

Mr. Griffin, a few questions. Thank you very much for plunging into this investigation, in a sense, on short notice. Briefly, let me reiterate—you and I have chatted on the phone—do you have the necessary resources to undertake the kind of thorough investigation that needs to be done regarding Phoenix?

Mr. GRIFFIN. Yes, sir. [Off microphone.]

Chairman SANDERS. Please use your microphone.

Mr. GRIFFIN. Yes, we do. We have, under Dr. Daigh's direction, 120 medical clinicians, who, for a number of years, have been doing reviews of VA medical centers, a 1974 West Point graduate, 26 years as an Army doctor, and 10 years with us.

Chairman SANDERS. OK.

Mr. GRIFFIN. The reason the IG system was set up the way it was is so that you will have people who have knowledge of the Department, and that is why we are the right group to do this review.

Chairman SANDERS. Let me ask you this. I think you have heard from almost all of the Members here the desire for you to do a thorough examination and investigation, and also to do it in a timely manner. Now, when you told us a few moments ago that you do not think you can do that until August, is there any way you can

give us some preliminary information before that, maybe a preliminary report, because I think many of the Members would like to get a sense of what you have found out there.

Mr. GRIFFIN. As the review progresses, if there appears to be a seam where it would be appropriate for that to happen, we would do that. But, remember, part of this review could lead to criminal charges being brought and we do not want to do anything to jeopardize the ultimate outcome of the facts in the case.

Chairman SANDERS. Let me ask you this, and maybe it is premature, but if you could answer, I would appreciate it. You know, what we have been reading in the media, and I will quote from one media report, "At least 40 U.S. veterans died waiting for appointments at the Phoenix Veterans Affairs Health Care System, many of whom were placed on a secret waiting list." At this particular point, can you tell us how many people you have identified who died while waiting on a secret waiting list?

Mr. GRIFFIN. I cannot give you that number because the number 40 that has been wildly quoted in the press does not represent the total number of veterans that we are looking at. That was one list that was created by the facility. We need to do an analysis of that list, both death records and VISTA records, by Dr. Daigh's clinicians. But, there are also other people who have come through the Congress, who have come through the media, who have come through our hotline. So, we have multiple lists, none of them identical.

We have begun to process on a preliminary basis of going through those lists. And the initial list that we were given, we have gone through, and there were only 17 names on that list. Our review to-date—we have more work to do on this because we want to have more than one set of eye look at all of the records—but on those 17, we did not conclude so far that the delay caused the death. It is one thing to be on a waiting list and it is another thing to conclude that as a result of being on the waiting list, that is the cause of death, depending on what the illness might have been at the beginning.

Chairman SANDERS. So, at this point, the one list of 17 names that you have looked at has not, at this point, identified anybody who has died as a result of being on a waiting list and not getting——

Mr. GRIFFIN. That is right, for our initial review. And I want to ask Dr. Daigh to expand upon that so you can understand the nature of these lists.

Chairman SANDERS. Right. This is complicated stuff. I do understand that.

Dr. Daigh, did you want to add.

Dr. DAIGH. Well, sir, let me try. So, we have been provided names of people who are on various lists, and it is true that those veterans whose names were on the list have died. We have looked at a substantial number of cases, and we have in looking at those cases determined that, yes, there was a delay in care frequently, as has been expressed. We have, in several cases, found that the quality standards were not met. In a subset of that, we found some patient harm. But, to draw the conclusion between patient harm and death has so far been a tenuous connection.

The records that we have looked at to date are mostly VA's medical records. So, to the extent that a patient died, we are in the process of getting death certificates and autopsy reports, if they were in another hospital then there are procedures we need to go through to get the rest of those records. We may need to interview people who are knowledgeable about the events surrounding the death.

So, it is a serious problem and it is going to just take my staff a little time to work through so that what we say, we can stand by, and that you are happy with the result.

Chairman SANDERS. OK. Thank you very much.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Ms. Draper, in the GAO report regarding outpatient appointment and wait times and scheduling, the conclusion states, "Unreliable wait time measurements has resulted in a discrepancy between the positive wait time performance VA has reported and veterans' actual experience." Now, this VA report that you are talking about was the report that was presented to the VA in December 2012.

Ms. DRAPER. That is correct.

Senator BURR. It became a public document in January 2013, correct?

Ms. DRAPER. That is correct.

Senator BURR. And, what I have said so far about your comments on it are accurate. Am I right?

Ms. DRAPER. That is correct.

Senator BURR. OK. In this report, GAO recommended, "The Secretary of VA direct the Under Secretary of Health to take actions to improve the reliability of wait time measures," and it went on to suggest, "The Secretary of VA direct the Under Secretary of Health to take actions to ensure the VAMCs consistently and accurately implement VA's scheduling policy." That is accurate?

Ms. DRAPER. That is correct.

Senator BURR. Ms. Draper, for the two recommendations, VA specified in their comments that these recommendations had a targeted completion date of November 1, 2013. Let me ask you, based upon the knowledge that you have today, has this process at VA been completed as it relates to those two actions in your report from December 2012?

Ms. DRAPER. It has not been fully completed.

Senator BURR. And, is this an ongoing conversation with VA about the completion of——

Ms. DRAPER. It is. I mean, they have told us they have taken steps, and we provided that in our written testimony, about the update on where they say the recommendations are. You know, to be quite frank, it has been almost a year and one-half. We would have expected more progress to have been made.

Senator BURR. I think most of the Members of this Committee would probably say that they associate with that statement.

Mr. Griffin, thank you for serving in an acting capacity. You are a stand-up guy and I just want you to know this Member, and I think I can speak for all Members, we have got great confidence in what you and your team will do, can produce, the accuracy of

it, and the reliability of it. I want you to understand that and please share that with the folks that are working so hard.

Mr. GRIFFIN. Thank you, Mr. Burr.

Senator BURR. Do you, or did your predecessor, have a regular scheduled meeting with the Secretary?

Mr. GRIFFIN. We have meetings with the entire leadership team every 2 weeks. My predecessor went to one; I went to the other one. And we have had occasional meetings with the Secretary at different times during the year.

Senator BURR. So, how many meetings have you had with the Secretary since the issue of Phoenix arose and you mobilized this IG review there?

Mr. GRIFFIN. Well, we had one meeting that was unconnected to the review. It was a budget-related meeting. And we had a second meeting when I went over to request that certain individuals be put on admin leave.

Senator BURR. But, from a standpoint of the actual investigation, the scope of it, all of that, who has handled that from a standpoint of——

Mr. GRIFFIN. During the course of the admin leave discussion, I gave an overview, not unsimilar to the seven bullets that I mentioned here, as to what we were going to be looking at. I would expect to be asked what is your basis for requesting that I put someone on admin leave. I think that was completely appropriate. But, I think, in the Secretary's words, we are independent and we cannot be told to do or not do something because it would violate our independence.

Senator BURR. I understand that. So, when the Phoenix report is finished, if it happens like every other IG report, will you or your staff physically sit down with the Secretary and brief him on the findings of that IG report?

Mr. GRIFFIN. Not on every report, but certainly, a report of this magnitude. We issue probably 300 reports a year——

Senator BURR. And how many——

Mr. GRIFFIN. Not all of them would rise to that level. But we do—at the Assistant Inspector General level, Dr. Daigh meets with the VHA senior staff on a recurring basis to discuss these things. As we just heard about the process of getting closure on reports, there is an ongoing follow-up process that our personnel do until we are satisfied that they have taken corrective action.

Senator BURR. How many years have you been in VA at some capacity in the IG's Office?

Mr. GRIFFIN. About 13 out of the last 16 years.

Senator BURR. And, how many times have you sat down with a Secretary and briefed them on an IG report?

Mr. GRIFFIN. Oh, I would say a report of this magnitude, I would brief him on maybe a couple times a year, depending on—again, there are 300 reports—I would say, maybe, at most, quarterly.

Senator BURR. On a report, or on multiple——

Mr. GRIFFIN. On a report, but the door is open. It is just the issues typically are resolved at the Under Secretary level.

Senator BURR. Have you ever requested a meeting with a Secretary while you have been there and the meeting was not made available to you?

Mr. GRIFFIN. No.

Senator BURR. OK. I thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Burr.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I want to thank, as with this panel, I want to thank you for your testimony.

Mr. Griffin, you said you have 120 medical investigators. Are there more investigators than that?

Mr. GRIFFIN. We have about 615 personnel in the IG organization. One hundred twenty of them work for David and they are health care inspectors. They are doctors. They are nurses. They are psychiatrists, psychologists, clinicians——

Senator TESTER. How many people——

Mr. GRIFFIN [continuing]. Physical therapists. We have about 150 criminal investigators. We have people in 39 cities around the country.

Senator TESTER. Got you.

Mr. GRIFFIN. We have over 200 auditors.

Senator TESTER. Let me cut to the chase.

Mr. GRIFFIN. OK.

Senator TESTER. How many people are working on this investigation——

Mr. GRIFFIN. So far——

Senator TESTER [continuing]. Total?

Mr. GRIFFIN. So far, 185 people have touched this investigation.

Senator TESTER. You have been working on it for how many weeks so far?

Mr. GRIFFIN. This is the third week.

Senator TESTER. Your testimony said you anticipate a final by August?

Mr. GRIFFIN. That is correct.

Senator TESTER. Do you anticipate a preliminary report before that?

Mr. GRIFFIN. To the extent that it will not impact——

Senator TESTER. Got you.

Mr. GRIFFIN [continuing]. The outcome of the work, to include the fact that we are working with two different groups from the Department of Justice, looking at possible criminal violations.

Senator TESTER. OK. I want to talk a little bit about senior management staff, including the Secretary in the VA. Have you—in this investigation, have you asked those folks for information?

Mr. GRIFFIN. No, we have not.

Senator TESTER. OK.

Mr. GRIFFIN. I mean, we——

Senator TESTER. Go ahead.

Mr. GRIFFIN. We did ask them for a list that they suggested to us that they had of veterans who died on an electronic list, but——

Senator TESTER. Have—let me put it this way.

Mr. GRIFFIN. OK.

Senator TESTER. This is where I want to get to. Have they been open and transparent and—what is the other word I am trying to think of—helpful in your investigation?

Mr. GRIFFIN. Yes, they have, and they have offered resources, but we do not want to give anyone the impression that our independ-

ence is in question, so we have not received any resources, nor do I intend to.

Senator TESTER. But, as far as up to this point, being fully transparent with what you need, when you ask, they deliver?

Mr. GRIFFIN. That is correct.

Senator TESTER. OK. Has there been any—maybe you can say this, maybe you cannot, if you cannot, do not—but, has there been any sign that, up to this point, that there has been two sets of books run on appointments?

Mr. GRIFFIN. I think that over the past 8 or 9 years—there are a list of reports that were mentioned earlier where we found that waiting times were not being accurately reported, most recently, on mental health, where it was reported at a 95 percent level. We looked at the exact same data and concluded it was 49 percent. So, it is not a new issue and I am confident that when we finish our work in Phoenix, it will be the same outcome as these previous reports.

Senator TESTER. OK. That is all, Mr. Chairman. I would just say, we look forward to the investigation. I know you need the time to do it right. Of course, in the society we live in, this case is already being litigated and convicted every day in the news media by some. So, it will be great to get the facts out there so that we can help VA do their job better to serve the veterans who served this country so well. Thank you all for being here.

Mr. GRIFFIN. Understood, and the only thing I can say about the rush is we are not going to rush to judgment at the sacrifice of quality. I know you are not suggesting that.

Senator TESTER. No.

Mr. GRIFFIN. We are going to nail this thing, and at the end, we will have a good product for you.

Senator TESTER. Yes, and at the sacrifice of people who are innocent. Thank you.

Mr. GRIFFIN. Sure.

Chairman SANDERS. Thank you.

Senator Moran.

Senator MORAN. Mr. Chairman, I understand there is only a minute or so left in the vote that has been called, so I will try to summarize very quickly.

Ms. Draper, and then I will follow up with Mr. Griffin, the GAO reports, what is the process by which you have assurance that your report is acted on by the Department of Veterans Affairs? What is the follow-through, and what has been the result of GAO reports at the VA?

Ms. DRAPER. Yes. For the report that we issued, it was publicly released in January 2013. We did a follow-up. They issue a 60-day letter on the status of the recommendations, so we do have that. Then we provided Congressional testimony for the House Committee in April. We followed up with VA to get an update on where the recommendations were. So, we have periodic updates with VA on the status of the recommendations.

Senator MORAN. You testified earlier about this particular report and its current status. About other GAO reports, do you have a sense that the VA is successful, or useful—that your report is use-

ful and they are successful in implementing the proposals that you suggest?

Ms. DRAPER. It varies. I think that we have quite a number of open recommendations at VA at this time across GAO.

Senator MORAN. Mr. Griffin, in regard to the IG's report, what—how are you able to determine whether or not your report and its suggestions, its recommendations, are followed through by the Department of Veterans Affairs?

Mr. GRIFFIN. We do it in two different ways. In some instances, we will review—if we say, you need a new policy on staffing, or you need a new policy on waiting times, or you need to train the schedulers and you need to create a methodology where you can audit the scheduling process to make sure someone is not cooking the books, if they can satisfy us that, here is the new policy and here is how we are going to make this work, we may close out at that time. More often, if we do not have a comfort level, we will send a team back 6 months later and go to the same facilities to see if the fixes are in place.

Senator MORAN. What is your sense—in your time as Acting, or if you have information about your predecessor—what is your sense of the Department of Veterans Affairs following the recommendations and implementing them following an IG report?

Mr. GRIFFIN. The answer is mixed. I think, frequently, policies emanate from Washington. The policies look good on paper, but they are not always followed by the managers in the field. So, it is an accountability question for the field managers; when they do not follow it, something needs to happen.

Senator MORAN. One of the things that I do not think you have anything to do with, but is an important component of an investigation of the Department of Veterans Affairs, would be the Office of Medical Inspector reports, and one of the things that we have discovered is that those are not made public and not submitted to Congress, so we do not know the results of those types of audits, investigations, or reviews. I am pursuing legislation to change that so we can see what that report says. We can excise the names and keep the confidentiality of patients straight, but I think there is a whole set of other reports that there is no ability for us to gauge whether or not a recommendation is followed.

Let me just ask, in conclusion, Mr. Griffin, are there IG investigations ongoing that involve facilities in Kansas?

Mr. GRIFFIN. I would like to take that for the record. I know that we have, in the past week and a half, our criminal investigators, who are located around the country, have had a rapid response to ten new allegations. And in the matter of 2 days over the previous week, they went to 50 medical centers, unannounced, in order to see if what was being alleged was occurring at those facilities, so——

Senator MORAN. I would be happy to know that. I actually was referring to more—not necessarily a current investigation beginning as a result of the current circumstance, but over the last year or so. The reason I asked the question is that there have been allegations of incidents, circumstances, consequences within the VA in my State, and our effort to find out what is going on, what response has the Department taken as a result of at least these sto-

ries that are out there, we have never received a response from anyone at the Department of Veterans Affairs, either here in Washington from the Secretary in his testimony or with Kansas officials, individuals who work at VA within our State. And, I do not know whether or not any of those circumstances that are at least part of a conversation are being investigated by you. If you would follow up with me, that would be——

Mr. GRIFFIN. I will. The majority of our audit and health care reports go to the member whose district that facility is located in. Some of the criminal reports take longer because of the judicial process and privacy issues involved with the criminal cases. You may or may not see quickly——

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

Chairman SANDERS. Mr. Griffin, I apologize for interrupting you. I think there are 95 Senators waiting for us to vote.

This was a great panel and I very much appreciate the wonderful testimony. Thank you all very much.

The hearing is adjourned.

[Whereupon, at 2:07 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Thank you, Chairman Sanders and Ranking Member Burr, for holding this important hearing. And thank you, Secretary Shinseki, for coming to speak with us today.

Secretary Shinseki, I think your record speaks for itself. You and your leadership have been working tirelessly on behalf of veterans has helped improve the VA health care system by leaps and bounds.

I will be honest with you, I am deeply troubled by the increasing reports of employee misconduct in VA facilities around the country. Stories like these, with the worst allegations coming from the VA facilities in Phoenix, are incredibly worrisome. They call into question our country's ability to address the needs of our veterans, and they damage the reputation of a system that has made great strides over the past few years.

If these reports are true, then appropriate action must be taken. Our veterans and their loved ones deserve nothing less.

Amidst stories of alleged secret waiting lists and falsified records, however, I do believe that it is important for everyone to remember one key fact: the VA treats millions of veterans every year, and it treats them exceptionally well. I know that the men and women employed by the VA—from the doctors to the nursing staff to the people who work in admission—are working day and night to improve the health of our veterans and honor their service. It is important not to forget this.

Currently, the VA faces major challenges. More people are enrolling in the VA than ever, and many of them have complex injuries. If the VA does not have enough doctors to see these patients, then these problems are a result of a lack of funding. And that is something that we in Congress can blame no one for but ourselves.

I applaud this Administration for its continued commitment to providing funding for veterans. The request for a three percent increase reflects the largest increase for any agency in the President's budget request. But if we're being honest about the needs of the VA, a three percent budget increase is not enough. As tens of thousands of our troops continue to come home—some with mental health problems or severe, debilitating wounds—we're funding an agency with incredible demands and health care costs at only half of our entire military budget.

We have a moral obligation to take care of our veterans. However, this Congress has been falling short of its obligations to care for our veterans when they return. And recently, it seems that it's only during crisis situations that we are forced to look at how we are prioritizing the care and long-term health of those who have fought for our country.

That is not to say that swift action must not be taken if the Inspector General determines there has been misconduct at the VA. But for as long as we continue to underfund the VA, I firmly believe problems will continue to arise.

Thank you.

PREPARED STATEMENT OF HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Thank you, Mr. Chairman, for holding this important hearing and for your leadership of this Committee.

I want to thank the VSO leaders who are testifying today and Secretary Shinseki for your continued commitment to serving our Nation's veterans.

We've heard some very serious allegations made against the VA. And, like any allegation, we are investigating the claims so we can ensure VA healthcare is the best possible care for our veterans.

The Inspector General said it would take a few months, perhaps as late as August, to do a tough, fair, independent investigation. But three months is too long when it comes to honoring our veterans. That is why this hearing is so important.

VA and this Committee are not sitting idly by until we hear from the IG.

The Secretary has taken these allegations very seriously. He requested the IG investigation. He removed employees accused from patient care responsibilities, placed several more on administrative leave, and ordered the Veterans Health Administration to complete a Nation-wide access review.

And, this Committee is performing its constitutional duties that include rigorous oversight, of which this hearing is a part.

So many of us admire the work done by Veterans Service Organizations. Their commitment to veterans cannot be questioned.

I was extremely troubled when I heard the allegations of wait lists leading to patient deaths and of employees allegedly cooking the books. These are serious claims.

If true, there must be reforms and serious consequences. And if true, this Committee will act swiftly and decisively.

But we should be cautious not paint the entire VA system with a broad brush—many VA workers serve our veterans honorably every day.

The Veterans Health Administration operates more than 1,700 sites, and conducts approximately 236,000 health care appointments each day. This amounts to approximately 85 million appointments each year.

We also know that Secretary Shinseki has a strong commitment to our veterans and our Nation as well.

We are short on time, so I will conclude my remarks and look forward to hearing from you.

Thank you Mr. Chairman.

MEMORANDUM SUBMITTED BY HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA, MEMORANDUM FOR THE RECORD

Department of Veterans Affairs

Memorandum

Date: APR 26 2010

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Inappropriate Scheduling Practices

To: Network Director (10N1-23)

1. The purpose of the memorandum is to call for immediate action within every VISN to review current scheduling practices to identify and eliminate all inappropriate practices including but not limited to the practice specified below.

2. It has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices sometimes referred to as "gaming strategies." Example: as a way to combat Missed Opportunity rates some medical centers cancel appointments for patients not checked-in 10 or 15 minutes prior to their scheduled appointment time. Patients are informed that it is medical center policy that they must check in early and if they fail to do so, it is in the medical center's right to cancel that appointment. This is not patient centered care.

3. For your assistance, attached is a listing of the inappropriate scheduling practices identified by a multi-VISN workgroup charted by the Systems Redesign Office. Please be cautioned that since 2008, additional new or modified gaming strategies may have emerged, so do not consider this list a full description of all current possibilities of inappropriate scheduling practices that need to be addressed. These practices will not be tolerated.

4. For questions, please contact Michael Davies, MD, Director, VHA Systems Redesign (Michael.Davies@va.gov) or Karen Morris, MSW, Associate Director (Karen.Morris@va.gov)

William Schoenhard, FACHE

Attachment

ATTACHMENT

Scheduling Practices to Avoid: Strategies leading to poor customer service and misrepresentation of Performance Measures/Monitors

Introduction

The purpose of this chapter is to provide assistance in ensuring scheduling accuracy during consultative site visits. It will provide an outline for consultants to better assess scheduling practices and recommend improvements.

As we strive to improve access to our veterans we must ensure in fact that improvement does not focus or rely on workarounds. Workarounds have the potential to compromise the reliability of the data as well as the integrity and honesty of our work.

Workarounds may mask the symptoms of poor access and, although they may aid in meeting performance measures, they do not serve our veterans. They may prevent the real work of improving our processes and design of systems.

We need to speak in a unified voice when interacting with staff at all levels. Our expectations are that there will be no workarounds, and that access will continue to improve with integrity and honesty in all the work that we do.

Systems Redesign principles provide us with the opportunity to improve not only access, but also quality, because without access there can be no quality; satisfaction, because waiting is a huge source of dissatisfaction; and cost of care because, delay creates waste and waste costs money. Please review the practices below to better equip you and your team during your upcoming site visits.

Scheduling Practices to Avoid

- Limiting/Blocking appointment scheduling to 30-day booking. Clinic profiles are created to allow for no more than 30-day scheduling. When patients require appointments beyond the 30 days,
    - they are told to call back another month to make their request, or
    - staff holds the appointments without scheduling until capacity opens within 30 days.
    - Evaluation Method: Ask the scheduler to make an appointment past 30 days. Review the use of recall system and EWL.
- Use of a log book or other manual system. Using this method, appointments are scheduled in VistA at a later date instead of placing patients on the EWL. This has been observed in mental health and in other clinics. The use of log books are now prohibited.
    - Evaluation Method: Interview clinical staff and scheduling staff, especially in mental health. Ask specifically about whether log books are used and ask whether patients schedule directly with the scheduler or if they must

schedule with the clinician. Check Display Clinic Availability listing to assure the patients are being scheduled in VISTA.

- Creation and cancellation of New patient visits: A New patient visit is created for a date within 30 days. This visit is cancelled by the clinic; however, it is entered in Appointment Management as "cancelled by patient" instead of "cancelled by clinic" and rescheduled for another date within 30 days of the cancellation. The performance measure would show a wait time under 30 days, though it should have been calculated at >30 days if entered correctly as "cancelled by clinic." There are several ways this has been observed:
  - Scheduling the New patient visit at a time the patient would prefer not to come in and then re-scheduling.
  - Creating a New patient appointment without notifying the patient. This creates a very high likelihood that the patient will no-show which allows for another rebooking with a restarted wait time.
  - Sites may also appropriately enter "cancelled by clinic" in Appointment Management, but inappropriately reschedule the appointment 1+ days later, which restarts the wait time clock.
  - Evaluation Method: Conduct random audits of patient appointments, sampling a variety of clinics. Critically assess the scheduling process using both CPRS and Appointment Management. Check performance measure clinics with unusually low no show rates and wait times.
- Auto-Rebooking: This scheduling option removes critical scheduling data (including Desired Date) from the Appointment Management scheduling package, which prevents us from verifying that the patient was scheduled within 30 days. Recommend against using this option.
  - Evaluation Method: Conduct random audits of patient appointments. Enter "Expanded Profile" in Appointment Management on the "*** Clinic Wait Time Information ***" screen and make sure that the "Request Type" does not state "AUTO REBOOK" (see screenshot below):

```
Expanded Profile            May 07, 2008@08:19:04          Page:    3 of    5
Patient: ZZTEST,PATIENT (7070)                                      Outpatient
Appointment #: 1                                         Clinic: WS/MHC-ZOMCHEK
+
                     *** Clinic Wait Time Information ***

             Request type: AUTO REBOOK
    'Next Available' Type: NOT INDICATED TO BE A 'NEXT AVA.' APPT.
             Desired date:
          Follow-up visit:
         Clinic Wait Time1: 12 days
         Clinic Wait Time2:

NOTE: Clinic Wait Time1 represents the difference between the date the
      appointment was entered and the date it was performed.  Clinic Wait
      Time2 represents the difference between the 'desired date' and the
      date the appointment was performed.
+        Enter ?? for more actions

Select Action:Next Screen//

   1(020,029)
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- Use of the recall system to "hold" patients until slots within 30 days open up.
  - Evaluation Method: Conduct random audits of patient appointments entered in the recall system. If recall is being used properly, there should be evidence in the CPRS Progress Notes supporting the appointment date in the recall system.
- Use of slot for Test Patient so that this slot cannot be used but then cancelling the Test Patient and scheduling a patient in the appointment slot. Some providers also use the Test Patient to book up their clinics if they are going on vacation so they do not have to cancel their clinic.
  - Evaluation Method: Interview schedulers and randomly look at the future clinic grids (e.g., t + 90 days) to see if test patients are scheduled.
- Block scheduling: Numerous patients are scheduled at one block of time (e.g., 8:00 – 12:00 pm) and have to wait a long time to be seen. Each patient should have his/her own appointment slot.
  - Evaluation Method: Randomly look at the future clinic grids to see if several patients are scheduled at one time. If so, ask the respective schedulers whether block scheduling is being used. Note: Clinics often legitimately schedule 2+ patients in each appointment slot because they are staffed with enough clinicians to manage patients 1:1.
- Cancelling patients before the appointment time has passed if:
  - the patient does not confirm the appointment in response to a reminder call/letter, or if

- o the patient does not show up 15 minutes before the appointment time.

This strategy inappropriately eliminates the patient from the Missed Opportunity measure and is misleading to patients who will show up for their appointments.

  - o Evaluation Method: Interview schedulers to determine if this practice occurs. Clinics with unusually low Missed Opportunity rates should be investigated more closely.
- For established patients, entering a Desired Date that is later than what the provider/patient agreed upon in order to fit the patient in within 30 days.
  - o Evaluation Method: Cross-reference the provider's desired date from CPRS (i.e., progress note) with the Desired Date entered in Appointment Management. Also interview schedulers to determine if this practice occurs. Verify that the dates on routing slips (if used) match the Desired Date entered in Appointment Management.
- Allowing providers to request RTC dates in windows (e.g., 4-6 months). This practice allows the scheduler to enter a Desired Date based on clinic availability instead of when the patient needs to be seen.
  - o Evaluation Method: Cross-reference the provider's Desired Date from CPRS (i.e., progress note) with the Desired Date entered in Appointment Management. Also interview schedulers and providers to determine if this practice occurs. Some facilities may have a policy allowing schedulers to make appointments within 2 weeks before and after the provider's date. Interview staff and request the policy if this is occurring. If this occurs, there needs to be an entry in the "Comments" section of Appointment Management describing the provider's/patient's preference.
- For Established patients, allowing the Desired Date not to be documented prevents sites from knowing whether the patient was given an appointment within 30 days:
  - o For call-ins and walk-ins, schedulers should enter patient requests into the "Comments" field in VistA's Appointment Management system.
  - o For normal RTC appointments, providers should document the Desired Date using electronic orders in CPRS. These orders must include the provider's name, the clinic name, and the requested RTC date. It is recommended that routing slips not be used, as they are shredded daily and the information is lost. Instead, some sites require providers to complete their treatment plan progress note before patients leave, which documents the RTC date in a CPRS progress note.
  - o Evaluation Method: Interview schedulers in various clinical areas to determine whether routing slips are being used for RTC appointments. Also, randomly sample appointments to determine whether adequate documentation exists for call-ins, walk-ins, and standard RTC appointments.
- Basing the Desired Date on clinic availability: When a provider writes RTC in 3 weeks, the clerk enters +3W to find the availability of future appointments. Once a date/time is found, the clerk exits the system and then starts over using the identified date/time as the Desired Date.
  - o Evaluation Method: Cross-reference the provider's Desired Date from CPRS (i.e., progress note) with the Desired Date entered in Appointment

Management to ensure they match. Also, witness schedulers making appointments, watching for this practice.

- When clinics are cancelled and the patients need to be rescheduled, patients will be called and offered the next available appointment for that clinic. If they accept it, the scheduler will enter that date as the Desired Date as per patients' request, instead of next available.
    - Evaluation Method: Try to observe the way appointments are rescheduled following a clinic cancellation. Interview schedulers to determine whether this is happening. One option is to call a sampling of scheduled patients and ask how their future appointment was offered to them.
- Patients (New and Established) are offered appointments beyond 30 days, but they are documented as being >30 days per patient request.
    - New patient appointments will still fail the performance measure because the clock starts on the Creation Date. Nevertheless, this strategy misrepresents the patient's Desired Date. Patients should be asked when they would like an appointment and that date should be entered as the Desired Date for Established patients and entered in the Comments field for New patients.
    - Evaluation Method: The team can interview front-line schedulers, asking for the wording used to schedule an appointment with patients. The best method for evaluating, however, would be to directly observe schedulers/patients while appointments are being scheduled. One option is to call a sampling of scheduled patients and ask how their future appointment was offered to them.
- Access data and Performance Measures meet the standard but when you view the clinic schedules, they are full for the next 30+ days. This suggests the site may be gaming the system.
    - Evaluation Method: Examine random clinic grids 30 days into the future to determine whether there are any open slots. If not, ask the respective schedulers and/or service chiefs how they are able to meet the 30-day standard when the grids are booked 30+ days.
    - It is possible that they are legitimately meeting the measure if they are feeing out all New patients who cannot get an appointment within 30 days, or if they open clinics for extended hours on an as needed basis to increase supply.
- Not including the patient in scheduling the appointment. This occurs most often in specialty clinics when scheduling New patients off consults. It creates poor customer service, a high Missed Opportunity rate, and considerable rework to reschedule these missed appointments.
    - Evaluation Method: For specialty services, interview schedulers and other staff to determine how consults are processed and scheduled. Is there clinical review of the consults? If a clinician reviews the consult, does he/she reschedule the appointment him/herself? Does a nurse review the consult and schedule the appointment him/herself? Ask staff if they include patients in scheduling initial appointments and, if possible, observe their practices.
- Consult management:

- When clinics are full within 30 days, consults are Cancelled or Discontinued with comments for the requesting provider to re-submit at a later date. This practice makes wait times appear shorter than they are and compromises patient care.
  - Evaluation Method: Interview Consult Manager to determine how consults are managed when no appointments within 30 days are available. Also, run the consult tracking report (Service Consults By Status [GMRC RPT CONSULTS BY STATUS]) to assess whether an unusually high percentage of consults are being Cancelled or Discontinued. If yes, investigate closer. This strategy may be occurring. The service may also have a Service Agreement in place that isn't working.
- Holding a consult without scheduling the visit but marking the consult as completed. This method does not give the patient timely care, yet it allows the service to pass the 7-day monitor to act upon a consult.
  - Evaluation Method: Use the Completion Time Statistics ([GMRC COMPLETION STATISTICS]) report. This will display how many consults are completed without results or without a note attached.
- Completing the consult when the appointment is scheduled rather than when the patient is seen.
  - Evaluation Method: Look in the Comments of the consult request. You will see that the appointment was made for a future date and the consult status is completed.
- Discontinuing/Cancelling consults for simple reasons, forcing the consult to go back and forth between the requester and specialist until the clinic has availability within 30 days.
  - Evaluation Method: Run the consult tracking report to assess whether an unusually high percentage of consults are being discontinued or cancelled. Services with poor access are more likely to use this method to decrease their demand. Also, randomly select discontinued/cancelled consults from the consult tracking report and examine them in CPRS to determine if they appear legitimate.
- Not linking the consult to a scheduled appointment. If the patient no-shows or cancels, it would have to be manually recorded on the consult to make it active again. If it were attached, the consult would automatically return to an "active status for no-shows or cancellations and show as incomplete. Thus, not linking the consult properly will falsely improve your compliance with the timeliness of acting on a consult.
  - Evaluation Method: Use the Completion Time Statistics ([GMRC COMPLETION STATISTICS]) report. This will show how many appointments are not linked to a consult.
- Cancelling and re-establishing consults on the day of the appointment. This practice effectively makes it appear that there are no outstanding consults and no waiting times for consults to be "acted on."
  - Evaluation Method: Run the consult tracking report and randomly select consults to review. Verify in CPRS that consults weren't being cancelled and re-established, as above. Auditors can also verify that

the requesting physician of the consult did not belong to the service receiving the consult.

- Consults are not "acted on" within 7 days, which delays the start of the wait time measure. Sites should develop a process to monitor this.
  - Evaluation Method: Run the VSSC New and Established Wait Time report. This will tell you the number of days between the consult request date and the appointment creation date.
  - Below is a Fileman Template for Action on a Consult, developed in VISN 12, that can help sites monitor this:

```
SORT TEMPLATE:
OUTPUT FROM WHAT FILE: REQUEST/CONSULTATION//
SORT BY: FILE ENTRY DATE// @'DATE OF REQUEST
START WITH DATE OF REQUEST: FIRST// T-7  (MAR 25, 2008)
GO TO DATE OF REQUEST: LAST// T  (APR 01, 2008)
WITHIN DATE OF REQUEST, SORT BY: (CPRS STATUS["ACTIVE")!(CPRS STATUS["PENDING")
WITHIN (CPRS STATUS["ACTIVE")!(CPRS STATUS["PENDNING"), SORT BY: TO SERVICE:
REQUEST SERVICES FIELD: ASSOCIATED STOP CODE    (multiple)
ASSOCIATED STOP CODE SUB-FIELD: ASSOCIATED STOP CODE:
CLINIC STOP FIELD: @AMIS REPORTING STOP CODE
    START WITH AMIS REPORTING STOP CODE: FIRST// 303
    GO TO AMIS REPORTING STOP CODE: LAST// 303
WITHIN AMIS REPORTING STOP CODE, SORT BY:
STORE IN 'SORT' TEMPLATE:    DE CONSULTS NOT ACTED ON
                              (Apr 01, 2008@07:47) User #673 File #123   SORT OUTPUT
FROM WHAT FILE:
SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE OF REQUEST'? NO// YES

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'AMIS REPORTING STOP CODE'?
NO// YES

PRINT TEMPLATE:
FIRST PRINT FIELD: PATIENT NAME;L25
THEN PRINT FIELD: TO SERVICE;L20
THEN PRINT FIELD: DATE OF REQUEST;L20
THEN PRINT FIELD: CPRS STATUS
THEN PRINT FIELD: TO SERVICE://
  THEN PRINT REQUEST SERVICES FIELD: ASSOCIATED STOP CODE


OUTPUT:

PATIENT NAME              TO SERVICE            DATE OF REQUEST        CPRS STATUS
ASSOCIATED STOP CODE
-----------------------------------------------------------------------------------
--------------------------


TEST     TEST            ECHOCARDIOGRAM - IRO        MAR 17,2008  12:12    PENDING
CARDIOLOGY
TEST     TEST            ECHOCARDIOGRAM - IRO        MAR 17,2008  14:34    PENDING
CARDIOLOGY
```

- Not scheduling consults for Established patients within 30 days. Sites may schedule only New patients within 30 days, even if the Established patient is presenting with a new problem. This practice provides untimely care to Established patients simply because they have been seen within the past 2 years.
  - Evaluation Method:

- Search consults for Established patients and lookup the appointment information in Appointment Management. Verify that the Desired Date was not entered for a date into the future. If so, the service is not providing timely care to these Established patients with new problems.
- The VSSC New and Established Wait Time Report will give you a list of established patients that have a consult linked to the appointment. You will need real SSN access to drill down to patient names.

9

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

Chairman Sanders and Ranking Member Burr, thank you for this opportunity and the dedicated work of the Veterans' Affairs Committee. I enjoy serving with you both and all the Members of this Committee, and I look forward to reviewing the testimony from today's hearing with Secretary Shinseki on the state of VA health care. Regretfully, I am unable to attend, as I am in Arkansas, recovering from a recent surgery. I appreciate Secretary Shinseki's willingness to come before our committee and address our questions and deep concerns so we are able to move forward and better serve our veterans.

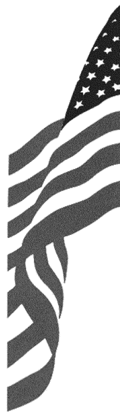
Last week I sent a letter to Secretary Shinseki expressing my disappointment regarding recent allegations of "secret" wait lists and preventable veteran deaths. I have asked Secretary Shinseki for assurances that none of these deplorable practices are happening at VA medical centers (VAMCs) used by Arkansas veterans, and have yet to receive an acknowledgement that he even received my letter. I anxiously await its arrival, and a response.

I understand that in most respects VA does provide good care, when and where it is actually available. Additionally, I know that employees in various roles at VA, like me, strongly support those who have served our Nation in uniform and believe the Federal Government should uphold all of its promises to our veterans and extend the best timely care to them. However, as recent reports indicate, this is not happening. This is a clear access problem, and warrants a full analysis of the future of VA health care as part of our effort at solving immediate problems. I have reservations about the ability of VA's "face to face" audits to produce meaningful reform that will increase access for veterans and bring accountability to the process. I am supportive of rigorous oversight by this Committee and I look forward to working with all of my colleagues on both the House and Senate Veterans' Committees, in consultation with the Department of Veterans Affairs, to ensure that these systemic problems are fixed.

In conclusion, we need to be thoughtful about our responsibilities and cautious about our steps forward in regard to these very important issues. As always, I appreciate opportunities to work together and I will be reviewing the testimony and the record of today's hearing to begin that process.

LETTER FROM DIANE M. ZUMATTO, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

15 May 2014



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The Honorable Bernie Sanders, Chairman
Senate Committee on Veterans' Affairs
332 Dirksen Senate Office Building
Washington, DC 20510-4503

Dear Chairman Sanders:

As you know, the cost of war has always been extremely high and those forced to carry the major burden of that cost have been the men and women who have served in our Armed Forces. Unfortunately, the true cost of war isn't known until years after the cessation of hostilities; however, it is safe to say that, veteran healthcare is perhaps the highest cost of war.

Looking back historically, it was the realization that those who serve their country in the military, especially during times of armed combat, have medical needs that differ from their civilian counterparts, which originally led to the development of the VA healthcare system.

Unfortunately, the current spate of problems within the VA healthcare system are neither new nor unusual. At the end of WWI, when congress held a series of hearings to determine why VA hospitals couldn't adequately meet the needs of our veterans, it was determined that, at the time, the VA hospital system was a nightmare of red tape, inefficiency and neglect. The point here is that, from its inception, the VA healthcare system has been plagued by difficulties.

What is needed now is a complete culture change, top to bottom. This is not a problem/situation that is going to be fixed by merely appointing a new chief or chiefs; drastic changes will be needed at each and every level of the organization.

Now is the time to change the way we deal with problems within the VA, because one could almost compare the VA to the mythical hydra – an isolated problem arises and we either throw money at it or chop it off, but before we know it, 3 more problems pop up to take its place. It's been said that the definition of insanity is doing

the same things, the same way and expecting a different outcome and yet this is historically how the VA has been operated.

It's time for the positives of the VA healthcare system to move into the limelight because there's been enough damaging media coverage and comments made during the recent hearing. Rather than complaining, AMVETS will be focused on developing positive recommendations for beneficial changes to the VA healthcare system over the next several weeks and will readily share that information with your committee when it is available.

In the meantime, AMVETS supports the suggestions already outlined in the FY 2015 Independent Budget as well as the following, for immediate deployment:

- double the patient load of all VA primary care physicians;
- tie future funding to the successful collaboration of federal agencies;
- raise the bar for all hospital administrators;
- identify best practices within both VA and civilian healthcare systems and put them into practice;
- enter into an open and on-going dialogue with all VA healthcare stakeholders;
- close the funding gap between the administration and the Independent Budget;
- appropriate funds for all authorized VA projects;
- allow veterans to make use of existing Community Health clinics to cut wait times.

Working together, we can eliminate the problems within the VA healthcare system.

Sincerely,

National Legislative Director
AMVETS
301-683-401
dzumatto@amvets.org

cc: Senator Richard Burr, Ranking Member, SVAC

LETTER FROM RONALD E. BROWN, PRESIDENT, NATIONAL GULF WAR RESOURCE CENTER

NATIONAL GULF WAR RESOURCE CENTER,
Topeka, KS, October 10, 2014.

Hon. BERNARD SANDERS,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR CHAIRMAN SANDERS: My name is Ronald Brown, and I am president of the National Gulf War Resource Center (NGWRC). I would like to submit testimony concerning issues our Gulf War Veterans from Operations Desert Shield/Storm (ODS) face daily at the Department of Veterans Affairs hospitals.

Numerous ODS Veterans experience long waits to see doctors—particularly specialists—and have a hard time receiving compensation benefits. In general, they don't receive proper medical care compared with other groups of veterans. Many ODS Veterans have been fighting for 23 years for benefits they earned from the honorable service they provided. Due to this honorable service, many are sick from exposures experienced on the most toxic battlefield in our Nation's history of warfare. NGWRC sent surveys to Veterans concerning their VA hospitals, and they responded to us that the issues exist and happen to Gulf War Veterans across the country. NGWRC wants to address problems and bring solutions to fix issues, ensuring that our veterans' health care is the best in the world.

In January 2014, NGWRC suggested solutions to the VA during a meeting with Principal Deputy Under Secretary for Health, Dr. Robert L. Jesse. If implemented, these solutions—derived from surveys from our Veterans—would help them at VA hospitals across the country. Issues these Veterans brought forward were:

1. Primary Care Providers (PCP) must be better trained on illnesses due to toxic exposures during Desert Storm. Many PCP doctors are not properly trained to provide care Veterans need for illnesses they suffer from due to environmental exposures. Many ODS Veterans feel their PCP does not believe them when they tell medical professionals their problems, yet science shows that Gulf War Illness is a physiological condition and not a psychological issue. Many Veterans, however, are still treated like it is a psychological issue. An ill Veteran should not have to educate the PCP on research that has been done on Gulf War Illness. This type of treatment must change, and the NGWRC must work with the VA to help our Veterans.
2. Veterans face long wait times for PCP visits and specialist, sometimes 6 months or longer. In our surveys, one Veteran responded that for clinics such as the sleep study, he encountered an 8-month backlog. Other veterans reported waits of 6 month or longer to referred specialty clinics like Rheumatologist for Fibromyalgia or Chronic Fatigue Syndrome. Some of these veterans were told they would not be seen in such clinics due to a current backlog. They were also told that they would have to pay out of pocket to have care provided for service connected illnesses. Accountability needs to be established at the upper levels of the Central Office of the VA and at the lower levels within our VA hospitals. It is deplorable that bonuses are issued for stellar care when it is far from stellar. Chronically ill Veterans should never have to wait months to get into specialty clinics or PCP follow-up visits.
3. Sadly, many claims have been denied for years due to medical professionals who are not properly trained to treat illnesses from which many Veterans suffer. Many Veterans feel they have been left to die, which is unacceptable. These Veterans are your constituents, and their voices deserve to be heard. Most of our chronically ill Desert Storm veterans have been voicing their concerns for two decades to the VA. They find their voices fall on deaf ears. How much science must show that these veterans are suffering with real illnesses before they are taken seriously? How many Veterans must die from cancer? What is the acceptable number of deaths before these cancers can be made presumptive to their service?

In conclusion, we are aware of the burden our VA health care system has on it. That will most likely get worse before it gets better, with the current war in Afghanistan winding down. There will be an influx of Veterans coming into an already overcrowded, understaffed, and underfunded health care system. The NGWRC feels that steps must be taken to relieve some of the burden on our VA health care system. This includes allowing Veterans to access care outside the VA with care paid by the VA. Another possible solution is stopping Veterans with no service connected disabilities who have private insurance from accessing VA hospital care. Most of

these veterans have jobs and private insurance, so they can go to outside doctors for care. Something must be done to fix issues with the VA to ensure veterans get proper care and services. Our expertise, obviously, is on the conditions suffered by Gulf War veterans and evolving treatments. The NGWRC is willing to work with anyone to come up with viable solutions to fix these issues.

Respectfully,

RONALD E. BROWN,
President.