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EXAMINING THE EFFECTIVENESS OF THE OFFICE OF INTEGRATED VETERAN CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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JUNE 21, 2023

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EXAMINING THE EFFECTIVENESS OF THE OFFICE OF INTEGRATED VETERAN CARE

WEDNESDAY, JUNE 21, 2023

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

The Committee met, pursuant to notice, at 3:30 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Brown, Blumenthal, Sinema, Hassan, Moran, Boozman, Cassidy, Tillis, Sullivan, and Blackburn.

OPENING STATEMENT OF CHAIRMAN JON TESTER

Chairman TESTER. I am going to call this hearing to order. Senator Moran will be here shortly. I know he has got conflicts. As we do with almost every one of these meetings, we have people who have conflicts with other meetings. We will apologize ahead of time. It is always a busy time, and this is no exception.

As we begin today's conversation on the "Effectiveness of the Office of Integrated Veteran Care," our focus is a simple one, ensuring veterans receive the top-notch care they deserve and have earned, whether in the VA or in the private sector.

As the largest integrated healthcare system in the country, VHA provided more than 115 million clinical encounters to more than 6.3 million veterans last year. That included 31 million telehealth appointments, 40 million in-person appointments, 38 million community care appointments.

Let me say that one more time: 31 million telehealth appointments, 40 million in-person appointments at VA facilities, and 38 million community care appointments.

Are there often problems accessing care, particularly in rural America? Well, the answer to that is yes. When that happens, we hear from constituents, we hear from VSOs, and we often rely upon entities like the VA Office of Inspector General and the Government Accountability Office to tell us what is going wrong and how we fix it.

Recently, a nationwide Medicare survey of patients showed VA outperformed non-VA hospitals on all 10 core patient satisfaction metrics. Those included overall hospital rating, communication with doctors, communication about medication, and willingness to recommend the hospital to another.

Study after study, including findings recently published in the Journal of General Internal Medicine, shows VA health care is as

good as, or superior to, what folks get outside the VA and veterans typically like their VA care more than their non-veteran counterparts like in the private sector.

But when veterans cannot be seen by the VA in a timely manner or they have to drive too far for the VA services, they need to be quickly connected with community care. Despite what some believe, the simple act of routing more veterans into community care is not the sole solution. The challenges of accessing care, particularly in rural and frontier America, are not specific to the VA. Communities in a state like Montana know that all too well.

And as I said at last week's hearing, improving access to care for rural veterans by purchasing care from the community may have a limited effect, especially in rural areas that are already underserved. You cannot buy it if it is not there.

So when veterans are sent into the community for care, VA certainly has room for improvement. There is no doubt about that. The Department must streamline its internal process for referrals so veterans receive faster access to care. That starts with establishing clear requirements for how long it should take for a veteran's appointment to be scheduled.

And the VA also must place special emphasis on hiring non-clinical support staff. VA cannot schedule if it does not have the medical support assistants it needs to facilitate those appointments. This is not news to any of you.

VA and community providers must be able to more easily share information about a veteran's health care so the VA can better coordinate services and make sure nothing is slipping through the crack. Why? Because we can outsource the care, but we cannot outsource the responsibility.

And to do that, the VA must adopt national interoperability standards for the electronic transfer of health information between the VA and community care providers. The Department must also reduce red tape in the community care program. When a patient and a provider jointly determine where the veteran should be best served, that decision needs to be final and not go through any extra layers of scrutiny.

Moving forward, I look forward to hearing other recommendations as to how to improve community care because the veterans deserve programs that work and that work for them. That is why in the coming weeks I will be introducing the Making Community Care Work for Veterans Act of 2023. This is meant to improve the program Congress put into place five years ago. That bill will include the provisions that I have discussed this afternoon, among others.

In the meantime, we have to keep working to bolster VA's internal capacity to provide care to veterans through the CAREERS Act and to give the VA the tools it needs to speed up the delivery of VA facilities through the BUILD Act. We have got to address the underlying causes of veterans opting for community care, and we cannot do that by focusing on community care alone.

With that, I am going to introduce the panel. And by the way, when the Ranking Member gets here, Senator Moran, if one of you are done speaking, I will ask if he wants to do his opening statement. You know, it is going to be a little bit flexible here.

I want to welcome Under Secretary for Health, the Honorable Shereef Elnahal. Dr. Elnahal is joined by the number one and number two from the Office of Integrated Veteran Care, Dr. Miguel LaPuz and Hillary Peabody. I want to welcome all of you to the Senate Veterans' Affairs Committee.

Dr. Elnahal, you have the floor.

STATEMENT OF HON. SHEREEF M. ELNAHAL ACCOMPANIED BY MIGUEL H. LAPUZ AND HILLARY P. PEABODY

Dr. ELNAHAL. Thank you, Chairman Tester. I want to thank Ranking Member Moran as well and members of the Committee. Thank you for inviting us here today to discuss how VA is ensuring veterans have access to the best care in a timely manner, as they have earned.

I am accompanied by Dr. LaPuz, Assistant Under Secretary for Health for the Office of Integrated Veteran Care, and Ms. Hillary Peabody, Deputy Assistant Under Secretary for Health for Integrated Veteran Care. We appreciate the opportunity to discuss the efforts IVC is leading to empower facilities to meet the challenges that Secretary McDonough set for this year, to provide more care and more benefits to more veterans than ever before.

Meeting the increased demand for veterans in our system and fully implementing the PACT Act requires us to build capacity and improve access to care, whether that be through VA care or in the community. To ensure we are meeting veterans' needs for timely care, VA established measurable goals for all facilities based on feedback from veterans. These goals represent the most important areas we need to focus on systemwide. We refer to these as our North Star metrics, and they include direct care, wait times from the date of request for new patients, time to schedule community care appointments, and veteran satisfaction with the timeliness of care. VA has taken several steps toward improving these metrics.

The most important way for us to build capacity is through hiring faster and more competitively. We set a goal of hiring 52,000 new employees this year, including 30,000 positions in the occupations most needed to ensure access to high quality care: physicians, nurses, practical nurses, nursing assistants, medical support assistants, environmental service technicians, and food service workers.

We have made significant progress on hiring, and with our concurrent progress on employee retention, we have already exceeded our goal for the year in increasing the total number of employees on board and we are still on track to meet our goal for external hires.

Additionally, we are leading an effort aimed at optimizing the time our clinicians spend caring for veterans by implementing standards for bookable hours and appointment links. The bookable hour initiative will ensure clinicians are available for veteran care for 80 percent of their designated clinical time. Implementing this represents an opportunity to improve veterans' access to care and will ensure a more equitable workload across providers.

Finally, we are leveraging every new modality we have to reach veterans with timely care. We continue to use telehealth, including VA Health Connect, our national network of call centers. Each year, VA Health Connect supports approximately 45 million calls,

serving as a virtual front door for veterans into VA. Through VA Health Connect, veterans can call 24–7 to talk to a nurse about a health concern, a medical support assistant to help with scheduling an appointment, a pharmacist to reorder a prescription when needed, and if needed, to meet a provider with a video appointment.

So how are we doing? Already, we have seen progress in the North Star metrics from quarter one to quarter two of this fiscal year. Wait times for primary care for new patients improved in nearly 60 percent of our facilities. Further, more than half of our facilities met our first quarter goal for reducing wait times for primary care and 40 percent reached the same goal for mental health appointments.

Primary care wait times are very important as we continue to implement the PACT Act because these appointments serve as the critical front door and coordinator for VA care, and importantly, we have seen these reductions in wait times even in the context of significant growth in the volume of new patient appointments. We provided 9.2 percent more of these appointments to veterans in our latest quarter of measurement.

We are also making progress on community care scheduling. While the number of appointments scheduled across all these services in the community also increased, most sites still saw improvements in the time to schedule those appointments. But we do have a lot more work to do there, as you mentioned, Chairman.

Candidly, we have seen fewer improvements in specialty care within our direct care system where salary constraints continue to make it difficult to recruit providers. I want to thank you, Chairman, as well as Senator Boozman, for introducing the VA CAREERS Act. This bill would eliminate the $400,000 cap on physician salaries and allow us to provide the market-based pay we need to compete for specialty providers in any market.

And here is what we are doing next to further improve performance on the North Star metrics. We currently have three efforts underway to improve scheduling: enhancements to our internal scheduling system to allow schedulers better visibility into appointments, piloting of new technology to improve visibility into community providers' schedules, and the expansion of veteran self-scheduling.

Veteran self-scheduling has already shown promise in reducing the time to schedule appointments in the community in our Bedford Medical Center, for example. One veteran in Bedford, who was referred to a community dental care appointment, explained to us that self-scheduling was the best option for him because he would often miss calls from community providers when he did not recognize the number. By simply providing this veteran with an authorization and the right number to call, VA empowered him to contact the provider on his schedule, which allowed him to secure his appointment in just two days.

Work is well underway in our Community Care Network next generation contracts, where we are incorporating important lessons learned to best ensure that our community providers are providing timely and high quality care that veterans have earned.

Chairman Tester, Ranking Member Moran, thank you again for the opportunity to appear before you today and for your continued support. We look forward to your questions.

[The prepared statement of Dr. Elnahal appears on page 27 of the Appendix.]

Chairman TESTER. I will now turn to Senator Moran for his opening statement.

OPENING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. Mr. Chairman, thank you. The Chairman has been kind enough to—we are working on cooperating with my new committee assignment, which is the Senate Committee on Intelligence that meets every Tuesday and Wednesday afternoons at 2:30, and after we had our schedule already determined what we were going to do here. So I apologize for my tardiness and pleased to be here.

I only heard, Dr. Elnahal, about the good news. As you would expect, I have continued concerns about the capabilities and the support for community care, and mostly what I know is what veterans tell me as they experience the opportunities and disappointments that occur, both at the VA.

We are also mostly here, I suppose, to review and see where the IVC is. It is a new office, combining previously two separate offices. The intent in combining those offices into a single entity was to streamline the efforts to improve access to both settings and make it easier for veterans to get the care they need. I do not see the evidence that that has been the case, but I am happy to hear the testimony that reassures me that it is.

A couple of stories that I would tell just as you were telling yours as I came in the door. A veteran who lives here in the Washington, DC, area has conveyed to me, to my staff, despite being a long-term patient at a VA medical center here, he decided to request a primary care appointment for the first time in a little over two years. He was categorized, he did not know why, as a new patient of the VA. When he tried to make an appointment a couple of months ago, he was told that it would be 30 days before he would get a primary care appointment. He did not think that was right.

He thought he was entitled to seek the option of community care, but when he asked the scheduler about community care, the scheduler quoted him access standard information that when shared with us was clearly not the right information, not the right standard. At one point, he was told he needed to see a VA primary care provider to make a referral to community care.

Eventually, the same scheduler told him that, well, if he would call back the next day, she or he could offer him an appointment in just two weeks to a different provider. It seems that there is—it is reported that there is a local policy in place that directs schedulers only to look at the availability of certain providers instead of the availability of all providers for possible appointments.

Closer to home, in Wichita, about a year ago, this veteran started to experience severe pain that was so bad he stopped eating and sleeping and could barely use the facilities. He contacted a VA doctor who advised that he should try Tylenol.

Tylenol was not the cure. He went back to the VA and asked over and over again for help, with repeated requests that the VA order tests and scans and eventually a biopsy, but it took months for those appointments to occur, months in which that veteran continued to have debilitating pain that had nothing to do with being solved by Tylenol. He kept asking the VA to work faster, to get him in sooner, but nothing like that happened.

Unlike this first veteran, he did not know about VA policies, was not familiar with the MISSION Act. He did not know that community care was something that he could ask for, little less know that he was entitled to. The VA referred him to the community for certain tests that his VA medical center could not perform in-house but never once offered him the option of seeing if a community care provider could get him the care he needed quicker.

A few days before Christmas, this veteran was finally biopsied with—finally got the biopsy he had been waiting for, diagnosed with prostate cancer. At that point, the cancer had spread to several other parts of his body. Fortunately, the veteran is doing okay today. He is in treatment that appears to be working, and his spirits are high. He has good things to say about his VA doctors and thinks that they were just as frustrated as he was about how long it took him during this wait time.

He describes the experience—and this sounds so much like veterans that I know. He just describes the VA care as an obstacle course that was extremely difficult to get through. He said that because it took the VA so long to get the care he needed, and he said that cancer got ahead of him. He will never get the months back and know whether his prognosis would be better if the cancer had been discovered sooner.

I understand these are just two stories, but they are stories that I hear, and I would assume others hear, on a frequent basis. And so I am in my continual mission of trying to utilize the MISSION Act in a way that it was intended, to see that those veterans who need faster care, specialized care, care related to the distance in which they would have to travel is available and available in a way that there are fewer barriers and less frustrations and less delays.

I do know that there are instances as you were describing, in which the VA in-house performs wonderful services and many veterans in Kansas, if not most, find the VA care very satisfactory and appropriate. I still am looking for the way to make sure that those who have a better option have no impediments toward getting that care, and I look forward to the conversations that tell me how the IVC is helping accomplish that.

Chairman TESTER. Thank you for your opening statement, Senator Moran.

Recently, Medicare did a nationwide survey of patients. VA hospitals, by their survey, outperformed non-VA hospitals on all 10 core patient satisfaction metrics. This is good news for you. Congratulations. The fact that VA is performing well above the average on metrics regarding patient-doctor communication and care transition is really a testament to your hard work and, more importantly, the hard work of the folks who serve under you, the hardworking employees.

So, Dr. Elnahal, what do you attribute VA's above average performance on that Medicare survey?

Dr. ELNAHAL. Well, thank you, Chairman, for the question. I think you alluded to this in your question, that the most important reason I believe that veteran satisfaction far exceeds the private sector on average in our system is because of our people. Our people are squarely dedicated to the mission. A third of our employees are veterans themselves, so many more have a veteran in their lives, and take the mission personally.

And so a lot of the questions on that standard survey issued to every hospital have to do with the respect that we offer patients in our medical institutions, responsiveness of hospital staff, the cleanliness of the environment, the quietness of the environment. All these are things that our employees pay attention to very closely because they know that every single veteran's experience matters.

We are not there where we need to be on every facility. Seventy-two percent of our facilities are four or five stars compared to about 48 percent in the private sector, which is great, but we will not rest until 100 percent of our facilities are doing that because every veteran, no matter where they live, deserves that superior treatment.

Chairman TESTER. Internal patient satisfaction surveys reaffirm that VA services are top-notch. One metric in particular from this survey stood out to me: 93 percent of veterans surveyed stated that they have total trust in their VA facility to take care of their primary health care needs. That is something that cannot always be said for the folks receiving care at other facilities in the private sector.

So, Dr. Elnahal, which metrics from this survey do you look at and say, this is a good indicator that the Department is meeting the needs of our veterans?

Dr. ELNAHAL. So I think first is the overall hospital rating. It is a summative assessment of what veterans tell us their overall experience was. That is a very important metric to look at.

And I think the next most important one is the willingness to recommend the hospital to other veterans. I often say that nobody cares more about veterans than other veterans, and that seal of approval for so many of our facilities really means a lot to us.

So those are the two most important I would say.

Chairman TESTER. So you have a VA integrated care model within the VA, or I should say you have an integrated care model within the VA, not to be repetitive. How does that impact the results from a positive standpoint?

Dr. ELNAHAL. I think that is the entire reason for the change we made to the way we organize ourselves here centrally. The fact is any veteran may need care in the community and may need care within our system, and if we take a holistic look at what is best for every single veteran who walks in the door, those processes should be coordinated. Veterans should not have to be ping-ponged back and forth from different departments.

The two veterans' stories that Senator Moran mentioned could be examples of that. I think hearing those stories are not only important but necessary for us to make the right improvements.

And what I can tell you is how this is working at our facilities so far is much better than our systemwide coordination of that integration. We still have some work to do on ensuring consistency of our processes, but I can tell you that excellence is really happening in a lot of our facilities and we are proud of it.

Chairman TESTER. So that is the positive side of the ledger. Let me tell you about the complaints that I hear, and the complaint that I hear from veterans in Montana, and Senator Moran referred to this, it is the length of time for an appointment to be scheduled. I mean, that is truthfully it. I mean, that is it. I mean, they really cannot complain about not having access if access is not there, but it is the amount of time it takes.

So, Dr. Elnahal, or either one to your right or your left, walk us through the reasons that there are delays and what are you doing to fix that.

Dr. ELNAHAL. So I think the most important reason we see delays in scheduling care in the community is that we do not yet have standardized, streamlined processes implemented across the system. That is one of the most important charges I have asked Integrated Veteran Care to focus on, to ensure that consistency and oversight. I will ask Dr. LaPuz to fill in some details there in a second.

But I also think that many veterans have told us that they would rather just schedule the appointment themselves. That is how the care works for care that they get outside of the VA. Veterans feel empowered when you give them an authorization and you give them a community provider within our network. We have seen success on this in Bedford and in areas of VISN 19 as well. And so we want to expand that opportunity to more and more services over time, and I think if we do the evidence shows that we will reduce the time to schedule.

I will also say that that is why this is one of our three most important metrics that we are tracking across the system. The time to schedule community care appointments is being tracked in every medical center with expectations for improvement throughout the fiscal year.

If we have time, Dr. LaPuz?

Dr. LAPUZ. Yes, thank you very much, Senator, for that question. So the other thing, too, that we are improving is the technology that is available to schedule veterans in the community. So we have actually—we have a pilot in order to improve the efficiency of scheduling, and that pilot has shown to be beneficial. And that is the reason why now we are in the process of the acquisition in order for us to have the technology so then we can roll out the technology nationwide, and we expect that that is going to be happening probably before the end of the calendar year.

The second thing that we are doing is we are—as Dr. Elnahal said, that we are improving the processes apart from veteran self-scheduling, that we are going to be rolling out and making sure that all of the facilities are employing veteran self-scheduling.

The other thing, too, that we are doing is we are improving the utilization of what we call Consult Toolbox. This is a process to allow us to get the veteran's preference ahead of time so then we will be able to schedule the veterans much more smoothly.

And then, finally, we thank Congress for the assistance that Congress has provided us so then we can hire the necessary staff because that is the other thing that we are having problems, particularly in the rural communities. That is hiring staff to actually be doing the scheduling. So we truly appreciate the assistance of Congress.

Chairman TESTER. Okay, Senator Moran.

Senator Moran [presiding]. Well, Chairman, thank you. I appreciate what you said about length of time it takes. It is a significant problem. I recognize that the proposal to have veterans schedule themselves seems like, to me, perhaps a common-sense solution although we have invested a lot of effort at the VA getting schedulers and policies in place.

And I appreciate what Dr. LaPuz said about—he added the thing that I was going to add to what the Chairman said, as my words, not his, but getting veterans to know they have the opportunity. In fact, they are entitled to have care in the community.

And it seems to me there continues to be an unwillingness, a lack of information. I do not know what it is. A failure, we can say it that way, for the VA to tell veterans, well, here is an option.

I do not want to do anything that undercuts the importance of the VA healthcare delivery system in-house, and it is why—but we crafted the MISSION Act in a way that was designed to make certain that the VA did not have a restricted gatekeeping role in providing care to the community.

And I have a mission myself of trying to make sure that that is still the opportunity for veterans who make the choice. If it is in their best interest, the criteria are met, that they have that access.

So I would add to the Chairman's comments about the length of time it takes to get an appointment that also the confusion or lack of information that comes with both the person scheduling and the veteran who often does not know what the rules are.

And it is often the case in my experience that what I learned from you, Dr. Elnahal, or anyone else in the VA leadership, this is our policy. It is not what the people in the VISN, in the local hospital know to be the policy. You said this earlier. I am just trying to confirm that what you said is still true. There is not a consistent application of the MISSION Act across the country and even across the VISN that I live in.

I would be glad to have your response. Mostly, I was just—that was my rant. That is the nature of—that is as bad as it gets.

Dr. ELNAHAL. Senator, I think you are correct in saying that we do not see at all times consistent application of these processes, and what is most important in all of this is affording veterans of all options that they are entitled to, including options under the MISSION Act for community care.

We articulate our priority on access by saying that veterans deserve the soonest and best care option available. Often, that is a VA care option. Often, it is a community care option. And veterans should be availed of that as we have discussed before.

I do want to give Dr. LaPuz a chance to talk about the oversight work that IVC is doing to make sure we get to a more consistent application of these standards over time. This is a very important effort that the Integrated Veteran Care Office is undertaking.

Dr. LaPuz?

Senator MORAN. Please do.

Dr. LAPUZ. Thank you, sir. We are aware, we are cognizant of the OIG findings that there is inconsistent application of policies that are happening in the field and that there is lack of awareness, like what you have said. And so what we are doing now is we are, first of all, reeducating and training all of the VISNs regarding our policies. So we are also reviewing our policies to ensure that the policies that we have are easily implementable.

The second thing that we are doing is we are actually coming up with guidelines and checklists so then we can share those so then every policy will have a corresponding guideline and checklist that we share to the facilities and to the VISNs. So then the VISNs can actually do their oversight over the facilities, and we can actually partner with the VISNs to ensure that those oversight visits are being done.

And then we are—finally, we are monitoring all of the oversight activities that are happening to ensure that again there is a consistent application of the policies and guidance that we have put out so then there is really a singular veteran experience.

Senator MORAN. I appreciate that answer. Let me tell you about a hearing we had last week in this Committee. The topic was substance use disorder. Suicide and substance use are often linked, overdose deaths have increased, and there is a nationwide fentanyl crisis.

I am not telling you anything you do not know, but I am telling you about a hearing in which the testimony was the importance of timely connection in the circumstance of substance abuse and suicide prevention that there is no—there can be no delay in the contact between a provider and the veteran.

As I understand it, the VA does not hold inpatient or residential substance use services to the same access standards that the VA uses for other mental health and suicide prevention services. Those are minimum coverage insurance policies under the Affordable Care Act to have basic access—the policies have access to inpatient mental health and substance use treatment. Shouldn't that change, and the criteria, the standards be the same?

Dr. ELNAHAL. I think it should change, Senator, and in fact we have charged a group to look into exactly what the policy change should be for our timeliness standards, for residential treatment for mental health issues, to include substance use disorder, and that group is going to be coming out with recommendations very soon that we will share when they are ready.

But I will tell you that prioritizing access to this critical therapy in light of the epidemiologic trends you were just mentioning around substance use disorder and overdose deaths, we are seeing similar trends, unfortunately, in the veteran population. So timeliness of care for this service is extremely important. We will be addressing not only our timeliness standards for internal care but when and how we refer care to the community.

Senator MORAN. One of the reasons that CHOICE ultimately became MISSION, was enacted by Congress, signed by the President into law, was the lack of providers, adequate number of providers within the VA, and this clearly has to be an area in which that is

the case as there are not enough providers any place when we get to mental health and substance uses. And so it is again seemingly—it seems to me that it is one of the areas in which the MISSION Act has a significant role to play as we try to bring in all the available providers to meet this growing demand.

Thank you, Dr. Elnahal. You have offered to come to Kansas and spend time with me on numerous occasions, and I look forward to me—it is my court, not yours, and I look forward to being able to tell you, yes, I would love to do that.

Dr. ELNAHAL. Thanks, Senator. Appreciate that.

Senator MORAN. Senator Tillis.

SENATOR THOM TILLIS

Senator TILLIS. You looked around the table, hoping you could recognize somebody else.

Senator MORAN. Well, you know the bipartisan nature of this Committee. I was looking for the Democrat.

Senator TILLIS. Thank you all for being here and for the work you do on behalf of veterans. I got a couple of questions. I mentioned in last week's hearing about the Patient's Bill of Rights. I know that we spoke on veterans—or we have spoken with Veterans Affairs since then, but I just want to make sure people understand what I am trying to do here.

My motive is at a time when millions of dollars are being spent to advertise, those Camp Lejeune toxics ads, which the bill was supported by and in large part written by my office, looks like a great opportunity to get veterans connected that have never been connected to the VA before.

So my first question, let us say a veteran who is connected to the VA already sees one of those ads and decides to call 1–800–VA, and they say I want to file a claim for Camp Lejeune toxics. What script do they read off to that veteran?

Dr. ELNAHAL. So we have a one-stop shop, essentially, for any veteran interested in getting PACT Act benefits. They can call 1–800–MyVA411 or www.va.gov/pact. We, in fact, screen for toxic exposures to include contaminated water at Camp Lejeune during the affected period, and what happens after that is that it is a warm handoff to VBA after that screening, to be able to send that veteran a letter encouraging them to apply for additional benefits. So we encourage that no matter where the veteran is coming from, whether internal or external.

Senator TILLIS. What about the touch point that they have to make with the Department of Navy as a part of the registration for Camp Lejeune relief? Have you talked about that?

Dr. ELNAHAL. I believe, Senator, that the PACT Act does offer the opportunity to veterans to essentially sue the Federal Government for conditions related to the contaminated water——

Senator TILLIS. Yes.

Dr. ELNAHAL [continuing]. At Camp Lejeune.

Senator TILLIS. Well, what I am trying to get at is there are—the majority of suicides that occur every day are nonconnected veterans, not connected to the VA. We always talk about—we had a substance abuse discussion last week. Same thing, fair to assume

that a lot of the people that are succumbing to overdoses and dying are likely not connected.

And it just seemed to me to be a perfect time to get two things accomplished. Number one, let these veterans who are not connected know we want them connected to the VA and also let them know they may not have to spend a dime to get the benefits that they are entitled to if they call a congressional office or if they call a VSO.

And so we are trying to put a bill together. We want to get the technical aspects of it right, but we are just simply saying: Before you sign a retainer for an attorney who is going to take some of the benefits that you would otherwise be eligible, have you at least contacted your Senators? Have you contacted your Congressmen? Have you taken—have you contacted a VSO that is focusing on this?

Do they understand all the resources that we want to give them that will not cost them a dime that could remedy it. For complex situations, go get an attorney.

But I am just trying to figure out—it seems fairly simple. It does not cost a whole lot. Probably will not make trial lawyers very happy. But it puts us in a position while this subject—and it will be through next year or summer of next year. It is going to be running through the ads. It just looks like a great opportunity to engage more people, I mean.

Philosophically, do you see any holes in what we are trying to propose here?

Dr. ELNAHAL. Absolutely not, Senator. I completely agree with you that we think the best outcomes for veterans are more possible if a veteran files a claim for their exposure to contaminated water.

Senator TILLIS. I just want them fully informed. It amazes me how people thank me for doing my job in constituent service, and I want them to know that that is what I get paid to do here and that is one of the primary reasons that I am here. So we are going to continue to work with you all and hopefully get your support for the bill.

I am not going to have time to go through some other questions, but I do have one on wait times. I have also got—I always say I do not do constituent service here. I am going to break my rule.

I know that the Salisbury VA currently does not have CAT scan capabilities on premise. Is that a violation of VHA directive?

Dr. ELNAHAL. They should have CT scan operations online, and we did look into this issue. The medical center is understaffed in the CT imaging department right now, which is why at certain periods of the week they do have to refer to a community provider to get that imaging.

We really should have that imaging up 24–7. CT scan is a fairly basic imaging modality that should be available at all times for a lot of reasons. And so rest assured the facility is doing everything it can, especially with the new PACT Act hiring, retention, and salary authorities, to make those CT tech jobs more attractive, and we hope they will be able to staff up soon.

Senator TILLIS. Well, we are watching that. You know, that particular center is a big catch basin, so I think it is something that we will be tracking.

And, Chair, can I ask one other question?

Chairman TESTER [presiding]. You bet you can.

Senator TILLIS. Since you have no alternative.

Chairman TESTER. Unless Senator Boozman has a fuss.

Senator TILLIS. Oh, I forgot. Senator Boozman, I will be real quick.

On the wait times, I know that we are getting the high level numbers, but how granular can we get? Can I go to a VISN level? Can I go to a geographic area so that we are all drilling down at the atomic level for me to know where—I have not seen that. I have seen the high level numbers and the trending, but is that something that you all can just submit back for the record?

Dr. ELNAHAL. We can, Senator. You can also go to www.accesstocare.va.gov. All of that information is transparently available to the public, wait times by medical center, wait times by VISN, across multiple services, but we are happy to take——

Senator TILLIS. Does it drill down beyond VISN?

Dr. ELNAHAL. Absolutely, by medical center.

Senator TILLIS. Okay. Then we will do the homework there. Thank you all.

Chairman TESTER. Senator Tillis, I have not heard the word "granular" since we used to meet with Bob McDonald.

Senator TILLIS. I miss him.

Chairman TESTER. Senator Boozman.

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Okay. Thank you, Mr. Chairman. Thank you and Senator Moran for holding this hearing. Taking care of our veterans has always been, and still is, our highest priority. Access to quality care, especially in rural communities, is essential regardless if they receive the care at the VA or in the community, and we do appreciate you all's hard work in trying to make that happen.

Dr. Elnahal, I am interested in knowing what the average time is for a veteran to receive an appointment, what is being referred to Community Care Referral Coordination Team for scheduling.

Dr. ELNAHAL. So, Senator, where we started this fiscal year was an inexcusably long interval of time. It was an average of about 28 days to be able to—for the veteran to get their confirmed appointment, which is not excusable, and it is also why we have put the time to schedule as one of the three main metrics we are tracking across the system.

I want to ask my colleagues if they have the latest average for time to scheduling for the Senator. If not, we can take it for the record.

Dr. LAPUZ. Well, just to be accurate, we will take that for the record, but I would like to actually add to the response that in fact since we have started looking into this, you know, the average time to schedule, community care, what we have seen is an improvement by 60 percent of the facilities, by over 60 percent of the facilities. So from first quarter of this fiscal year to the second quarter, over 60 percent have improved in three categories. That is primary care, mental health, as well as in specialty. Specialty not so much,

but in primary care and mental health, we are showing around 60 percent of the facilities are improving.

Senator BOOZMAN. No, that is good. And again, I am not being critical yet and just really trying to understand. I know how difficult it is to schedule patients, you know, outside of the VA. Just within the community to other community members, it is difficult.

Do you break it down? If you have got somebody that maybe came in with really significant neurological conditions, somebody that you felt like, you know, was in a situation that really acutely needed care then, do you break it down how much time it takes to get to that specialist versus just kind of lumping it all together?

Dr. ELNAHAL. Absolutely, Senator. So if the referring provider classifies a consult as urgent, we have a standard for that veteran to be seen within two days, and thankfully, we are meeting that standard for urgent appointments.

Senator BOOZMAN. Good, very good. Veterans in a rural state, like my State of Arkansas, face unique challenges to care. I say, unique. You know, this is something that happens all over the country, but some of these challenges include lack of access to broadband and long driving distances to access quality of care.

According to the GAO, about one-third of veterans enrolled in the VHA live in rural areas. Additionally, GAO found that 17 percent of people living in rural areas lack broadband access. Given these challenges that rural veterans face to receiving care, can you speak to what the VA is doing to ensure rural veterans are receiving access to community care?

Dr. ELNAHAL. Absolutely, Senator. First, on your point with broadband, and I will pass the community care part of the answer to Ms. Peabody in a second. But we have a program with the FCC that actually does allow for support in the form of financial support for veterans to be able to get broadband, and we also do have a program that offers devices to veterans to be able to receive telehealth appointments. And there has been some significant uptake in that program, especially in rural areas.

I have also charged our Office of Rural Health to look into other options to potentially offer broadband within our current authority, and we will come back to you with ideas on that if we do not have the authority to do so.

Ms. Peabody?

Ms. PEABODY. Thanks for the question. Two things I would like to mention, Senator. One is our VA Health Connect, which Dr. Elnahal mentioned in his opening testimony. That is already taking about 45 million calls a year. That really serves as VA's front door. So we want to be able to expand some of those capabilities with VA Health Connect, expanding what we are doing in the several VISNs where it exists today so that a veteran just call.

We are looking at doing tele-emergency care through VA Health Connect as well. So I think that is one way that we should be able to reach more rural veterans.

With respect to our community care program, we are currently in the thick of some pretty heavy market research for our community care next gen contract, and so one of the things we are looking at is getting some industry feedback on how we can do that better,

what are some unique industry ways we can do that in rural areas. Thank you.

Senator BOOZMAN. Can I ask one more question, Mr. Chairman?

Chairman TESTER. You bet.

Senator BOOZMAN. What is your biggest obstacle? You are in situations where people need to get into the community for various reasons. You know, you do not have the ability to take care of them. What is your biggest hindrance to that?

I said earlier I understand. You know, I was a former provider. I understand how difficult it is and referral patterns are anyway. Is it that? Is it lack of access to specialists, or is it are we not paying enough? Is that a factor where perhaps providers are limited their access to VA care that way?

What is the biggest handicap that you have as far as getting people in the hands of these folks?

Dr. ELNAHAL. So candidly, Senator, I think the biggest bottleneck now is our scheduling process. I takes much too long. It requires our currently, in many places, understaffed offices of community care throughout the field to go back and forth between community providers and veterans themselves.

I mentioned an example in my opening about a veteran out of Bedford who was able to schedule his own appointment in two days because at that medical center they have veteran self-scheduling across all of their community provider appointments. Because the veteran knows their own schedule, give them an authorization and providers within our network; they can do it themselves, which is another reason—which is the major reason why we are doing self-scheduling across more and more specialties, to include optometry, by the way, your field. And so as we continue to try to increase that option, we hope to see that process get better.

Senator BOOZMAN. So your schedulers do not seem to have that much flexibility. Is that correct? I mean, is it more rigid than in private practice?

Dr. ELNAHAL. I think they are understaffed. That is one of the major issues. The workload is significant. And I also think the systems that they are using are not meeting the needs for an efficient workflow, which is why Dr. LaPuz highlighted earlier our acquisition effort for a community care scheduling system whereby we can work directly with our community providers, see directly into their grid should they agree, and make that process a lot easier.

Senator BOOZMAN. Good. That is helpful. Thank you all very much.

Thank you, Mr. Chairman.

Chairman TESTER. Just a quick follow-up, I think Senator Blackburn is going to be coming in, in a second. So we have had many hearings on electronic health records. Does the electronic health record potentially fix the scheduling issue?

Dr. ELNAHAL. It——

Chairman TESTER. As a community care component.

Dr. ELNAHAL. It does not in and of itself, Senator. So we are actually in the market for a scheduling system that would meet the need for community provider scheduling.

We do have the option to use that scheduling module. It is in use in one place, in Columbus VA, and it is part of a number of things

that we are going to try to improve across the five sites during the reset period for the electronic health record. But that is not the system we have committed to using because, you know, again a lot of these improvements need to be made.

Chairman TESTER. Okay, Senator Sullivan.

SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman, and appreciate the witnesses here today. I have kind of a really important issue and have kind of been here before, but we really need your help on it, and it is with regard to call centers.

So when I first got elected in 2015, I think it was the MISSION Act; they had removed the local call centers that were based in Alaska I think down to Louisiana or something. So we had the VA call centers that were really good and effective in Alaska, and then they were moved, and then you had people in the lower 48 who were making appointments for veterans based in Alaska who had no idea about Alaska.

You know, it is a very big state, and you would have—let me give you one example. You would have someone from Ketchikan, and they would call, and these guys would say, oh, you can just drive to Anchorage. Well, you cannot drive to Anchorage from Ketchikan, right? So it was this basic stuff, and it really in many ways collapsed the system.

So the new incoming Under Secretary, Dr. Shulkin, who later became Secretary, he came up to Alaska, saw this chaos, and committed to me to fixing it, which he did, brought the call centers back.

Well, we are having the same problem again. As you probably know, VISN-level call centers are to ensure a consistent experience for veterans. Alaska is part of VISN 20, which includes Washington, Oregon, and West Idaho, which of course, would make it the biggest region by far. And we once again have call centers that have been moved out of the state, and so the number of veterans—so we have nobody who understands the geography just making the basic appointments.

And so I am trying to get you guys to commit to supporting a new VISN call center—this is kind of going back to 2015—that would be based in Alaska to support the consistent experience for veterans, which is what you testified to. It just makes sense.

The number one issue I am hearing from our veterans right now is this issue, call centers. They do not understand that the wait times are long again, but—the VA does a great job in my state when they are local, but when they are outsourced to other places—you know. I mean, it is not their fault really, but they just do not understand the geography and what it takes.

So you know, we do not have a full-service hospital, the VA, in the whole State of Alaska. We have more vets per capita than any state in the country.

I am just hopeful that you guys can bring back call centers to have better service, so I would like to get your view on this. I have raised it with the Secretary. I think he is amenable, but this would give—again, to your testimony, it would ensure a consistent experience for veterans regardless of where they live.

Dr. ELNAHAL. I am also amenable, Senator, and I appreciate you making me aware of those concerns for your constituents. This may have been a function of the transition to VA Health Connect, which is the centralized VISN-level call centers——

Senator SULLIVAN. It was.

Dr. ELNAHAL [continuing]. As you were mentioning. And so I understand that Alaska is a unique environment. I do hope to visit at some point.

Senator SULLIVAN. Yes, we would love to have you out.

Dr. ELNAHAL. Perhaps, I can travel——

Senator SULLIVAN. This summer.

Dr. ELNAHAL. Yes.

Senator SULLIVAN. When the salmon are running.

Dr. ELNAHAL. But absolutely something we have to look into because we need to serve vets in Alaska to the best extent we can.

Senator SULLIVAN. Okay. And again, I appreciate the commitment. My staff and I will work with all of you. It is just déjà vu all over again. It got fixed last time by Dr. Shulkin, and we are in the same spot, and we are hearing the same challenges. And so if we can work with all of you on dealing with this issue for community care, especially care, it would be really helpful.

So, thank you for that approach. I think the Secretary is, like I said, amenable. And we all share the same goal, which is getting our vets the care they have earned, and this is an important way to do it in my state. Thank you.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Blackburn.

SENATOR MARSHA BLACKBURN

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you all for coming in. Let me give you an example of some of the problems Tennesseans are having with implementation on community care, which is something they really want.

And I had one veteran from Chattanooga, recently was giving me her story of trying to get community care for mental health services, and she was telling me how frustrating this was. And she likened it to going to the DMV and having a really bad experience and having to jump through all the hoops that were there. And finally, after meeting everything the VA made her do on community care, eight months later, eight months, she was able to see a mental health specialist in Chattanooga.

This is so totally unacceptable, and it is as if the VA is trying to stonewall people and not let them into the community care program. Some of these individuals do not have someone that can take a day off work and drive them to a VA facility, and when they call they are needing help then.

Likewise, right now—and we check regularly to see how long the wait times are—if you wanted, in Clarksville, to go to a primary care physician, let us say you are sick and you call today and say you need to see someone in primary care at the VA, 28 days. In other places in the state, it is 74 days, 100 days, to see somebody. So we have got to do something about allowing veterans to get to the care they need at a place where they are able to get the care, and that is the whole purpose of community care.

And I have got a Veterans Health Care Freedom Act that would create a pilot program that removes these requirements that a veteran has to get all this preauthorization and jump through these referrals.

Dr. Elnahal, do you think that veterans can make these decisions on their own? Do you all trust them to make these decisions?

Why are we getting these continual roadblocks? Is it the employee's union that does not want this to work? What is the issue?

Dr. ELNAHAL. Well, Senator, the first thing I will say is if the veteran is amenable and your office is amenable, we are happy to do everything we can for the veteran you just mentioned. You know, that is an inexcusably long wait time, I agree, and we have to do better.

Senator BLACKBURN. We have a long list of those.

Dr. ELNAHAL. Yes.

Senator BLACKBURN. That is just one.

Dr. ELNAHAL. And again, we are happy to review every single one and meet their needs. We have a patient advocacy office that can help us with that.

More broadly, it is why—the problems you are mentioning are exactly why I have identified the time to schedule veteran appointments in the community as one of the most important metrics we are tracking across the system. And where we are seeing deficiencies and inexcusably long wait times, we are honing in on trying to improve them and standardize those processes.

We are also trying to expand the program that allows us to simply hand a veteran an authorization and a list of providers in the community that are in our network and empower that veteran to schedule the appointment themselves. Where we have tried this in certain areas of the country, Bedford, Massachusetts, VISN 19, we have seen success. We have seen that care coordinate sooner.

Senator BLACKBURN. That is what veterans want. Well, let me ask you this: If that is your goal, is to say, here you go, here is a list, you know, if they call the VA, they can e-mail that list back to them right then so they call through, then why did the VA take down the MISSION Act website?

Dr. ELNAHAL. So I think, Senator, the website has the content that it has always had. The purpose of the update to the website was to offer a one-stop shop to veterans online to understand all our programming, both internally within the VA and in the community.

I am squarely focused, in addition to improving access to our direct care system, on making sure that the veteran experience through our community care program gets better and better. And again, we have identified that time to schedule, the coordination of care in the community as the most important things we have to improve, and you can be assured that I am very focused on that.

Senator BLACKBURN. Well, I would encourage you to try one of your pilot projects in Tennessee because we could give you a list of stories like this, a list of people that are waiting, as I said, 30, 70, 100 days to see a primary care physician, a list of people that are waiting for oncology and they are waiting months. So we would invite you to try one of these pilot projects in Tennessee.

Thank you so much for being here today.

Dr. ELNAHAL. Thanks, Senator.

Chairman TESTER. The good Senator, Dr. Cassidy.

SENATOR BILL CASSIDY

Senator CASSIDY. Thank you, Chairman Tester. I am going to probably ask some questions that are kind of 101 just to try and understand, and I apologize if others have asked.

So somebody is referred to a cardiologist. Now the cardiologist has a whole list of things that the cardiologist could order. Does that authorization to the cardiologist's office include a preauthorization for whatever test the patient—for whichever test the doctor would order?

Dr. ELNAHAL. I will ask Ms. Peabody to help with that question, Senator. Thank you.

Ms. PEABODY. Senator, yes, that is correct.

Senator CASSIDY. So now I am going to approach this from the other side. There are some providers who are overutilizers, and if you overutilize you obviously have an increased risk of complications. So if somebody goes with chest pain, you get an EKG, you get an echo, you get a treadmill, you get a radionuclide study, and other tests. I am a little rusty on my health care. Could they go all the way to a cardiac catheterization on that same authorization?

Ms. PEABODY. Senator, one of the things that Dr. Elnahal has actually charged our office with is taking on looking at appropriateness of care. As we look at our future CCN contracts, we know that we have got to find unique ways to better address making sure our veterans get the right quality of care. So as part of that, we are in the process of developing a strategic plan and roadmap for how we will be looking at that.

Senator CASSIDY. Can I stop you a second?

Ms. PEABODY. Yes, sir.

Senator CASSIDY. But now—I am just speaking now, not as developing a roadmap—if I had that preauthorization for that doctor's office, could that doctor take me all the way to a cardiac catheterization with no review of whether or not that cardiac catheterization would be appropriate or not?

Ms. PEABODY. Dr. LaPuz, do you want to add?

Dr. LAPUZ. For outpatient, not necessarily. So cardiac catheterization is not authorized for outpatient care. Now on the other hand, if the veteran went to the emergency room, that cardiac catheterization would be part of the SEOC for that emergency room visit.

Senator CASSIDY. Now, are you doing—because we also want to make sure that the veteran gets the care the veteran needs, but we also want to be protective of taxpayer resources. And we know that—I am a physician, so I will just say that there is a subset of physicians that will greatly overutilize if there is no check on what they order. So has there been any ongoing evaluation of the people to whom the VA refers or has in their provider network as to the amount of testing they order and, by extension, the appropriateness of that testing?

Dr. ELNAHAL. So, Senator, I will say that you are highlighting one of the major risks that we see right now. The good news is that

in my charge, as Hillary mentioned, to Integrated Veteran Care on doing more work on appropriateness of care, a lot of this data is already public vis-à-vis Medicare. So we have ways——

Senator CASSIDY. I am with you on that. So I know; believe me, I understand. You can understand if somebody is ordering this test, you know, two standard deviations more than everybody.

Dr. ELNAHAL. Yes.

Senator CASSIDY. And there are guidelines for the cardiologist that say, no, you should only be ordering to here.

Dr. ELNAHAL. Yes.

Senator CASSIDY. Is the VA looking at that and looking at the—okay, this is how much I am being charged? Are you looking at a frequency distribution to make sure that we are only putting people as providers who are ordering tests appropriately, knowing that they could appeal, there can be a review, there may be some extenuating circumstances, but also knowing that some people will order too many tests?

Dr. ELNAHAL. So, Senator, we do not consistently look at that right now when we do authorizations, and I have identified that as a risk to veterans, most importantly, because overutilization is not just a cost issue.

Senator CASSIDY. Now let me ask because I think it was a couple of years ago that I asked this same question.

Dr. ELNAHAL. Okay.

Senator CASSIDY. And so is there—and I cannot blame you all. I mean, Ms. Peabody is from Tulane, and I will forgive that. I am an LSU graduate. But I am just teasing. You are an LSU—you are a Louisiana person. I like that.

But I guess my point is having raised this issue before and finding that there is not a program in place, but like every insurance company in the nation has a program like this.

Dr. ELNAHAL. Yes.

Senator CASSIDY. This is not new territory. And in the MISSION Act, the VA is effectively an insurance company.

So is there any thought of contracting with a third-party administrator, using off-the-shelf tools to allow them to immediately apply a system as opposed to the VA developing their own? I just say that because I do not want two years from now to be asking the same questions and finding the same answer.

Dr. ELNAHAL. I think you have the right focus, Senator. I think there are things not only—and I will ask Ms. Peabody to talk about what we are thinking for the next generation community care contracts with the TPAs. But there are also operational things we can do on just data visibility, if we execute it right, that will show which providers are high quality, meeting our standards for veteran care and where appropriateness of care measures are deviated——

Senator CASSIDY. I am totally with you on that.

Dr. ELNAHAL. Yes.

Senator CASSIDY. But I would like to move from the theoretical to the operational.

Dr. ELNAHAL. Me, too, Senator. Absolutely.

Senator CASSIDY. And can you give us a timeline of when you think you would either contract with a third-party administrator or

be able to use this kind of transparency because ultimately I do not care what you do? You are either spending money—but even minor tests can have complications.

Dr. ELNAHAL. Yes.

Senator CASSIDY. I mean, I can just tell you. You know, you do procedures. Sooner or later, you have something going on. So I am just sensitive to this.

Ms. PEABODY. Senator, there is one thing that gets at what you are asking I think that we have put in place. We just have not implemented it universally, and that is our High Performing Provider program. So we are using from both of our TPAs, from TriWest and from Optum. They are already, you know, normal insurance industry-recognized standards, and they have done some customization for VA.

And you can see within PPMS, which is our internal provider directory that the schedulers use to find a provider for our veterans when they are scheduling, they can see if the provider has that HPP designation. What we have not done is mandated that you must schedule to that or that you have to tell the veteran. So we are working on figuring out how we can better optimize that.

And then as part of that CCN next gen contract, getting to your question about timeline, I think we will most likely put some additional requirements in place under that contract, which will be in place in the next couple of years.

Senator CASSIDY. I am not a cardiologist, but I also say, going back to Dr. LaPuz's point, just because someone goes to the ER with chest pain does not mean they should be cathed. There is a lot of other reasons for chest pain that can be evaluated before cath.

It also seems like that is sort of—and every now and then somebody dies from a catheterization. So it does seem as if you could do a frequency distribution there.

I am just asking that and would ask you all to implement it ASAP for the variety of reasons that we discussed. So, thank you.

Chairman TESTER. Senator Cassidy, I want to thank you for that line of questions because I think it is spot-on. I mean, if you take a look at the growth in money that we are putting out for community care, it is exponential, predicted to be $2 billion a year for the next three or four years, additional to the 23.5 we are at right now. And I think that point is a point you talked about, spending taxpayers' dollars appropriately.

And so I am willing to work with you. I am willing to work with you guys to make sure that people are doing the right thing, basically. So, thank you.

I want to thank you guys for being here today. Appreciate it very much. I look forward to continuing to work with you to ensure veterans receive timely, quality care in the VA and in the community.

And we will keep the record open for a week, and as long as there are some questions you have already taken for the record, I would like you to get those answered as soon as possible. With that, this hearing is adjourned.

[Whereupon, at 4:36 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statement

STATEMENT OF THE HONORABLE SHEREEF ELNAHAL
UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

JUNE 21, 2023

Good afternoon, Chairman Tester, Ranking Member Moran and members of the Committee. Thank you for inviting us here today to discuss how VA is ensuring Veterans have access to the best care in a timely manner, as they have earned. I am accompanied by Dr. Miguel Lapuz, Assistant Under Secretary for Health, Office of Integrated Veteran Care (IVC) and Ms. Hillary Peabody, Deputy Assistant Under Secretary of Health for IVC. VHA's approximately 390,000 employees, one third of whom are Veterans, come to work every day with one goal in mind: to serve Veterans, their families, caregivers and survivors as well as they have served our country.

This year, Secretary McDonough set a goal to provide more care and more benefits to more Veterans than ever before. To meet this goal and fully implement the Honoring our PACT Act of 2022 (the PACT Act, PL117-168), we must continue to increase access to care, whether that be through our medical facilities or through care in the community. We appreciate the opportunity to share how IVC is working to empower facilities to meet that challenge and to hold the system accountable for meeting the needs of Veterans.

To ensure that we provide timely access to care, while providing more care than ever before, and while continuing to earn each Veteran's trust, VHA has established measurable goals for all facilities on three "North Star" metrics:

1. Direct care wait times from the date of request;
2. Time to schedule community care appointments; and
3. Veteran satisfaction with timely care.

Already, VA has taken several steps towards improving these metrics. First, VHA has set a goal of hiring 52,000 new employees this year. This includes 30,000 positions in the occupations most needed to ensure access to high quality care - physicians, nurses, licensed practical nurses, nursing assistants, medical support assistants, environmental services technicians and food service workers.

Second, IVC is leading an effort aimed at optimizing the time our clinicians spend in clinic by implementing standards for bookable hours and appointment lengths. The bookable hour initiative will ensure clinicians are available for veteran care for 80% of their designated clinical time. Implementing the bookable hours and appointment length standards is a significant advance in both improving Veterans' access to care through more efficient use of resources locally and across the enterprise, as well as ensuring a

more equitable workload across providers. VA continues to make progress with implementation across the enterprise.

Finally, we are leveraging every modality available to reach Veterans with timely, appropriate care. VHA is completing an overhaul of its disparate call centers and transitioning to standard, VISN-level Clinical Contact Centers that operate on a fiber network with trained staff using the same customer relationship management system across the enterprise to track and manage calls, ensuring a consistent experience for Veterans. This clinical contact center modernization program is called VA Health Connect. In a concerted effort to support in-person care, we continue to use telehealth, a core service in VA Health Connect. Through VA Health Connect, Veterans can call 24/7 to talk to a nurse about a health concern, a medical support assistant to help with scheduling an appointment, a pharmacist to reorder a prescription and, in some cases when clinically appropriate, meet with a provider using a video appointment. VA Health Connect involves a technology modernization effort which is well underway, and we anticipate completion in the next 2 years. Further, we are utilizing Clinical Resource Hubs (CRH) to provide virtual care options to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities.

Progress this Fiscal Year

For each North Star metric, VHA has a clearly outlined a long-term goal with short- and medium-term goals to track improvements over time. Already this fiscal year, we have seen progress in all three metrics.

North Star Metric 1: Direct Care Average Wait Times

The first North Star metric focuses on reducing average wait times in the direct care system. We will hold ourselves accountable by measuring average wait times for completed new patient appointments, with a target reduction of 3% in FY23 Q2 as compared to FY23 Q1 for facilities not currently meeting the designated wait time standards. The long-term goal for this metric is to improve Veteran appointment availability by encouraging facilities to decrease average wait times by up to 15% by the end of this fiscal year or to meet the designated wait time access standard of 20 days for primary care, mental health, and non-institutional extended care services and 28 days for specialty care. In FY22, average wait times for established patient appointments in VA for primary care (5.9 days), mental health (5.2 days) and specialty care (8.6 days) were all well within VA's designated access standards. Established patient appointments historically account for 85% to 90% of the total outpatient care provided each fiscal year. For the 10% to 15% of outpatient care for new patients, the average completed appointment wait times in FY22 were 18.8 days for mental health, 22.9 days for primary care, and 28.6 days for specialty care.

While new patient appointments historically comprise only between 10% and 15% of all completed appointments, they typically take longer to schedule in both direct and community care. Accordingly, we are focusing our North Star improvement efforts on new patient appointments. While the goal is overall reduction in wait times, to measure our success in reducing the wait times Veterans experience in the short- and medium-term, we have set facility level targets to decrease wait times. Using FY23 Q1 as the baseline for new patient completed appointment average wait times, VHA established a goal of a 3% decrease from the previous quarter's wait times, followed by more aggressive targets of 8% and 15% over the next 6 and 12 months respectively. The FY23 Q1 baseline data for completed appointment average wait times for new patients is: 21.4 days for mental health, 26.3 days for primary care, and 30.6 days for specialty care. For the direct care average wait times, VHA will also track the percentage of outpatient appointments cancelled by VA. Decreasing cancellations will ensure that we minimize rescheduling of Veteran appointments and ensure the best care in a timely manner.

Table 1 displays facility performance in meeting our 3% quarter over quarter improvement goal for average wait times for new patient appointments in VA's direct care system. VA considers Veterans to be a new patient if they have not been seen by a provider or a clinical service at the same medical center for the same, or a related, health care need in the past 3 years. Veterans who had an appointment in a clinical service at the same medical center for the same or similar health care need in the past three years (either in person or via phone/video), are considered established patients.

Table 1: North Star Metric - Improving Average New Patient Wait Times for Completed Appointments in Direct Care System from FY23 Q1 to Q2.

VHA Direct Care System	*Facilities That Met 3% Target*	*Facilities That Met 3% Target or Showed Improvement*
Primary Care	72 out of 134 (53.7%)	79 out of 134 (59.0%)
Mental Health	54 out of 135 (40.0%)	62 out of 135 (45.9%)
Specialty Care & All Other	28 out of 135 (20.7%)	48 out of 135 (35.6%)

Table 1 highlights the number of facilities meeting or moving towards our improvement targets for direct care access in the face a significant increase in demand for direct care in VHA. In FY23 Q1, Veterans completed 1,538,037 new patient appointments in VHA, as compared to 1,680,931 new patient appointments in FY23 Q2. In FY23Q1 Veterans completed 11,380,289 established patient appointments, as compared to 12,314,585 established patient appointments in FY23 Q2. This is a 9.2% increase in direct care new patient appointments and an 8.2% increase in direct care

established patient appointments since the beginning of the fiscal year. This means that many facilities are building capacity to deliver accessible care while experiencing such growth. For new patient appointments with a referral, the referral date is the starting point used for measuring average wait times, and the end point is the date care is received. For new patient appointments without a referral, the average wait time starts with the earliest consistently recorded date in the process of receiving care to the date care is received.

As we look at direct care access within VA, most facilities are meeting our 3% quarter-over-quarter improvement goal for primary care, with even more moving in the right direction. We are also seeing improvements at some facilities for new patient appointment timeliness within VA for mental health care. The majority of sites are struggling to improve specialty care access for new patient appointments. Further, appointment cancellation rates decreased across all the categories of care (primary care, mental health, and specialty care), demonstrating that improvements in average wait times is an indication of improved access and not simply attributed to appointments canceled by VA.

As stated above, we are improving in timeliness of care at the same time demand for care is growing substantially, with a 9.2% and 8.2% increase in direct care new patients and established patients respectively, quarter-over-quarter. This presents an overall optimistic picture in anticipation of increased access resulting from the PACT Act. To improve specialty care access within VA, we are leveraging every hiring and retention authority under the PACT Act and other laws. While we have made significant progress in hiring since the enactment of these authorities and those granted in other laws such as the RAISE Act (Div. S of PL 117-103), challenges remain in recruiting specialty care providers.

North Star Metric 2: Time to schedule community care appointments

As with the direct care system, VHA has clearly outlined metrics and associated goals for improving community care scheduling timeliness. There are three critical points in the community care scheduling process that are important for the second North Star metric: the starting point is the date the referral is made; the second point is the date on which the appointment is set; the third point is the date the appointment takes place.

The second North Star metric focuses on reducing the amount of time between the first two points in the process, with a goal of reducing that time by 3% initially, with the more aggressive targets of 8% and 15% over the next 6 and 12 months respectively. For community care appointment scheduling timeliness, most sites are showing improvement. In addition, the number of appointments scheduled in FY23 Q1 increased in FY23 Q2 across all three services (primary care, mental health and specialty care).

North Star Metric 3: Veteran Satisfaction of Timely Care

Finally, the last North Star metric is focused on ensuring VHA is meeting its commitment to providing the best Veteran customer experience. VHA gathers Veteran feedback through multiple channels, including Veteran Signals (VSignals) surveys, which measures the Veteran customer experience with widely accepted customer experience metrics, including ease, effectiveness, emotional resonance, and VA-wide and service specific trust. For both direct care and community care, VA has established a goal of 80% responses at "Strongly Agree" or "Agree" on the trust score in its VSignals surveys. Additional measures, including those focused on providing an appointment when needed as well as care coordination, are part of the metric for the direct care system. Similarly, additional community care specific questions on scheduling and care coordination are included in the metric. Results of the Vsignals surveys demonstrate that 83% of sites met the goal of 80% responses at "Strongly Agree" or "Agree" for 5 out of the 7 survey questions[1]. VHA is using these survey results to identify areas for improvement.

Staffing

Although the COVID-19 national emergency has ended, and related hospitalization rates have stabilized across the U.S., hospitals nationwide face an ongoing staffing shortage. The mass retirement of baby boomers and widespread post-pandemic burnout within the U.S. health care industry have left many workforces unequipped for the volume of patients they receive. Similarly, VA is facing staffing challenges, even as demand for care continues to rise. IVC has initiated a collaborative approach, working together with teams at the Veterans Integrated Service Network (VISN) and medical center levels. We are listening to Veterans, Veterans Service Organizations (VSO), oversight authorities such as Government Accountability Office and Office of Inspector General. Further, we have implemented new authorities crafted by this body to help Veterans get the care they deserve in a timely manner.

To provide timely, high-quality care, we need to grow the size of our workforce. Right now, VHA is hiring at a record pace, with 5,800 more hires in the first 6 months of FY 2023 compared to the same time period last year, and a net increase in staff of over 11,000 employees combined with increased retention. Further, VHA has hired more than 27,000 employees who are new to the agency and onboarded the highest ever

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[1] *Direct Care Questions:*
Question 1: I trust (provider name) for my health care needs. ***meeting***
Question 2: I got my appointment on a date and time that worked for me. ***meeting***
Question 3: My provider explained things in a way that I could understand. ***meeting***
Question 4: My provider listened carefully to me. ***meeting***

Community Care Questions:
Question 1: I trust VA community care to coordinate my care with my community provider. ***Not meeting***
Question 2: I was contacted to schedule my community care appointment shortly after I chose to use VA community care. ***Not meeting***
Question 3: I trust VA community care to address my medical needs. ***meeting***

number of new hires for that time period. We are continuing to add staff where needed, with another 30,000 active recruitments going through the onboarding process.

In addition to several clinical positions, VHA is prioritizing hiring and retention efforts for Medical Support Assistants (MSA) – it is the MSAs who schedule most Veteran appointments. We have already seen a net increase in our total employees onboard for each of the seven occupations[2] we have identified as being most critical to ensuring timely care as of March 31, 2023. Of the seven professions, nurses and MSAs saw the largest growth in total employees onboard, with 4.2% and 3.9% growth respectively.

Referral Coordination Initiative (RCI)

IVC is continuing our efforts to simplify the process for a provider to refer a Veteran to another provider. The Referral Coordination Initiative (RCI) aims to ensure Veterans have comprehensive information about their care options when scheduling takes place as a result of these referrals. Referral coordination teams include local staff with administrative and clinical expertise who talk to Veterans about their available care options with a VA provider, in-person or virtually, or when eligible, through the Veterans Community Care Program.

Last August, we released a systemwide update that allows clinicians to capture the clinically appropriate care options for these referrals. Additionally, the staff scheduling the requested care can document discussions with Veterans regarding the full range of care options and the outcome of that conversation. As of December, we have seen a 24% improvement in scheduling internal consults for key RCI specialties across VHA, with average times decreasing from 10.4 days to 7.9 days. We are also planning RCI 3.0, an initiative focusing on telehealth at VA medical centers supported by RCI triage teams. We continue to improve and standardize documentation and discussion notes, as well as roles and responsibilities for the referral coordination teams. Additional guidance will be included in the new Consult Management policy expected later this year.

Next Steps

Veterans' timely access to care is central to our mission and a top priority, regardless of whether Veterans receive that care in VA or in the community. Thus, we have several initiatives underway to continue to improve performance on the North Star metrics described below.

Scheduling Modernization

[2] These occupations include: Medical Officer, Nurse, Practical Nurse, Nursing Assistant, MSA, Environmental Services Technician/Housekeeping Aid, Food Service Worker

VA is rolling out a multi-year comprehensive roadmap designed to guide the efforts to modernize our scheduling systems. All major stakeholders and efforts that impact direct care, virtual care, community care and Veteran self-scheduling have been integral in creating a single vision, business case, and roadmap for scheduling.

We are taking two paths to provide our schedulers with better tools to simplify the scheduling process for Veteran appointments. The first piece of our scheduling modernization roadmap involves making enhancements to our internal scheduling system to provide schedulers visibility to all appointment availability for a particular provider, across locations, for both in-person and virtual appointments. With these improvements, including increased visibility into provider schedules, our schedulers will be able to schedule across VA locations. Another update will be an automated community care eligibility calculation, which will eliminate the need for schedulers to manually calculate whether VA can schedule an appointment within the designated access standards.

The first phase of implementation for VA's Internal Scheduling System is expected to take place early next fiscal year. The second piece of our scheduling modernization roadmap is focused on community care. IVC has been testing new software to reduce the amount of time it takes to schedule community care appointments.

In late 2020, we started a pilot program at the Orlando VA Medical Center (VAMC) in VISN 8. Our teams worked with a vendor to define the existing community care scheduling process and identify opportunities to reduce the time it takes VA staff to schedule community care appointments. After some early success, VA expanded the pilot earlier this fiscal year to the VAMC in Columbia, South Carolina, in VISN 7. These efforts further demonstrated benefits from gaining visibility to multiple internal and external appointment applications in a single view for VA staff coordinating the scheduling of community care appointment.

Based on our pilot experience and evaluation, we are presently working on a Request for Proposals that could lead to new scheduling software to improve the scheduling process when eligible Veterans choose appointments with community care providers. Improving our scheduling system for both internal VA appointments and for appointments scheduled with community providers will make it easier for our teams to schedule appointments, which will have the real potential to reduce the time it takes to schedule appointments and resulting in a better experience for Veterans.

Another IVC effort will make it easier for Veterans to schedule their own community care appointments through Veteran Self-Scheduling (VSS). Once Veterans have an approved VA referral to community care, they have the option to use the VSS process to contact community providers directly, eliminating the need for Veterans to coordinate appointment availability and preferences with VA schedulers in this process. VA first made self-scheduling for community care available for select services at some locations back in late 2020, and we have captured best practices to support a relaunch

of this effort now that the pandemic is largely behind us. Based on feedback from the field and key lessons learned, IVC is developing resources and training to bolster understanding of the VSS process within the Veterans Community Care Program. This includes reinforcing national training for VA staff involved in VSS, which began the week of May 29th so that the process can be effectively scaled across the country.

IVC will continue to evaluate VSS and identify opportunities to improve and incorporate feedback from Veterans, staff and community providers as we refine and enhance the process. As we hear from Veterans, VSOs, Congress and our teams in the field, including our third-party administrators about ways to strengthen community care, we have expanded services, and we continue to add community providers to our network. We also have led expanded access to emergency care for Veterans in acute suicidal crisis to combat Veteran suicide. Through the COMPACT Act (PL 116-214), Congress created a new option for more Veterans and other eligible individuals than ever to access emergent suicide care at the nearest medical facility. This is available for all Veterans and for former Service members with other than honorable discharges. Veterans can access emergent suicide care, including inpatient or crisis residential care for up to 30 days and outpatient care for up to 90 days.

At the same time, our community care network now includes more than 1 million providers, with coverage in all 50 States and U.S. territories, and we are working to make our network even stronger. IVC is preparing for the next generation of community care network contracts, while also working with our current third-party administrators to ensure we have the comprehensive coverage and the quality of care Veterans deserve.

Standardization, Oversight and Accountability

As we continue to improve oversight across IVC, we are identifying key elements to ensure we meet our objectives while providing guidance as needed. IVC is developing the framework for a comprehensive oversight and monitoring program that includes an effective monitoring approach. IVC is working with leadership across VA Central Office to provide greater accountability as we use checklists to address differences in criteria used by VISNs to assess compliance with policy and procedure. Using agreed-upon checklists for field-based audits promotes efficiency, equity, and trust. We have established coordination efforts across IVC for external reviews and audits to ensure timely and appropriate responses, identify themes to address performance gaps and monitor the effectiveness of changes in process.

IVC is developing a program office whose sole mission is to perform oversight. This will result in internal autonomous reviews of processes and testing of internal controls. We are working to achieve accountability at all levels of the workforce, which includes performing a risk analysis spanning the entire

office to allow internal identification of problem areas, provide a baseline for an individualized oversight and monitoring program, and a move towards a proactive versus reactive approach.

Conclusion

Veterans today have more options for care than ever before. We are serving record numbers of Veterans both in VA and in community care with significant progress toward our timeliness goals. IVC's mission is to ensure timely access to world class health care, regardless of location or modality. In just its first year, IVC has taken important steps to get the right people in place. We have hired and continue to hire at a record pace across VHA. Our teams have streamlined processes and revised policies. We are using technology to reach more Veterans and improve their health care experience. While we have established a solid framework, we have much work to do. Our plans for continued improvement will keep us focused on providing the soonest and best care for Veterans.

We appreciate your continued support and look forward to answering your questions.

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Examining the Effectiveness of the Office of Integrated Veteran Care (IVC)

June 21, 2023

Questions from Senator Mike Rounds for Dr. Shereef M. Elnahal, Under Secretary for Health, Department of Veterans Affairs

I have some questions regarding the process for secondary authorization requests, or requests for service (RFS), within the Veterans Community Care Program. I would like to share an anecdotal example of what seems to be a recurring problem with the RFS process, that my office received from a constituent who manages billing for a physical therapy (PT) clinic that is part of the Community Care Network. This PT clinic sees a lot of veterans for new knees and shoulders. According to my constituent, these particular knee and shoulder surgeries have standard post-operative PT protocols that are ordered by orthopedic physicians—for instance, a new knee typically requires 24 visits, and a new shoulder usually requires 32 visits. However, my constituent reports that VA only initially approves 15 visits at a time, no matter what the case is. As a result, my constituent says they have to submit new RFS paperwork about midway through a veteran's 15 visits and hope to receive an additional authorization before those visits are done in order to avoid disrupting care for the veteran. Unfortunately, my constituent says that the RFS is not always approved in time, resulting in some veterans having to stop PT in the middle of their rehab. Please describe the RFS process in detail and provide answers to the following questions.

Question 1.a: How does VA determine the initial number of visits for PT—and other specialties—in the community?

Question 1.a.i: How do VA's numbers for standard episodes of care compare to those within TRICARE (Prime, Select, and For Life) and Medicare?

VA Response: The number of visits listed on the Standard Episodes of Care (SEOC) are determined by the National Program Offices for the specific specialty based on standard practices and average treatment duration across multiple scenarios. SEOCs are not designed for a specific diagnosis. If toward the end of the number of visits allowed on the SEOC the Veteran has not met the goals from the initial treatment plan developed by the community provider and they feel additional visits are needed, the community provider submits an RFS along with supporting documentation to request additional visits. The VA clinical reviewer evaluates the request, and, if additional visits

are needed, a new referral is entered and the appropriate SEOC applied. This process also allows VA to closely monitor and care coordinate the Veteran's care to ensure the treatment has been successful, there is documentation of improvement in symptoms and an alternate plan of care is considered if the care has plateaued.

VA does not have access to the full data sets from TRICARE or Medicare to provide a comparison. Further, since VA is an integrated delivery system and not an insurance plan, there is no one-to-one comparison. That being said, many Medicare Advantage and commercial insurance plans cover a similar number (often 12 to 24 visits) prior to requiring a prior authorization. Again, VA's model is not a direct comparison, but it is also not significantly different, particularly when considering that VA is an integrated delivery system and not just a payer.

Question 1.a.ii: Is there a difference between care provided in the community and at VA facilities? For instance, if a veteran were to see a physical therapist at a VA facility, would the veteran only be authorized 15 visits?

VA Response: Veterans receiving physical therapy (PT) in VA facilities do not have a preauthorized number of visits because the care delivered in VA facilities is not delivered pursuant to a contract where cost controls and oversight are critical. In fiscal year (FY) 2022, Veterans treated by PT in VA averaged between 3 and 4 visits per episode of care. The number of visits per individual Veteran provided is based on the unique needs, goals and progress of the Veteran.

Question 1.a.iii: Please send me a list of the national standards that VA used to determine the 15-visit standard for PT, including how those national standards compare to what VA currently offers veterans at VA facilities and in the community.

VA Response: Some examples of information related to the guidance in SEOCs included reviewing:

1. The Guide to Physical Therapy Practice created by the American Physical Therapy Association.
2. Published data that looked at over 1,840 episodes of care where the average number of visits for knee and shoulder therapy were 8.4 and 8.0, and post-surgical averages were 11.6 and 13.1: Physical Therapy, Volume 91, Issue 3, 1 March 2011, Pages 330–345, https://doi.org/10.2522/ptj.20090290.
3. Recent literature on the number of in-home visits for Medicare ages for post-surgical total knee arthroplasty optimal level to be in the 6-9 visit range.[1] Reviewing therapy network consortium data of over 38,330 episodes of care and the average number of visits post-surgical was 15.4 and non-surgical visits averaged between 8 and 9 visits.

[1] Falvey JR, Bade MJ, Forster JE, Burke RE, Jennings JM, Nuccio E, Stevens-Lapsley JE. Home-Health-Care Physical Therapy Improves Early Functional Recovery of Medicare Beneficiaries After Total Knee Arthroplasty. J Bone Joint Surg Am. 2018 Oct 17;100(20):1728-1734. doi: 10.2106/JBJS.17.01667. PMID: 30334882; PMCID: PMC6636791.Medicare Archives - Home Health Care News.

Question 1.b: When a community provider submits a new RFS for a veteran that needs additional care, or more than 15 visits, who in VA gets that request from the provider? How long does it take VA to process an RFS on average? What does VA policy say the turnaround time should be? What percentage of RFS are denied? And what are the reasons for denials? What role do Third Party Administrators play in this process?

VA Response: The third-party administrators do not play a role in the process. The process for requesting additional visits is that the community provider submits an RFS back to the local VA community care office. Supporting medical documentation must accompany this request for service. If the local VA community care office does not receive sufficient medical documentation to support that the Veteran needs continuing care, the clinical reviewer in the local VA community care office may deny the RFS. The Field Guidebook requires processing within 3 business days. The average processing time for FY 2020 is 0.64 days. See the Veterans Health Administration (VHA) IVC Office Community Care, Field Guidebook (FGB), Chapter 3, §3.42: Request for Services.

Question 1.c: How many community care appointments did VA authorize and complete for PT in 2019, and how many appointments were authorized and completed for PT in 2022?

VA Response: See the following table for Veterans Community Care Program (VCCP) visit counts:

Category of Care	FY 2019 VCCP Visit Count	FY 2022 VCCP Visit Count
Physical Therapy	2,249,487	1,986,943

Source: IVC_CDS Claims, IVC_CDS Claim Lines, IVC_CDS Referrals Fact, IVC_CDS PCM Claims.
Notes: Appointments are calculated from individual dates of service reported on paid claims. The date of service is counted only if the claim line contains a paid amount. Physical therapy services needed for follow up care are now bundled in the SEOC and included under the specialty category of care itself. For example, PT services needed after orthopedic surgery would be under the Orthopedics category due to the orthopedic SEOC including it.

Question 1.d: In addition to PT, can you please also provide this data for dermatology, chiropractic, cardiology, and mental health?

VA Response: See the following table for Veterans Community Care Program (VCCP) visit counts:

Category of Care	FY 2019 VCCP Visit Count	FY 2022 VCCP Visit Count
Chiropractic	988,327	1,344,078
Mental Health	851,672	1,278,152
Physical Therapy	2,249,487	1,986,943
Dermatology	66,004	346,433
Cardiology	327,762	665,862

Source: IVC_CDS Claims, IVC_CDS Claim Lines, IVC_CDS Referrals Fact, IVC_CDS PCM Claims.
Notes: Appointments are calculated from individual dates of service reported on paid claims. The date of service is counted only if the claim line contains a paid amount.

Questions from Senator Angus S. King for the National Veterans Health Administration, Department of Veterans Affairs

Question 1: In highly rural settings, where both VA and community partners have challenges with access due to lack of services, what is VA doing to ensure that veterans are receiving quality care?

VA Response: Veterans living in rural communities often face unique challenges, such as long distances to clinical facilities and a shortage of qualified providers, which limit their access to health care and can put rural Veterans and their families at risk for worse health outcomes. To overcome these challenges and reach rural Veterans with critical health care needs, VA has expanded access through telehealth programs. This access includes the development and ongoing expansion of Clinical Resource Hubs, which is a network of VA centers in large, urban settings skilled in delivering services to Veterans in rural areas at medical centers, VA community clinics and in the home through telehealth technology.

In highly rural areas, VA operates the Accessing Telehealth through Local Area Stations (known as ATLAS) program, which is a collaboration between VA primary care, VA telehealth providers and community organizations. This collaboration makes it easier for Veterans to access care through VA by establishing convenient locations for Veterans to receive VA care, thus reducing obstacles such as long travel times to appointments and poor internet connectivity at home.

In addition, through the Veterans Rural Health Resource Centers, host-VA medical centers focus on improving care coordination for Veterans, including those Veterans who use VA and community care; developing innovate mental health treatment delivery models for rural Veterans; identifying and sharing innovative ways to address substance use disorder; and developing and implementing interdisciplinary treatment models to improve the quality and efficiency of care.

Question 2: Can you discuss VHA's educational roll out plan to changes to guidelines. What is your timeline for instructing local VAMC's about these changes?

VA Response: When new processes are developed and released to facilities from VHA's IVC Office, VHA ensures employees receive the information from several avenues. National email communication regarding the updates is distributed; the content is presented on training calls, office hours or existing national calls that are recorded and made available for users that are unable to attend; and the information is updated in the appropriate chapter of the IVC FGB. VA staff can sign up to receive email alerts when new content is added to the IVC FGB to ensure they are aware of any changes to guidance.

Question 3: When SEOCs are created, is there a plan to make them more encompassing versus having to enter multiple consults to treat the same

disease/condition, and will that plan include frontline staff involvement? For example: Create a General Oncology SEOC—this could cover medical oncology, radiation oncology, PET/CTs or other imaging, any lab work including bone marrow biopsies, etc.?

VA Response: SEOCs are developed through collaboration with field/end user input, National Clinical Program Offices across VHA, VA Chief Medical Officers, Chiefs of Staff and VHA's IVC Office. They are developed based on a clinical specialty or subspecialty and not based on a diagnosis or clinical condition. In addition, there is a new SEOC Request Tool that can be accessed from the updated SEOC Solutions Page for internal VA staff that allows the field/end users to submit a request to either modify a current SEOC or request a new SEOC along with a request justification. Requests are reviewed with the appropriate stakeholders based on the specific request.

When a Veteran is referred to a specialist and a different specialty is needed, the community provider would have to follow the RFS process to request services that fall within a separate specialty.

In the example provided, a Medical Oncology SEOC would allow for ancillary labs and imaging, as well as visits and procedures performed by an oncologist. When the Veteran needs to be referred to a different specialist, such as a Radiation Oncologist, for radiation treatment, a new referral would be needed for that radiation oncology treatment. This requirement follows the standard RFS process that all community referrals follow since Radiation Oncology is a different specialty.

Question 4: Veteran Care Agreements can be confusing and are often questioned by community partners. In an ideal state, there should be a specific office or point of contact to support community partners with billing issues. At this time, this responsibility falls to the local VAMC. Is there a plan at the National level to address this lack of support for our community partners?

VA Response: Yes, national support from VA is currently in place to assist community providers with Veterans Care Agreement (VCA) billing concerns or other questions. This information is located on the VA Community Care internet website at https://www.va.gov/COMMUNITYCARE/. Basic billing instructions for VCAs are provided on the Community Care File a Claim for Veteran Care website located at https://www.va.gov/COMMUNITYCARE/revenue_ops/Veteran_Care_Claims.asp**,** which also includes an FAQ section that answers questions such as where to send claims and who to call for questions about a claim. Claim inquiries can be made to VA Customer Call Center at 877-881-7618, 8:00 a.m. to 9:00 p.m. Eastern Time, Monday-Friday.

Question 5: What is Optum doing to ensure that the community understands the process of billing, utilizing the correct CPT codes and can reach Optum in a timely manner with billing questions?

VA Response: VA issues Community Care Network (CCN) referrals to participating providers containing an SEOC, which includes the list of pre-approved Current Procedural Terminology (CPT) codes. Optum processes claims for services provided by contracted community providers as well as non-contracted ancillary community providers.

All community providers must determine the most appropriate CPT code to bill for services performed. Optum publishes guidance on the reimbursement and claims process within the VA CCN Provider Manual, which may be viewed online at https://www.vacommunitycare.com/training-and-guides. Once the landing page opens, click on "VA CCN Provider Manual and Resources for Medical/Behavioral Providers" and after the drop-down list appears click on "VA CCN Provider Manual."

Optum provides a wide variety of on-demand tools on their provider portal under training and guides. The portal also contains on-demand webinars that include a section on medical documentation and claims. Finally, Optum's VA CCN Provider Customer Service Center is available to support all providers with a claim-related concerns and may be reached based on Region using the following corresponding phone numbers:

Region 1: (888) 901-7407
Region 2: (844) 839-6108
Region 3: (888) 901-6613

Question 6: What is Optum doing to ensure that there are services available in the community, particularly in remote areas?

VA Response: In consultation with Optum, VA highlights that there are multiple ways that Optum ensures there are services available in the community, particularly in remote areas. First, the contract requires monthly meetings between Optum and VA medical centers (VAMCs) to discuss network needs. In these meetings, VA can notify Optum about situations that may require expanded community care. This notification allows Optum to proactively analyze the network capacity and add the needed resources. Second, the CCN contracts were designed to ensure the network would be dynamically built. With this expectation, Optum is monitoring the network constantly for trends in demand and will build the network independently when an increase in demand is identified.

VA has specific contractual requirements that Optum must meet in building and maintaining community care networks, and its performance under the CCN contract is evaluated against specific metrics. Since transitioning to the new contractual drive time standards in Fall 2021, Optum has analyzed its networks across every health care specialty in every zip code designated as highly rural. In instances where Optum is not meeting the designated metrics, it is required to develop corrective action plans and report to VA regularly on what actions they are taking to improve access to care.

Optum is continuously evaluating its network of providers contracted to participate in the VA's CCN. Optum's network of providers is assessed against corresponding contractual

requirements, as well as several other factors, which include, but are not limited to, actual Veteran utilization, areas with increased demand for a specific specialty, changes in local VA services, and so on. Optum prioritizes network recruitment and expansion-based areas of greatest need. For example, if a VCA is set to expire and the rendering provider has not yet entered into a contract with Optum, Optum would prioritize contracting efforts of said provider to support continuity of care. Optum also focuses its contracting efforts on providers who offer a unique or specialty service (e.g., an open Magnetic Resonance Imaging).

Question 7: What is the process for utilization review to ensure that billing is accurate and timely?

VA Response: For Regions 1-3, prior to all claims being provided into Optum's claims system, they are put through several compliance and business edits (e.g., Optum applies industry standard edits such as National Correct Coding Initiative edits) based on VA CCN contractual requirements. All CCN claims must be submitted within 180 days from the date of service. Optum is contractually permitted to override timely filing with proof the provider submitted the claim timely to VA or a VA third-party administrator and was denied within 180 days from the date the claim is submitted to Optum. Timely filing requirements are outlined in Optum's VA CCN Provider Manual, which can be found online using the link and following the directions noted previously.

Question 8: How does Optum determine its saturation rate for services? Is the process standard for every service even though every service is not standard and is there special consideration for rural areas?

VA Response: VA's contracts with Optum have performance standards for network adequacy through which VA measures Optum's performance based on real access using claim and referral data. Optum is required to meet its contractual standards for access to care, which is differentiated between urban, rural and type of care (that is, primary care, specialty care, complementary integrative health). With respect to special consideration for rural areas, VA's contracts with Optum allow Optum to request a rate waiver for contract providers based on their being in a highly rural area or furnishing a scarce medical service.

VA has mechanisms to review utilization and works collaboratively with Optum's process to assess saturation to continuously monitor the network proactively to ensure proper access. Optum continuously evaluates its network of providers contracted to participate in the VA's CCN, inclusive of rurality. Optum's network of providers is assessed against corresponding contractual requirements, as well as several other factors, which include, but are not limited to, actual Veteran utilization, areas with increased demand for a specific specialty, changes in local VA foundational services and requests received directly from VA. Optum prioritizes network recruitment and expansion based on areas of greatest need and any requests received directly from VA in support of continuity of Veteran care.

When a market becomes over-saturated, which results in barriers to scheduling Veterans, VAMC staff work closely with Optum through their monthly meetings to discuss network needs. In addition to referring Veterans through CCN, VA can enter into VCAs if there are network adequacy barriers through CCN. As VAMCs are scheduling the care, they are at the forefront of identifying areas of saturation creating barriers to access.

Question 9: Is there a plan for VAMC frontline staff to have a direct line with Optum claim adjudicators?

VA Response: Optum has dedicated phone lines for VA staff to reach out to Optum with claims-related questions. Should a VA staff member's question require additional expertise, the concern is escalated to the appropriate subject matter expert, and follow-up is made directly back to the appropriate VA staff member. In addition, VHA's IVC Office has a Stakeholder Relations team that handles high profile claims resolution matters. When an issue is escalated to VHA's IVC Office, the IVC Office Stakeholder Relations team provides special attention to work the issue between Optum, the provider, facility staff and VA's acquisitions/contract management teams, if applicable. In some cases, to resolve the claims matter, VA's contract team needs to provide technical direction to Optum, and having our Stakeholder Relations team assist with these matters is essential for these cases.

Question 10: Is there a plan to implement the use of an Advanced Coverage Determination form and process, similar to the ones used by our community partners?

VA Response: VHA does not have advanced coverage determination forms and does not have plans to implement them. If a Veteran needs a wheelchair urgently or emergently (e.g., a Veteran cannot be discharged from the hospital without a wheelchair), a community care provider can provide a wheelchair without pre-authorization. For routine requests for wheelchairs, the provider can submit an RFS to VA. If the RFS is approved, VHA will provide the wheelchair. Thus, many aspects of advanced coverage determination are part of current workflows for community care providers.

Questions from Senator Bill Cassidy for Dr. Shereef M. Elnahal, Under Secretary for Health, Department of Veterans Affairs

Question 1: At the hearing, I asked you a question regarding the appropriateness of care given to veterans. Note that I have asked this same question to VHA leadership a couple of years ago. How are you tracking care providers to identify and weed out those who over-utilize care authorizations; who prescribe tests and care that are inappropriate to the needs of the veteran? Over-utilizers can create significantly higher risks for patients, and increase the risk for complications, while also greatly increasing costs to the taxpayer. What is your plan going forward on this? How can we ensure this is being addressed, so we will not be in this same situation, with me asking the same question, two years from now?

VA Response: Several initiatives within VHA's IVC Office address provider over-utilization. First, our SEOC that accompany referrals to community care providers include limitations to select services. For example, a typical orthopedic SEOC limits physical therapy approvals to 15 visits. Community care providers are required to submit an RFS for additional visits, which are reviewed by local VA community care staff for appropriateness. Second, similar to other health plans, we have developed medical policies to provide coverage guidance for high-cost services (https://www.va.gov/COMMUNITYCARE/providers/Medical-Policy.asp) and are finalizing a plan to develop utilization management teams to review and approve these services. In parallel with medical policy, VHA's IVC Office recently established a payment policy team that is developing requisite payment policies, as well as a reimbursement manual that will serve as the authoritative source on reimbursement for the community care network.

Question 2: In a November GAO report on the Community Care program, they note that VHA's IVC Office developed the capability to independently monitor network capacity, which is a key tenet of the MISSION Act. Having that type of data visibility is good. When it comes to scheduling, when will we get to a point where VA deploys a tool that can independently monitor appointment availability between VA & Community, wait times, and other MISSION Act metrics in real-time?

VA Response: VA is engaging in an enterprise scheduling modernization effort to improve internal, direct care scheduling as well as community care scheduling systems. The internal systems improvement work is led by an Office of Information Technology development team, working in close collaboration with VHA. The community care scheduling systems improvements are intended to be accomplished through an acquisition of technology to allow viewing and scheduling directly into community care provider clinic grids. Getting this community scheduling data is a critical step in VA's efforts to create a pilot for an online Veteran self-scheduling program as set forth in section 131-134 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022. The ability to measure the point in time when care is requested is an established requirement for these

modernization efforts. Pilot efforts to date for community care scheduling systems, at two sites, have demonstrated a significant boost to scheduler efficiency, as well as a reduction in time from care request to Veteran first appointed to a community care provider.

Question 3: I spoke in a recent hearing of requiring that long term care facilities prominently post hotline numbers so that patients or their family members can file complaints regarding standard of care given to the resident. In response, the VA suggested that this could be done. Will this be done and if so, when? How will this be tracked by the VA?

VA Response: VA-purchased long-term care for Veterans is managed through VA's Community Nursing Home (CNH) Program. In August 2022, VA developed and implemented the use of a Patient Rights and Contact Information Flyer. This Flyer briefly highlights the rights afforded to each Veteran as a resident of a CNH. The Flyer also contains important points of contact information should Veterans feel their rights have been violated, or they otherwise wish to file a complaint. The Flyer contains the name and direct telephone number of the individual VAMC CNH program staff and the contact information for the State Long-Term Care Ombudsman. This Flyer is required by program guidelines to be provided to each Veteran or their representative at the time of the initial CNH program visit, occurring within the first 45 days of the Veteran's placement in the nursing facility. The Flyer also is required to be provided to the Veteran or their representative a minimum of annually thereafter, or when points of contact information change.

Veterans residing in a long-term care facility under a VA purchasing authority receive quality oversight visits by VA CNH Program staff within a minimum of every 45 days for those Veterans in the facility less than 1 year, and a minimum of once annually for those Veterans placed 1 year or longer with no quality concerns. During these oversight visits, VA staff meet with the Veteran or their representative to assess and address any quality-of-care concerns. Clinical documentation is required to be completed by the VA staff member.

As of April 2023, the clinical documentation follows a standardized documentation template that requires notation of the provision of the Flyer as well as documentation of Veteran satisfaction and preservation of patient rights. Data tracking features are built into the standardized documentation templates to allow VA to track and monitor that these requirements are followed.

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