S. HRG. 114–595

KEEPING THE PROMISE FOR ARIZONA VETERANS: THE VA CHOICE CARD, MANAGEMENT ACCOUNTABILITY, AND PHOENIX VA MEDICAL CENTER

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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DECEMBER 14, 2015

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WITNESSES

KEEPING THE PROMISE FOR ARIZONA VETERANS: THE VA CHOICE CARD, MANAGEMENT ACCOUNTABILITY, AND PHOENIX VA MEDICAL CENTER

MONDAY, DECEMBER 14, 2015

U.S. SENATE
COMMITTEE ON VETERANS' AFFAIRS
Gilbert, AZ

The Committee met, pursuant to notice, at 11:08 a.m., at Gilbert Town Hall, 50 East Civic Center Drive, Gilbert, Arizona, Hon. Dan Sullivan presiding.

Present: Senators Sullivan [presiding], McCain, and Flake.

OPENING STATEMENT OF HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

The CHAIRMAN. The Senate Veterans' Affairs Committee oversight hearing will now come to order. I would like the first panel of witnesses to take their seats.

Good morning, everybody. My name is Dan Sullivan. I am a U.S. Senator from Alaska, a Member of the Senate Veterans' Affairs Committee, and a veteran myself with 22 years of Active Duty and Reserve service as a Marine Corps infantry officer.

Today's hearing is a continuation of oversight hearings we have been conducting on how the VA has been implementing a series of laws passed in 2014. I am very pleased to be joined by my distinguished Senate colleagues, Senator John McCain and Senator Jeff Flake.

Alaska and Arizona are big States, proud States. While our winter temperatures might differ some, we have many things in common, in particular a large population of veterans.

As many of you know, Arizona has over 535,000 veterans making up over 8 percent of this State's population. I am sure my colleagues from Arizona would agree that it is our strong population of proud veterans that truly makes the States of Arizona and Alaska resource-rich.

This morning, we are here to continue the important work of ensuring that each and every veteran in Arizona, in Alaska, and throughout the country, gets the care they have earned and the care they deserve.

Less than 2 years ago here in Arizona at the Phoenix VA, our country learned that our veterans here and across the Nation were not getting the care that they deserved, the care that they need, and the care that they have earned. From hidden waitlists and

poor reporting, the VA was simply not doing its job, and veterans were falling through the cracks.

Rightfully, the country was outraged; our veterans were outraged. Then, their elected officials in Congress acted.

A few months after these issues came to light, Congress came together and passed the Veterans Access, Choice and Accountability Act of 2014, better known as the Choice Act. This bill was passed by a very bipartisan majority in the House and Senate. Within a week of its passage, the Choice Act was signed into law.

One of the many reasons I am honored to be on this dais with Senators McCain and Flake today is that they were two of the leaders in the U.S. Senate to make this happen. Senator McCain, in particular, has been advocating for the Choice card and choice issues for years.

However, since this bipartisan effort to pass the Choice Act, the implementation of the law has been rocky at best. Our veterans are still not seeing the quality of care or access to it that they deserve. They are still waiting too long for appointments.

Twice Congress has had to correct issues with implementation since the passage of the Choice Act, once when improperly calculated distance requirements by the VA had to be changed in law; and, again, when the VA ran out of money to implement the Choice Act.

Thus far, we have seen that while Choice is working in some areas, it is failing in other places like my State of Alaska, and is having serious implementation problems here in Arizona.

I understand that the implementation of such a large program like the Veterans Choice Act is difficult. However, the fact that something is difficult cannot and should not be used for justification for delay or failure. Regardless of how challenging the task may be, our veterans always deserve the maximum effort and the best results from the VA and Congress.

When the call went out for our veterans to serve, they put their country first and answered the call. We are here in Arizona today because, as a Nation, it is our turn to answer the call and put them first.

Today's oversight hearing marks the sixth one that the Senate Veterans' Affairs Committee has held on the Veterans Choice program, the sixth one just this year: three in DC and field hearings in Alaska, Georgia, and now Arizona.

The Committee felt it was particularly important to have such a hearing here, given that many of the problems were originally recognized here, and, as I mentioned, the leadership of Senators McCain and Flake in playing such an important role in devising the comprehensive solution to some of our VA problems throughout the country.

I would also like to mention, under the strong leadership of the Veterans' Affair Committee, Chairman Johnny Isakson of Georgia has sought to remind the senior leadership of the VA who they really serve—not Congress, not the President, but our veterans.

We have an outstanding group of witnesses today. As you see, with regard to the first panel, we have a former VA employee and a whistleblower who took a lot of courageous actions. It will be very interesting to hear from her. That is Dr. Mitchell. We have two Ar-

izona veterans, Mr. Byers and then Ms. Morris, who is stuck and a little bit of traffic but she should be joining us soon.

I would like to welcome all the veterans who are here today in the audience. It is important to recognize that although we will not be taking testimony from everybody, we will have the opportunity to hear from all of you. If you would like to submit written testimony, you can do so at this address. It is public_testimony@Sullivan.Senate.gov. We can provide that again. I know that some of the veterans here wanted to make comments. You can submit written testimony that will be part of this official Senate hearing record. We will certainly be reading that.

Without further delay, I now would like to recognize the chairman of the Senate Armed Services Committee, a veteran, a war hero, my good friend, Senator John McCain, for his opening remarks.

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

Senator MCCAIN. Thank you. I appreciate Senator Sullivan from the great State of Alaska being here to chair this field hearing of the Senate Veterans' Affairs Committee today. Senator Sullivan is a proud Marine, and he has worked diligently and tirelessly over the past year to improve our Nation's security and fight for those who have served in uniform. Veterans of this country are fortunate to have Senator Sullivan advocating on their behalf.

I want to thank the Chairman of the Veterans' Affairs Committee, Senator Johnny Isakson from Georgia, who was unable to be here with us today. He is doing a great job as Committee chairman. He is examining many things, including how veterans are using and in some cases how the VA is not helping the use of the VA Choice card.

I am grateful to the city of Gilbert for hosting us in this facility. Being here is very helpful to our having a full discussion. I would like to take a minute to recognize and thank the city of Gilbert for their support of veterans through their various programs such as Operation Welcome Home and support of homeless veterans through the Homeless Veterans East Valley Partnership. I would also like to congratulate the city of Gilbert, which was recognized this year as being in the top five best cities in the United States for veterans.

I will never forget the town hall forum I hosted in Phoenix where I heard directly from the families of four veterans who passed away in recent months. They came and stood before a crowded room to tell their stories. With tears in their eyes, they described how their loved ones suffered because they were not provided the care they needed and deserved. They recalled countless unanswered phone calls and ignored messages, wait times and delays, mountains of bureaucratic red tape, while their loved ones, those who selflessly served their country, experienced painful, debilitating, and ultimately fatal conditions.

No one should be treated this way in a country as great as ours. But, to ignore the pleas for help and care from those who have sacrificed on behalf of the United States is unconscionable. We should all—all of us—be ashamed.

The scandal at Phoenix led to revelations of similar problems at other VA medical centers around the country where bureaucrats were gaming the system to get better bonuses by denying care to our veterans. This strategy created a crisis of confidence toward the VA, the Federal agency that was established to care for them.

I am happy to note that Congress responded quickly in a bipartisan manner to this crisis in a matter of weeks. The House and Senate passed the Veterans Access, Choice and Accountability Act. This bill provided an unprecedented $15 billion in immediate emergency appropriations that was added on the Veteran Health Administration's regular annual budget of about $60 billion to hire more doctors and nurses and to issue the VA Choice card for those veterans who could not get into a VA for their health care.

The bill also gave the VA direct hiring authority so that all of the cumbersome rules and regulations for bringing on board new Federal employees could be waived to fill vacancies.

We will be discussing more about the budget and resources provided to the VA on the next panel.

Congress also provided the Secretary of the VA with nearly unprecedented ability to terminate senior executives who fail to care for our veterans. No other Cabinet official has this powerful tool to ensure performance and results from its department's top officials.

I continue to be disappointed that Secretary McDonald has not used this authority to its fullest extent. As I have said, it is past time for accountability and leadership at the VA.

I want to thank our witnesses today on the first panel. Dr. Mitchell is a former employee of the VA Medical Center and a whistleblower. She will have very interesting comments to make.

Mr. Charles "Chuck" Byers is a Vietnam veteran himself and an advocate for all veterans here in Phoenix. His ability to receive care through the Choice program is a success story.

Finally, Ms. Nicole Morris, who is still not here.

I am sure everyone in this room agrees we owe a solemn debt to those in uniform who fought on our behalf in faraway places.

I just want to make a brief comment on the makeup of our second panel, which will consist of VA witnesses, as there has been a last-minute change.

Last Friday, my staff was informed that the VA determined that a senior manager at the Phoenix VA, who was originally due to testify today, retaliated against a VA whistleblower. In light of this recent information, he will not be testifying this morning while we determine what has occurred with his case.

Needless to say, all of us take issue with whistleblower retaliation at the VA very, very seriously. We have been discussing the matter with Secretary McDonald, especially in light of concerns about systemic problems in this regard that the Office of Special Counsel raised directly with the President a few months ago.

After today's hearing, Senator Flake and I are sending a letter to Secretary McDonald to find out exactly what occurred in this retaliation case we were just made aware of and how it was handled.

With that in mind, we have a number of issues that more broadly impact Arizona veterans to cover, and many of those veterans are here today to tell us about their experiences. Today, we will be

focusing on the Choice card implementation and continuing problems with excessive wait times that our veterans face.

For the 9 million American veterans who are enrolled in the VA today and for the families who lost loved ones awaiting care that never came and are still grieving their losses, it is time to live up to the VA's mission today, "To care for him who shall have borne the battle and for his widow and his orphan."

I thank you again, Senator Sullivan, for being here. I am very pleased to note, we did not have this hearing in Alaska. I thank you. [Laughter.]

The CHAIRMAN. Thank you, Senator McCain.

As I mentioned, it is truly an honor to be on a panel with both Senator McCain and Senator Flake, who, in my discussions with him over the course of the last year, I know is fully committed to taking care of our veterans. Again, the two Senators from Arizona played such leadership roles in addressing the issues that it is an honor to be here with both of them.

Senator Flake, your opening statement?

STATEMENT OF HON. JEFF FLAKE,
U.S. SENATOR FROM ARIZONA

Senator FLAKE. Thank you, Chairman Sullivan. Thank you for chairing this hearing, and thank you for coming all this way and bringing Alaska winter weather with you anyway.

I just want to say, from the beginning, with problems long before that, Senator McCain has been advocating for veterans. Throughout this issue, with the Phoenix VA as the epicenter of this latest problem that we had, Senator McCain from the beginning was pushing hard to make sure that veterans received Choice and that there is accountability. This field hearing is part of that.

I am glad to have had the Choice Act passed. Yet, as Senator McCain and Senator Sullivan both said, there are issues with its implementation. We want to make sure that it goes forward.

Also, in light of the October VA Inspector General report, noting problems still in the urology department in particular at the Phoenix VA, talking about substandard care there and delays that may have contributed to the deaths of veterans, we remain concerned and want to make sure that those issues are fixed. It is beyond unacceptable if we are still having those kinds of issues.

Obviously, we want to make sure that, as I mentioned, the Choice Act continues to be implemented, and that the problems we had early on are dealt with.

Thank you, Senator Sullivan, for coming here and thank you, Senator McCain, for pushing this issue all the time.

I can tell you, being in the Senate, Senator McCain is always pushing veterans' issues and making sure that the veterans here and across the country get the care that they deserve. So, thank you for being here.

The CHAIRMAN. Thank you.

Now we will begin with our first panel. I would ask the witnesses to please try to keep their opening statements to 5 minutes. Our goal is to have each panel for about an hour.

Mr. Byers, the floor is yours.

STATEMENT OF CHARLES "CHUCK" BYERS,
VIETNAM VETERAN

Mr. BYERS. Thank you, Senator Sullivan, Senator McCain, and Senator Flake. Thank you for inviting me today to speak about the VA Choice card, management accountability, and the Phoenix VA Medical Center, and, as we say, keeping the promise to Arizona veterans.

In August 2013, I moved to Arizona from New Jersey. I was enrolled in the Philadelphia VA health care system. I knew I had to transfer my eligibility to the Phoenix VA hospital care system. In September of that year, I applied to the Southeast Clinic in Mesa Arizona.

I was told it would be at least 1.5 years before I could get a primary care doctor. I was even told that it might be sooner if I go down to the Tucson VA. I could not wait because I was receiving medication from my VA in Philadelphia. But, if the doctors do not see you, they will not renew your prescriptions.

I went downtown to the Phoenix VA Hospital, which is about 50 miles away from my home and was told the same thing. Then I spoke to an advocate. I was able to get an appointment in about 9 months. They told me the reason for such a long wait time was due to a decrease in staffing and staff leaving for better paying opportunities outside the VA system.

I was not satisfied so I called the Office of Inspector General in Washington, DC, and filed a complaint. In about 2 weeks, I received a call from a VISN that oversees the Phoenix VA system and was given an appointment for a primary care physician at the Mesa Southeast Clinic.

I know how to advocate, but there are a lot of veterans out here who do not. Some of them will just give up.

Now I am officially enrolled in the Phoenix VA health care system, and I am out there seeing my primary care physician and receiving my medication.

Before I left the Philadelphia VA, I was being seen for a urological condition and should have a follow-up. I requested an appointment for urology to my primary care physician. I waited over a year for my request for a urology appointment and was finally contacted by TriWest to see an outside urologist.

I received excellent care with multiple visits with the outside group. At this time, the Phoenix VA offered very little urological services, and there were a lot of veterans who were referred out to this group for their care.

After a follow-up visit, I was told the urology practice has dropped their contract with TriWest because of delayed payments for services provided. I understand that that issue has since been resolved.

The Phoenix VA hospital has taken back my urology appointments now and also in the future. I feel the Phoenix VA health care system is improving and correcting some of the previous shortfalls. But, I am concerned that the level of care for veterans like myself will continue and not repeat some of the problems that we have had in the past. There are a lot of dedicated employees at the Phoenix VA system, and they are starting to see more and more veterans working in the health care system.

I think it is important to continue the Veterans Choice card. However, I feel that there are still barriers that prevent the veterans from using it. For instance, the language states, "40 miles to the closest VA facility that has a primary care physician." There are multiple CBOCs here in Arizona within those 40 miles. However, they cannot provide all the services that are needed for veterans and still have to travel great distances for care to the local VA hospitals. Sometimes this can be over 200 miles here in Arizona.

I understand no system is perfect and a lot of these programs are new. But, I think it is important that we veterans keep the Choice card for an added insurance policy for our earned and deserved health care from our government.

Us Vietnam veterans, we say, never will one generation leave behind another generation. Thank you.

[The prepared statement of Mr. Byers follows:]

PREPARED STATEMENT OF CHARLES G. BYERS, VIETNAM VETERAN

Keeping The Promise To Arizona Veterans

Thank you for inviting me today to speak about the VA Choice Card.
Management Accountability, The Phoenix VA Medical Center

In August 2013 I moved to Arizona from New Jersey.
I was enrolled in the Philadelphia VA Healthcare System. I knew I had to transfer my eligibility to the Phoenix VA Health Care System. In September of that year I applied to the SE VA Clinic in Mesa and was told it would be at least a year or more before I could get a primary Doctor there. I was even told it might be sooner if I enrolled in the Tucson VA.
I could not wait because I was receiving medication from my VA in Philadelphia but if the Dr's don't see you-they will not renew your prescriptions. I went downtown to the Phoenix VA Hospital which is about 50 miles from my home and was told the same thing. I then spoke to an Advocate and was able to get an appointment in 9 months. they told me the reason for such a long wait time was due to decrease in staffing and staff leaving for better paying opportunities outside the VA System.
I was not satisfied and called the OIG's office in Washington and filed a complaint. In about two weeks I received a call from the VISN that oversees the Phoenix VA System and was given an appointment for a Primary Physician at the Mesa SE Clinic .
I know how to advocate but there are a lot of veterans that would have given up.
Now I am officially enrolled in the Phoenix VA Health care system, seeing my primary care Physician and receiving my medication. Before I left Philadelphia VA ,I was being seen for an Urological Condition and should have a follow up. I requested an appointment for Urology to my primary physician. I waited over a year for my request for Urology Appointment and was contacted by Tri-west to see an outside Urologist.
I received excellent care with multiple visits from this outside group. At this time the Phoenix VA offered very little Urological Services and there were a lot of veterans that were referred out to this group for their care. After a follow up visit I was told that the Urology Practice has dropped their contract with Tri-west because of delayed payments for Service provided. I believe that issue has been resolved.
The Phoenix VA Hospital has taken back my Urology appointments now and in the future.
I feel the Phoenix VA Health Care System is improving and correcting some of the previous short falls but I am concerned that the level of care for Veterans like myself will continue and not repeat some of the problems we had in the past.
There are a lot of dedicated employees the the Phoenix VA System and we are starting to see more and more veterans working in the Healthcare System.

I think it is important to continue with the Veteran's Choice Card Program, however I still feel there are barriers that prevent Veterans from using it. The language states the 40 mile rule to the closest VA facility that has a primary physician. There are multiple CBOCS here in Arizona within those 40 miles, however they can not provide all the services that are needed for the Veterans and still have to travel great distances for care to the local VA Hospital. Sometimes this can be over 200 miles here in Arizona.
I understand no System is perfect and a lot of these programs are new but I think it is important we veterans keep the Choice Card for an added insurance policy for our Earned and Deserving Health Care from our Government.
Thank you,

Charles G. Byers
5462 South Peachwood Drive
Gilbert, Az 85298

The CHAIRMAN. Thank you, Mr. Byers.
Dr. Mitchell?

STATEMENT OF KATHERINE MITCHELL, M.D., FORMER EMPLOYEE OF THE PHOENIX VA HEALTH CARE SYSTEM

Dr. MITCHELL. I am deeply grateful for the opportunity to testify today. I am a former VA nurse and current VA physician with over 16 years' experience working within the Phoenix VA. A little over 1 year ago, I transferred from the Phoenix VA to the VA network office in Gilbert, AZ. However, I have maintained my Phoenix VA contacts.

In April 2014, following in the steps of Dr. Sam Foote, I became a public whistleblower to report dangerous ER nursing triage, ER staffing shortages, whistleblower retaliation, and facility scheduling violations, among other issues.

In my opinion, not much has changed with these issues since that time, except the scheduling rules are now being followed and there are certainly more staff in the ER.

Throughout the last 20 months, Phoenix VA employees have privately contacted me to describe instances of poor patient care, delays in care, violations of policy, and retaliation for reporting problems. I was also made aware of significant problems for patients scheduling appointments through the Choice program.

Although I continue to advocate for improvements within the Phoenix VA ER, in my current position, I have been told that I am not allowed to address issues that are still there. The continued presence of dangerous triage conditions in the Phoenix VA ER, as well as problems in the mental health clinic triage, were substantiated in a VA Office of Medical Inspector (OMI) report that was released internally to the national VA in March of this year and publicly released in September by the Office of Special Counsel.

This official VA report called the Phoenix ER nursing triage "a significant risk to public health and safety."

Although there were serious flaws in the OMI investigation, it still found many problems, including grossly inadequate nursing triage, nurses who failed to perform EKGs when ordered and failed to act upon orders for serious patient complaints such as chest

pain. The triage in the walk-in mental health clinic was substandard and nursing triage protocols were called inadequate.

After this OMI report's internal release to the VA in March, the Phoenix VA ER nurses were trained in a triage tool called Emergency Severity Index, or ESI. Unfortunately, while ESI is a valuable adjunct to triage care, ESI training does not teach triage symptom recognition nor imply a mastery of triage skill. In fact, the ESI fits on this small slip of paper and consists of only six questions.

Watching the news, in my opinion, the Phoenix VA has misled the public into believing that ESI training resolved the safety deficits in triage. Problems, however, are still reported to me by Phoenix VA ER staff.

Despite my formal recommendation, there has been no in-depth, standardized nursing triage training that would give the nurses the broad knowledge base needed to effectively evaluate patient symptoms. There are still no minimum qualifications to be a triage nurse.

Nurses who jeopardize patient safety by not following patient care orders are still working in the ER.

I have been told that there have been additional episodes of unstable patients escaping from the Phoenix VA ER since February 2015.

Ill patients still wait too long, greater than 6 hours to be seen. The ER continues to be flooded.

An email series just last week stated that all rooms were full and there were 30 people waiting in the waiting room. This email series also reported other conditions that were described in the email as "a recipe for disaster."

I also remain extremely concerned about delays for consult care and appointments. I have encountered recent cases in the spring and summer where the failure to receive a timely VA appointment or consult may have contributed to a veteran death or, at a minimum, taken away quality-of-life before the veteran died.

I am prepared to discuss some of these incidents today with the Committee, if it so chooses.

Since the VA scandal erupted, there has been no significant change in the dysfunctional institutional culture there. Several of the offending senior administrators have voluntarily left the Phoenix VA without ever facing any consequences for their retaliatory behavior. Other unscrupulous Phoenix VA administrators and supervisors remain in positions of power.

In fact, one administrator remains in a key leadership position although he has caused problems in several areas. According to a 2014 VA Office of Accountability and Review investigation, this same administrator retaliated against a whistleblower.

Because your committee monitors the entire VA, I want to make you aware that the issues of which I speak are not only at Phoenix but potentially across the Nation. The national VA has never established standardized nurse triage training nor developed standardize nursing triage protocols, even though such training and protocols are readily available in the private sector at low cost or free.

Whistleblower retaliation is rampant throughout the VA. Retaliation against physician whistleblowers has driven physicians out of

the Phoenix VA specifically and elsewhere, which is discouraging others from applying.

Because of time limits for this opening statement, I cannot go into detail regarding multiple other issues, including the dangerous design of the new ER that is obsolete even before it is built, gross difficulties with telephone access within the Phoenix VA, lack of digital faxes needed to avoid delays in record receiving, and the inappropriate switching of consults type without the ordering provider's approval.

I must say that I am grateful to the many dedicated Phoenix VA staff both in and outside the Phoenix ER who have brought forward the issues of which I have spoken today. The Phoenix VA has the potential to be a stellar VA facility, because of the staff, but desperately needs your help to achieve this goal. Thank you.

[The prepared statement of Dr. Mitchell follows:]

PREPARED STATEMENT OF DR. KATHERINE L. MITCHELL, FORMER EMPLOYEE OF PHOENIX VA HEALTH CARE SYSTEM

CONTENTS

Section I: Introduction & Summary

My name is Dr. Katherine Mitchell. I am a VA physician who worked within the Phoenix VA Emergency Department (ED) for almost 10 years until I involuntarily was transferred to a defunct VA clinic in retaliation for repeatedly identifying dangerous ED patient safety deficits. After years of having my reports of life-threatening conditions ignored by internal Phoenix VA mechanisms I publically became a whistleblower in April 2014 in an attempt to have the VA resolve those many serious problems. I alerted the public and Congress to unsafe conditions in the Phoenix VA Emergency Department, whistleblower retaliation, facility scheduling irregularities, and other issues. After the Veterans Health Administration (VHA) formally acknowledged the workplace retaliation against me, I accepted a position within the VA Veterans Integrated Service Network (VISN) 18 office as a Specialty Care Medicine coordinator. Although I continually advocate for improvements at the Phoenix VA ED and Mental Health Clinic, in my current position I have been told by VA administrators that I am not allowed to actively address the known dangerous conditions that still exist there.

The presence of these dangerous conditions was substantiated in a September 2015 Office of Special Counsel (OSC)/ VA Office of Medical Inspector (OMI) report that was released internally to the VHA in March 2015. This official report called the Phoenix VA Emergency Department triage "a significant risk to public health and safety" and detailed substandard nursing care in the Phoenix VA ER and Mental Health Clinic, a significant lack of nurse triage training, and inadequate nursing triage protocols. The report also substantiated "that nurses failed to perform EKGs when ordered, and...failed to act upon orders for serious patient complaints such as chest pain".

After the OSC/OMI report's March 2015 internal VHA release, Phoenix VA ED triage nurses were trained in a triage algorithm called Emergency Severity Index (ESI). Unfortunately, while the ESI is a valuable adjunct to triage care, this ESI training does not convey triage symptom knowledge nor imply a mastery of triage skills.

The Phoenix VA has misled the public into believing that ESI training resolved the safety deficits in the ED. In fact, there has been no significant standardized triage training that would actually give the nurses the knowledge base to effectively evaluate patient symptoms. There are no minimum qualifications formally required for a nurse to work in triage and no definitive policy regarding triage standards. Nurses who chose not to follow patient care orders for serious patient complaints still remain within the ED. Issues with patient elopement still occur.

Unlike the private sector, there is a lack of standardized triage nurse training within the entire VA system, no minimum qualifications to be a triage nurse, and an absence of standardized VA triage nursing protocols. Therefore, the problems present within the Phoenix VA Emergency Department and Mental Health Clinic are likely mirrored at VA medical facilities throughout the nation.

There are recent cases where a Phoenix VA veteran died potentially because of lack of timely follow-up appointment or consult. I encountered these cases after being alerted to the method of Phoenix VA

closure of consults for deceased veterans. Although the VA is supposed to disclose situations were a delay in care could have contributed to a patient's death, there was no evidence on the charts to indicate the charts had ever been reviewed by Phoenix VA quality management staff.

Since the Phoenix VA access scandal erupted there has been no significant change in the dysfunctional institutional culture of the Phoenix VA Medical Center or sister VA facilities. In Phoenix and elsewhere administrators who are known to retaliate still occupy positions of leadership. Based upon conversations I have had with VA staff throughout the country, VA employees today still risk backlash for bringing up patient care problems, identifying misuse of facility resources, and questioning violations of VA policies and procedures.

Therefore, the purpose of my written testimony is to outline the dangerous conditions that still exist in the Phoenix VA Emergency Department and Mental Health Clinic, emphasize the potential for these deficiencies to be mirrored in VA ERs and mental health clinics throughout the nation, cite examples of Phoenix VA patient care delays potentially contributing to veteran death, and highlight the persistent culture of retaliation against whistleblowers at the Phoenix VA and other VA facilities.

By focusing on these issues, I am hoping Congress and the public will demand that national VA correct these deficiencies immediately in order to reduce the imminent risk of patient harm in Phoenix as well as other VA facilities, improve employee recruitment and retention efforts in our grossly under-staffed VA system, and enable the VA to meet and exceed the standards of high quality health care.

Section II: Dangerous Conditions Persist within the Phoenix VA Emergency Department

Background

Emergency Department (ED) nursing triage should be the first step in patient assessment upon arrival to an ER. Such triage will determine how soon the patient will be referred for medical care in the Emergency Department setting. It is vital that nurses who perform initial triage have adequate training and follow standardized protocols for evaluating patients. Without adequate nurse triage training or standardized triage protocols, significant medical complaints will not be recognized or evaluated properly on arrival to the ER. As a result, serious ill patients may not be treated in a timely or appropriate manner resulting in potentially life-threatening delays in care.

The need for appropriate nurse triage extends into urgent mental health clinics. Symptoms of psychological crises must be recognized by the triage nurse so the patient's care can be expedited.

Long-standing Phoenix VA triage deficits in the ER and Mental Health Clinic.

For the last 6 years, there have been significant patient safety issues within the Phoenix VA Emergency Department (ED) triage. During the years 2006-2012 when I was a Phoenix VA ED co-director and director, nurse triage mistakes were rampant during high volume patient flow because of inadequate nurse staffing and inadequately trained and/or overwhelmed triage nursing staff. Hundreds of actual serious triage nursing errors were reported by me through the Phoenix VA nursing and medicine chains of command without any significant attempt by the facility to correct the clearly identified gaps in nursing triage knowledge or lapses in triage judgment. Though not all ED patients suffered actual harm from those nurse triage mistakes, there were serious negative consequences for many veterans and the potential for irreversible patient harm was ever-present.

After I was transferred from the Phoenix ED for retaliatory reasons, the nursing mistakes continued but were not consistently reported because the remaining staff did not want to suffer retaliation. In my new position, I became aware of continuing triage errors and significant delays in care related to poor nursing triage. One example was a patient who was sent from clinic with stroke-like symptoms and was told to just sit in the waiting room because the nurses were too busy with other patients.

Although a few Phoenix ED triage nurses were sent to triage nurse training in either late 2011 or early 2012, there have been no attempts to provide structured, formal didactic training for the majority of Phoenix VA ED triage nurses since that time. Those nurses who received formal training classes in 2011/2012 eventually left the ED. In 2015 the Phoenix VA did initiate Emergency Severity Index (ESI) training for its ED triage nurses in response to an investigation. However, ESI training is merely a very brief step-wise tool for assigning triage priorities and doesn't teach nurses how to recognize when symptoms are serious.

In the interim since I was Phoenix VA Emergency Department medical director, the facility has not enacted any in-depth standardized triage nurse training even though it has improved overall VA ED staffing and expanded the quantity of patient care rooms. While the Phoenix ED may state it has hired experienced triage nurses, a recent investigative report from the VA Office of Medical Inspector indicated there may be a significant absence of formalized didactic triage training among those new hires. Mistakes and lapses in nursing care still occur.

Problems with mental health nursing triage became obvious to me in 2013 when I was assigned to the Phoenix VA Post-Deployment Clinic. Unenrolled patients who presented for mental health triage were referred to the Eligibility Clinic for enrollment prior to a nurse triage screening exam. Patients who presented to the Walk-in Mental Health Clinic would often leave because of extended delays either before or after nursing triage. There were many occasions I noted that the triage nurses did not appear to notify any physician regarding patients in mental health crisis who left prior to being seen by a provider. There remains no routine follow-up for patients who leave the clinic without being seen.

There was a particularly egregious mental health clinic nurse triage case where a veteran seeking help reported in triage that he was randomly shooting at individuals whenever he was inebriated. Without escalating his care or immediately notifying the physician on duty, the triage nurse told the veteran not to own a gun and then simply gave him the Substance Abuse Clinic phone number. Alone in the lobby, the veteran eventually left prior to being seen by the mental health physician. The mental health clinic triage nurse also never alerted any provider to this patient's complaint or initiated any follow-up. Unfortunately, this veteran did not return for any mental health care because he was arrested shortly thereafter by community police investigating a rash of random shootings.

When I raised concerns regarding the quality of his triage care, the Phoenix VA nursing service inexplicably stated the triage nurse met the standard of care. This stance is ridiculous because a well-trained triage nurse or, frankly, even a lay person with common sense nurse would have recognized this veteran was in obvious mental distress and would have escalated his care so the patient could be seen immediately to a provider. Any individual with common sense also would have known to initiate follow-up for this patient if the patient left without being seen by a mental health provider.

<u>Subsequent disclosure of safety deficits to federal agencies after internal Phoenix VA mechanisms failed.</u>

In 2013 I filed an Office of Inspector General complaint (OIG) regarding these serious Phoenix VA nurse triage issues, other safety concerns, and scheduling irregularities. Phoenix VA administrators denied the existence of any problems and the truncated OIG investigation subsequently was closed. I publicly became a VA whistleblower in April 2014 and openly discussed the dangerous triage conditions at the Phoenix VA as well as other issues. I disclosed the Phoenix patient safety deficits the Office of Special Counsel (OSC) which subsequently requested that the VA Office of Medical Inspector (OMI) investigate.

OMI investigation into my allegations of unsafe conditions in Phoenix VA triage areas & other issues.

That OMI investigation into my allegations occurred over 2 site visits in late 2014 and early 2015 at the Phoenix VA. The investigative team reviewed more than 110 examples of potentially life-threatening nurse triage errors that I identified. Although the overall quality and depth of that OMI investigation was extremely poor, it still substantiated 3 out of 4 of my allegations and stated the fourth allegation was true at the time of my complaint but had since been corrected. That OMI report was released internally to the VA in approximately March 2015 so that the VA could start remedying the severe deficits noted.

September 2015 public release of Phoenix VA OSC/OMI report identifying dangerous conditions in Phoenix VA Emergency Department triage and Mental Health Clinic triage.

On 9/17/15, the Office of Special Counsel (OSC) publicly released a key letter, summary OSC report, and related Office of Medical Inspector (OMI) reports regarding the conditions found within the Phoenix VA Emergency Department (ED). Despite the significant deficits involving the depth of the OMI investigation and the nature of some of its recommendations, the OMI still verified the presence of extremely poor nursing triage at the Phoenix VA ED as well as the presence of nurses who "failed to perform EKGs when order, and...failed to act upon orders for serious patient complaints such as chest pain". (The entire report as well as my analysis of the report deficits can be found at osc.gov in the 2015 public files.)

As per the OMI investigation based on 110+ cases presented to it, the OMI concluded there was "a significant risk to public health and safety" because of poor triage in the Phoenix ED. (Please note that the phrase "significant risk to public health and safety" is a direct quote from the OMI investigative team.) The investigators also found evidence of poor triage in the walk-in mental health clinic, inadequate local triage protocols, and inadequate staffing of the vascular lab.

The report findings indicated only 11 out of 31 nurses had any training in Emergency Severity Index (ESI), a common triage tool used in the VHA. The report did not specifically list whether any of those nurses had completed any didactic training for triage skills but the wording appeared to imply none of the nurses had completed any type of formal classroom triage training. The report did not analyze the triage training of nurses in the Mental Health Clinic.

The OSC summary report not only recommended ESI training but also stated that the OMI "further recommended a review of training and educations records to assess whether nurses have appropriate training and experience necessary to work in the ED , in accordance with Emergency Nurses Association (ENA) guidelines. " Those ENA guidelines recommend that a triage nurse complete a formal, didactic training course prior to being placed in a triage role.

Phoenix VA misleading response to OSC/OMI report.

The Phoenix VA publicly responded to the September 2015 OSC letter/OMI report by stating that it has since completed training of ED triage nurses in ESI as recommended in the OMI report to

which it had internal access since March 2015. Because the ESI training has been completed, the Phoenix VA indicated to the media that the issues have been addressed. By implying all ED triage nurses are now adequately trained to be in the triage role, the Phoenix VA is grossly misleading the public. (In fact, any VA facility that cites ESI training as "proof" of adequate triage nurse training is being deliberately deceptive.)

In actuality, the ESI found is merely a very short algorithm or brief step-wise guide used to classify a patient by assigning a number of 1 to 5 inversely based on the number of interventions (labs, x-rays, IV fluids, etc.) that the triage nurse estimates that the patient will require. In general, the more resources that a patient is estimated to require, the lower the number and the more critically ill the patient. As a rule of thumb, patients assigned a 1, 2, or 3 have much more serious complaints than patients assigned a 4 or 5. If all relevant aspects of a patient's complaint are identified, patients that are rated with a 4 or 5 should never require hospitalization. However, if the triage nurse doesn't understand that a symptom is serious or doesn't have the experience to elicit relevant symptoms, the nurse will misinterpret the algorithm and grossly underestimate the number of resources the patient will require. As a result, patients will be assigned an inappropriate ESI number and potentially experience serious delays in medical care.

Because the ESI tool cannot be used to determine the potential seriousness of a symptom, ESI training is never a substitute for in-depth triage training or triage expertise. If the triage nurse doesn't understand that a symptom is serious, the ESI number will be inaccurate and critically ill patients potentially will wait hours for care while their medical condition deteriorates. In fact, the agency that developed the ESI specifically writes in its ESI Implementation Handbook "The ESI is intended for use by nurses with triage experience or those who have attended a separate, comprehensive triage educational program." (It should be noted that the number of years in triage does not equate with mastery of triage skills. If a triage nurse is poorly trained, then there will likely be deficits throughout his or her career.)

The need for standardized formal Phoenix ED nursing training is evident. Based on my 10 years of working at the Phoenix VA ED, many of the nurses who have spent years in Phoenix VA ED triage have continued to make the same triage mistakes because they were never properly trained and never completed formal, didactic triage training. Unfortunately, at least for those trained within the Phoenix VA ED, the triage nurses doing the training were grossly inexperienced and thus produced trainees who were underprepared for the role of ED triage nurse. (I do not know the training background for the mental health triage nurses at the Phoenix VA Mental Health Clinic.)

<u>Failure to timely address key nursing issues identified by the OMI report</u>.

The OMI report on my Phoenix VA allegations was released internally within the VA in March 2015, 6 months before the public September 2015 release. The Phoenix VA should have had ample opportunity to address the all issues identified. However, to the best of my knowledge, the Emergency Department only remedied the lack of ESI training and did not address the fundamental lack of standardized triage training. Most importantly, administration has not addressed the complicit willingness of certain nurses there to commit retaliation against physicians by withholding/slowing down the completion of physician orders. The Phoenix VA

remained silent on the state of mental health triage training or the qualifications of the triage nurses there.

Based on Phoenix VA employee anecdotal reports to me, there are still pervasive issues with the Phoenix ED nursing triage and elements of basic ED nursing care. Ill patients frequently wait excessive amounts of time in the waiting room. Telemetry monitors remain without a dedicated staff member to monitor them. Alarms still ring while nurses, blocking out the sound of those alarms, fail to investigate. Although the majority of ED nurses conduct themselves professionally, anecdotal stories indicate there is a group of nurses who are still routinely rude to patients, fail to follow procedures, and are willing to retaliate against physicians who report improper care.

The OSC/OMI report with grave implications nationally for every VA Emergency Department & VA mental health clinic.

The Phoenix VA ED is not unique. The national VA has never set minimum standards for nurse triage qualifications, instituted standardized triage training, nor developed national standardized nursing triage protocols. Therefore the quality of nursing triage can vary widely on arrival to any VA Emergency Department depending on the time of day, day of week, and nursing staff present. As a result, veterans are at high risk for receiving substandard care. Although every veteran who presents to a VA Emergency Department deserves high quality care, in reality receiving proper nursing triage care can be a matter of pure chance.

In contrast, Emergency Department nursing triage care outside the VA is quite different. The Emergency Nurses Association, the professional body representing emergency room nurses, has set minimum recommended training standards required before a nurse can perform ED triage. In community hospitals, triage nurses have in-depth ER experience in addition to focused, standardized triage training. In the private sector, triage nurse protocols are quite common. In conjunction with adequate triage training, such protocols ensure a standardized, expedited approach to patient symptom evaluation.

Community standards for ED nurse triage training and triage qualifications.

The Emergency Nurses Association (ENA) has minimum criteria set for ED triage nurse training. Within its guidelines is written "A specific amount of time and experience in emergency care alone may not ensure that a registered nurse is adequately prepared to function as a triage nurse. To perform triage with a high level of accuracy and competence, registered nurses should complete a triage-specific educational program, as well as other appropriate courses and certifications, and should demonstrate qualities...that facilitate successful triage... Emergency nurses should complete a standardized triage education course that includes a didactic component and a clinical orientation with a preceptor prior to being assigned triage duties."

To ensure that veterans have access to appropriate nurse triage processes, the VHA needs to recognize and adopt the community standards for triage nurse qualifications. The VHA also needs to prioritize the development of standardized nurse triage protocols.

VHA failure to prioritize the standardization of nursing triage.

The VHA has not responded to multiple avenues by which I have emphasized the importance of implementing standardized triage training, establishing minimal nurse qualifications, and developing triage protocols. Conversations with VA administrators locally and nationally have not resulted in any known actions. My Phoenix ED nurse triage training suggestion never received a response. Most recently, I even submitted the idea through the MyVA Idea House. The feasibility was rated as "easy", the effectiveness was rated as "extremely", and veteran/employee/outcome categories were rated as "high". Unfortunately, the idea was not elevated to the next level of VHA consideration because it was rated low at only a "3" on a scale of 1-10 in terms of "urgency" and given only a "6" on a scale of 1-10 in the category of "importance". Because the VA mission is to care for "those who have borne the battle" it is inconceivable to me that triage nursing care, a critical element in patient care, is ranked so low on the priority list.

Availability of inexpensive online triage training modules & nursing triage protocols.

Within the private sector market there are many face-to-face and online triage training modules that cover the ED nurse triage basics and separate courses that teach that teach geriatric ED triage and psychiatric emergency triage. To my knowledge, despite the availability of these courses, neither the local VA nor national VA administration has attempted to make those modules available for triage nurses. The VHA has not developed its own triage training modules. Ironically, while ignoring nurse triage training, the VHA remains the leader for physician resident training.

(One example of inexpensive on-line training courses are those produced by the ENA. The ENA fee for general nursing triage review is $500 total for a group of up to 20 nurses who would then be able to take the intense online triage training modules. It would take $1000 total to provide modules to the 34 nurses at the Phoenix VAMC. The fees for geriatric and psychiatric emergencies are reasonable but substantially higher because those costs are on a per nurse basis.)

Standardized nursing triage protocols are quite common in the community. Unfortunately, VHA has never adapted any for use within VA facilities. The OMI found deficiencies in the Phoenix VA ED nurse triage protocols. These deficiencies would likely be mirrored in the triage protocols in other VA facilities because there are no national VA standardized triage protocols.

Specific strategies to ensure Phoenix VA and other VA medical centers review & improve ED triage nursing care.

In order to promote safe, consistent care in VA Emergency Departments across the nation, the VA should formally define VA ED nurse triage qualifications in order to perform triage, implement standardized triage training, and establish standardized ED nurse triage protocols. This is the best method to ensure that veterans presenting to VA Emergency Departments receive high quality care.

In the interim, based on the 2015 OMI Phoenix VA ED report recommendations, Exhibit A contains items that would serve as positive steps toward swiftly and proactively ensuring the safety and

quality of care for patients presenting to the Phoenix Emergency Department or walk-in Mental Health Clinic.

In addition, elected officials have the ability to evaluate how well his or her respective home state VA facilities/VA Emergency Departments are performing. Initial strategies for monitoring VA ED performance at Phoenix and elsewhere are listed in Exhibit B.

Section III: Phoenix VA Consult/Appointment Delays Contribute to Deaths

The VHA has stated that any consult not completed after 90 days be reviewed if a veteran has died before that consult could be completed. The purpose of the review is to determine if the delay in consult completion could have contributed to a patient's death. When a delayed consult does contribute to the death of a veteran the local VA facility is supposed to disclose this information to the family.

The national VA has offered no guidance on what to do with consults less than 90 days old if the veteran has died. Some facilities will do a review to determine if the delay in consult contributed to the veteran's death. Other facilities simply close the consult and never look deeper to see if the delay in consult care contributed to the veteran's death.

In the event of a patient's death there is no quality mechanism at the Phoenix VA that automatically reviews consults less than 90 days old.

When a Phoenix VA patient dies with a recent consult (<90 days old) that has not been completed, the consult is administratively closed. There is no automatic review of those consults to determine if the veteran's death could have been delayed or prevented had he or she had the consult completed.

There are recent cases where Phoenix VA veterans potentially died because of lack of timely follow-up appointment or consult.

The VA Office of Inspector General issued a 2015 report regarding the life-threatening delays in Phoenix urology consults. When I reviewed the OIG's Phoenix VA 2014 report regarding deaths on the waiting list, I found several instances where delays in care reasonably contributed to a patient's untimely death. However, these are not the only areas that were affected. I recently have found cases where a consult delay potentially appeared to have shorted patients' lifespans.

I became aware of these cases a few months ago when I was contacted privately by a Phoenix VA employee who was concerned about the closing of recent consults (<90 days old) belonging to deceased patients without actually ever reviewing the chart. Based on information received, I reviewed 78 charts wherein a pending consult was discontinued because a veteran died. None of the charts appeared to have been reviewed by quality management staff or a clinical reviewer.

Based on my review, in 74 cases a delayed consult did not appear affected the veteran's lifespan. However, there were 3 cases where the consult, if done in an appropriate time frame, potentially could have delayed or prevented death. There was one additional case where the delay may not have affected lifespan but certainly constituted inhumane/callous treatment. Those cases are as follows:

Case 1: A veteran with severe heart disease/cardiomyopathy was eligible for an ICD (implantable cardiac defibrillator) that would prevent death by shocking his heart back to a normal rhythm if he developed a life-threatening heart rhythm. The original consult for the ICD placement was ordered on in late Spring 2015 to be done at Tucson VA. However, per Tucson consult note done 5 days later, the

patient was symptomatic from abnormal heart rhythms yet the VA could not place the ICD in a timely fashion. The vet opted to have Fee Basis consult for ICD placement so it could be placed sooner. The Tucson provider indicated the Phoenix provider would order the Fee Basis/non-VA care consult.

However, there was no evidence of the fee basis consult/non-VA care consult ever being ordered in the chart. As a per a chart note about 16 days after the Tucson appointment, the patient had a pending cardiology appointment but doesn't specify where the appointment was to be done. Unfortunately, the patient died on about one week later with no evidence of a cardiology follow-up appointment having been done and no evidence of a non-VA care consult for ICD placement even though he clearly was symptomatic with heart arrhythmias 25 days earlier. (I don't have access to TriWest portal to confirm that there was no private ICD appt.)

Issues of Concern: The community standard would have been to place the ICD within one week at the latest if no symptoms were present. When a patient is symptomatic from arrhythmias, the community standard would be to place the ICD within 24 hours. Unfortunately, this high risk cardiology patient at risk for life-threatening arrhythmias died one month after his cardiologist first recommended ICD placement that could have treated those arrhythmias immediately and prevented death.

Case 2: A veteran had a cardiac catheterization in Spring 2015 that showed significant abnormalities which would indicate he needed cardiac bypass surgery (CABG). The veteran was told the results/options at a cardiology clinic appointment 2 weeks later. Because the patient desired surgery, a consultation to discuss CABG surgery with Tucson VA surgeons was placed at that appointment. For reasons not entirely clear, the patient stated it was a burden to travel to Tucson and desired a surgery locally. A non-VA care consult was ordered about 9 days later. The patient died the next day, about 3 weeks after the initial cardiac catheterization that clearly identified the need for CABG surgery to prevent death.

Issue of Concern: In the community the CABG surgery would have been discussed at the time of the heart catheterization and a consult would have been placed immediately for the patient to have the surgery. There would not have been a 3+ week delay to refer him to a community provider who could perform the CABG.

Case 3: A very elderly male with new onset aflutter (heart arrhythmia), worsening ejection fraction (ability of the heart to pump), and bilateral blood clots in his legs was discharged from the hospital and scheduled for a post-hospitalization cardiology follow-up in a reasonable time frame in Spring 2015. The cardiology provider was sick so the post-hospitalization follow-up appointment was re-scheduled for almost a month later for this high risk patient. The patient died about 2 weeks before that follow-up appointment.

Issue of Concern: In the community a post-hospitalization visit for such a high risk patient would have been completed sooner and may have been able to address/prevent medical complications that ultimately led to the patient's death.

Case 4: A veteran with newly discovered gastrointestinal cancer mass died before he had the work-up completed for the cancer and before he was ever told his prognosis. A large cancerous tumor was seen on VA endoscopy in midsummer but a VA staging CT scan was not done for 2 weeks. There was no evidence of an oncology appointment for the patient. The veteran was doing poorly at home from a physical standpoint with difficulty eating/drinking fluid/caring for self. The wife pleaded with VA staff to have the patient admitted for work-up/cancer treatment. In desperation, the wife finally took the veteran to a private hospital 10 days after the CT scan. The VA was notified by the private hospital and approved stat non-VA care consults for radiation and surgery to be done at the private hospital. Unfortunately the patient died on the same day those stat consults were ordered.

Issue of Concern: Cancer staging work-up was not expedited/completed for this patient with gross evidence of cancer nor did he have timely referral to oncologist prior to his death. Without actual work-up results it is unclear if a timelier work-up would have changed the course of this suspected advanced disease but it is clear that such a work-up/oncology appointment would have been a more humane method of dealing with this veteran/family instead of leaving them in limbo for 3+ weeks until the wife initiated taking the veteran for private care.

(In general, because the system is so complicated to navigate, the national VA should recommend the facilities have a cancer care coordinator to expedite appointments/work-ups. Such a coordinator would help prevent patients from needless delays in care and stop patients from "falling through the cracks" in the VA system.)

Section IV: Persistent Culture of Whistleblower Retaliation within the Phoenix VAMC and Other VA Facilities

Publicly coming out as a Phoenix VA whistleblower in April 2014, I reported many Phoenix VA issues including unsafe conditions in the Emergency Department, whistleblower retaliation, and facility scheduling irregularities. I eventually was able to transfer away from the Phoenix VA senior administration that condoned years of retaliation against me.

I currently work within the VA Veterans Integrated Service Network (VISN) 18 Gilbert, Arizona office as a Specialty Care Medicine coordinator. I have been able to freely report serious patient care safety deficits to the VISN leadership who have been receptive to such notifications. Unfortunately, I am not told the outcome of the care situations I report. Although I have not been allowed to be involved in Phoenix VA ER/Mental Health Clinic issues, I have been able to do other quality management projects to help improve patient care elsewhere.

My interaction with Phoenix VA employees amid persistent culture of retaliation within the Phoenix VA.

Although I do not physically work inside the Phoenix VA, I have maintained communication with Phoenix VA employees. Over the last 20 months since the access scandal broke, I have been contacted privately by staff in the Phoenix VA service lines of medicine, nursing, social work, mental health, and environmental management. The information they have shared has varied upon the circumstances, but the common concern remains a strong fear of facility administrator retaliation for reporting patient safety deficits, inappropriate staff behavior, policy violations, and consequences of delayed care.

Although I have not been allowed to actively address the known deficits at the Phoenix VA Emergency Department or the Mental Health Clinic, I peripherally have dealt with patient care issues inside the Phoenix VA in both an official capacity and as a private citizen. I have provided some Phoenix VA employees with suggestions on how to address issues for those who fear retaliation if they openly report conditions to Phoenix VA administration. For immediate patient care concerns I rapidly notify VISN leadership of the patient care issues while keeping anonymous the identity of the Phoenix VA employee.

VISN 18 leadership has been receptive to my notifications and have stated they will investigate. However, in my current position I am not routinely privy to the outcome of those investigations. Some issues I have reported include inadequate stroke care for veterans in the ED, deliberate understaffing of a busy mental health clinic for the convenience of supervisor's personal schedule, inappropriate actions of ER nurses, and patients whose deaths may have been prevented if their consults had been completed in a timely fashion.

Phoenix VA administrators who retaliate remain in key positions.

I am not surprised that there remains persistent Phoenix VA front-line employee fear of senior management's willingness to retaliate. Several of the offending senior administrators have voluntarily left the Phoenix VA without ever facing any consequences for their retaliatory behavior. Other unscrupulous Phoenix VA administrators and supervisors remain in positions of power.

Within the last 20 months, Phoenix VA employees in mental health, medicine, and social work service have described to me ongoing retaliation for reporting poor patient care and violations of policy. Brandon Coleman, a Phoenix VA mental health specialist, has remained on administrative leave for most of this year. Based on all available evidence, it appears he was placed on that leave in retaliation for publically reporting the series of patient elopements from the Phoenix VA ER.

The case of which I am most aware involves the senior executive who flatly declined in April 2012 to ever investigate the overt ED nursing retaliation against me that greatly impeded my ability to care for ill veterans. He refused to investigate even though five other ER physicians and I simultaneously told him that nurses were delaying my orders, not giving me verbal reports, refusing to hand me EKGs, and not answering my questions in the nurses' station. Not only did that his refusal to investigate violate local and national VA policy, but it also violated basic medical ethics.

An internal VA Office of Accountability and Review (OAR) investigation in August 2014 cited this same administrator as retaliating against me. Unfortunately, the OAR team never interviewed any of the physician witnesses to the administrator's actions during that April 2012 meeting so the OAR report listing his retaliatory behaviors is grossly incomplete. I subsequently learned that this administrator had retaliated against two other Phoenix VA physicians who reported patient care deficits in other areas of the Phoenix VA. Unfortunately, this senior administrator has not been held accountable and remains in a position of power. It is concerning that this unethical and ineffective executive is making daily decisions that affect the quality of medical care for all Phoenix VA veterans.

In December 2014 Jose Riojas, VHA Chief of Staff, sent a letter to the Office of Special Counsel stating that an administrative board of investigation (AIB) would be convened "to resolve leadership accountability issues presented in the [November 2014 OMI] report and in related retaliation claims". I have not been notified of any such AIB.

(Please note that the OAR investigators also concluded that two mid-level management physicians had also retaliated against me when they were my supervisors. Although these individuals enacted retaliatory measures, I believe they were simply following orders from their respective senior administrator in a system that did not allow these physicians to do anything other than carry out such orders from senior executives. If they had refused to do those orders/perform those retaliatory actions, both physicians immediately would have jeopardized their own VA careers and risked suffering a cascade of events leading to their own termination. They had no practical avenues to seek help. Although I did not agree with their actions, I truly believe both

men are deeply dedicated to the VA system and are extremely effective administrators except on those rare occasions when their superiors backed them into an untenable situation. I do not believe it is either just or wise to discipline these physicians who were at the mercy of unethical senior executives.)

Phoenix ED nurses who retaliate remain in the Emergency Department.

Phoenix VA ED nursing retaliation against me is not a pressing issue by virtue of my transfer from the area. However, it remains very disconcerting that several nurses who compromised patient safety via retaliation against me are still actively working within the Phoenix VA Emergency Department (ED). Their demonstrated willingness to jeopardize patient care poses an inherent danger to all future Phoenix VA ED patients if those nurses choose to penalize a particular physician or colleague for identifying ED triage issues. In addition, lack of accountability for their retaliatory actions has a chilling effect on physician willingness to call attention to those ED nursing care problems which are still present today.

National VA investigation into Phoenix VA retaliation against me deliberately obscures evidence of nursing retaliation.

Despite a VA Office of Medical Inspector (OMI) investigation, I have never been asked by any VA administrator or investigator locally or nationally to identify the nurses who retaliated against me. While the OMI report substantiated nurses' complicit disregard for my orders, it failed to substantiate my allegations of nurses withholding verbal report from me or other types of retaliation.

Unfortunately, even though the VHA restructured the OMI in July 2014, the VA OMI investigation into those nurses' behavior appeared to be deliberately geared not to find any results of such retaliation. The VA OMI investigators failed to ask any pertinent questions of the Emergency Department (ED) physicians with whom I had worked closely for 3+ years and who had first-hand knowledge of the retaliation I experienced. Although the original investigative team spoke with 4 of these physicians during a September 2014 investigation, I was informed by some of those witnesses that no questions were asked about specific retaliatory actions toward me. On the second site visit, none of these physicians were interviewed even though locating these ED physicians should have been a very simple task – all of them are still currently employed within the Phoenix VA ED. On both site visits for the OMI investigation, the OMI team did not interview ED front-line nursing staff including any of the nurses with whom I worked for up to 10 years prior to my involuntary transfer from the ED. Many of those nurses are still employed by the Phoenix VA and were witness to the retaliatory actions of a select group of ED nurses. Investigation witnesses on the second site visit told me that no questions were asked about the retaliation against me.

In stark contrast, the VA OMI investigators did take the time to interview 6 nursing administrators and executives, all of whom were part of the nursing chain of command that repeatedly failed to halt the overt retaliation against me that was impeding the care of ill patients in the ED. That nursing chain of command was also the group that refused to launch any systematic improvements in nurse triage care despite the hundreds of cases of serious triage mistakes that I

reported to them. Those nursing administrators have a strong motive to deny that such retaliation occurred. The OMI team also accommodated interviewing 3 other VA executives who were directly responsible for retaliatory actions against me through the chains-of command for medicine and human resources.

"Sham" professional peer reviews at VA facilities nationwide discourage/discredit actual VA physician whistleblowers and prevent appropriate physician retention and recruitment.

In the private health care arena, a professional peer review board is initiated by a health care facility only when there is legitimate concern a particular physician may not be following medical standards of care. The impartial members of this peer review board complete a formal, lengthy review done of a physician's cases to determine if the medical care was appropriate. The physician who is the subject of the peer review has the opportunity to review all cases in advance and appear in front of the peer review board to answer questions or explain medical decision-making. The final outcomes are based on objective findings of the peer review board, not subjective opinion or hearsay.

If the professional peer review board determines the physician's professional practice constitutes substandard care or grossly inappropriate behavior, the physician often will lose some or all privileges to practice at that medical facility. When the medical performance deficits are significant, the professional peer review board will report a physician to the state medical licensing board. In either case, the consequences for the physician are severe and can impede further employment opportunities in any setting.

In the VA system, illegitimate professional peer reviews are used to strategically punish physician whistleblowers and discourage other physicians from openly identifying facility care issues. For instance, if a physician has repeatedly reported facility safety issues, the physician's supervisor may suddenly announce the physician's practice is substandard and place the physician on administrative leave. The peer review board will be assembled and usually consists of an unscrupulous administrator and his or her cronies. Without having any legitimate care concerns identified, a crooked professional peer review board will pull a random assortment of the physician's patient charts and state those charts contain evidence of substandard care even though no violations of care exist.

Even though no legitimate medical care issues found in the patients' charts, this board will still hold a hearing. The physician is often not provided the patient records in advance and cannot prepare any defense. At the board hearing, patient cases are generally not reviewed but instead there is discussion of problems reported by unnamed employees. Without any objective evidence of substandard care or legitimate testimony of improper physician conduct, the professional peer review board then concludes the physician is "unsafe" or "undesirable" and can no longer be employed by the VA. In many cases the peer review board reports the physician to a state medical licensing board.

The purpose of the "sham peer review" is to sabotage a physician's credibility/professional reputation, scare the physician into silence, and, in the extreme, prevent future employment in

any facility. Although a physician can overturn a sham peer review, the process can take years during which the physician is professionally and financially devastated. I am aware of 5 instances of such sham peer reviews over the past few years with Dr. Huttam's case being an example from the Phoenix VAMC. (Of note, Dr. Huttam's case involved the same administrator who retaliated against me.)

Unfortunately, such sham peer reviews are not defined by legal statute as a prohibited personnel practice so the Office of Special Counsel generally does not intervene. VA supervisors and peer review board members face no VA repercussions for participating in such reprehensible and overt retaliation against whistleblowers.

There are many other common tactics commonly used against physicians and other VA employees in order to discourage the reporting of serious VA problems and ostracize/fire employees who dare voice concerns. The end result of physician retaliation is that veterans are denied the skills of talented, well-qualified physicians when those providers are relieved of patient care duties or fired due to unjustified accusations of poor medical skills or substandard conduct. Patient care is delayed as yet another VA physician chooses to resign or retire instead of facing a sham peer review. VA physician vacancies go unfilled as promising physicians avoid the VA's well-known reputation for retaliation against employees.

Sham professional peer reviews and other tactics endanger patient safety by suppressing legitimate care concerns.

In a system where there is rampant whistleblower retaliation or fear of such retaliation, qualified, dedicated VA employees from all service lines are prevented from providing high quality care and services for veterans. Every veteran suffers when legitimate patient care safety concerns in the medical facility are ignored or suppressed by dishonest administrators. Potentially dangerous health and safety problems perpetuate when front-line advocates for quality care are removed from clinical settings.

The VA will only be able to fulfill the mission to "care for him who has borne the battle" when employee whistleblower retaliation ends and supervisors are held accountable for their actions.
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Exhibit A: Specific Steps to Ensure the Phoenix VA Compliance with OMI Report Recommendations

The following actions, based on OMI Phoenix VA report recommendations, would serve as positive steps toward swiftly and proactively ensuring the safety and quality of care for patients presenting to the Phoenix Emergency Department or walk-in Mental Health Clinic:

1. Request the facility formally verify that it has followed the OMI recommendation to perform "a review of training and educations records to assess whether nurses have appropriate training and experience necessary to work in the ED, in accordance with Emergency Nurses Association (ENA) guidelines. " (Those ENA guidelines require that a triage nurse complete a formal, didactic training course prior to being placed in a triage role.)

   While the OMI did not specifically state the mental health triage nurse training records/qualifications should be reviewed, the OMI identified unsafe conditions in the mental health clinic triage. Therefore, it the training and qualifications of nursing triage staff there should be reviewed.

2. Request that the Phoenix VA provide specifics regarding the number of ED and Mental Health triage nurses that currently have completed a formal didactic triage training course (other than ESI training) and the dates/types of those training courses. (This allows baseline assessment of triage training in those high risk areas. This specifically should not include any TMS or ESI training because neither type of course confers basic triage assessment skills.)

3. Request that the Phoenix VA leadership verify and provide evidence of a concrete plan with an actionable time table for providing timely, standardized training to all triage nurses in the Phoenix VA ED and Mental Health Clinic who have not completed formal, didactic triage training. (This forces the Phoenix VA to develop a specific, concrete action plan instead of allowing it to brush off the inquiry by stating the issues are "being reviewed". The management still has not come up with a plan even though it has had access to the OSC/OMI report internally since March 2015.)

   (They do have a proposal to have out-of-state VA personnel come to "assess" triage in likely December 2015 but that is an extremely limited/slow plan considering the magnitude of the problem and there has been internal assess to the OSC report for 8+ months. Phoenix VA leadership have known that the OMI called the Phoenix VA ED a "significant risk to public health and safety" since at least March 2015 and yet have done nothing significant to improve the triage skills except to have the nurses complete a short ESI training module. As previously stated, ESI training is ineffective if the nurses aren't able to recognize serious symptom presentation.)

4. Request that the Phoenix VA provide proof that it has updated all nursing triage protocols to address the inadequacies noted by the OMI report, specifically following the OMI

recommendation to "revise all diagnosis-based protocols to make sure they are symptom-based".

5. Request that the Phoenix VA verify and provide evidence that it has established a local performance metric for ED nurses on timeliness of procedures, e.g., EKGs and medication orders, to make sure that ED nurses adhere to standards of care.

6. Request that the Phoenix VA verify and provide evidence that it has established a local performance metric for ED staff on proper specimen labeling procedures to eliminate processing errors, and repair the label printers to prevent labels from being improperly printed.

7. Request that the Phoenix VA provide verify and provide evidence of 24-hour coverage of the Vascular Service by qualified vascular technicians as recommended by the OSC/OMI report.

8. For any negative responses to items 4-8, request that the Phoenix VA provide a detailed explanation why it hasn't completed the recommendations of the OMI report that has been available internally to the VHA/Phoenix VAMC since March 2015.

Exhibit B: Evaluating Nurse Triage Care & Staffing in VA Emergency Departments Nationwide

In order to promote safe, consistent care in every VA Emergency Department (ED) across the nation, I urge Congress and the public to demand that the VA to establish minimum qualifications for VA ED nurse triage, define appropriate triage training, and develop ED nurse triage protocols. These are the best methods to ensure that veterans presenting to any VA Emergency Department consistently receive high quality triage care.

In the meantime, each elected official has the ability to evaluate how well his or her respective home state VA facilities/VA Emergency Departments are performing. Initial strategies include:

1. Ask the facility to provide the number of patients with an ESI rating of "4" and "5" who were admitted to the hospital each month. According to the ESI system, only patients with ratings of 1, 2, or 3 are considered to have symptoms severe enough to potentially require admission. According to the ESI, patients assigned a "4" or "5" rating should have only minor medical problems and, with extremely rare exceptions, never require admission. If a patient rated as a "4" or "5" was admitted, then quality management should review the case. This could indicate a severe problem with ED nurse triage symptom evaluation.

2. Ask the facility to provide the number of ED patients who "left without being seen". This represents the number of ED patients who were triaged but left without seeing a medical provider. This number can easily be generated on a daily basis by the facility. It indicates that patients were waiting so long that they chose not to remain. Although this may not be reflective of poor quality triage, this does indicate an issue with ED patient flow and capacity. Typically, in poorly staffed Emergency Departments this number flares on weekends, the day before a holiday, and the first business day after a holiday. With the exception of Thanksgiving and Christmas, most holidays will also have a high number of patients who left without being seen if that ED hasn't specifically prepared for the onslaught of veterans presenting for care.

3. Ask the facility to provide the number of patients who waited "more than 6 hours". This number is tracked on a daily basis and is easy to obtain. Large numbers of patients waiting greater than 6 hours indicates problems with flow and capacity either within the ED or within the hospital. Often, when this number is high, the quality of triage deteriorates and seriously ill patients can wait hours for treatment. As noted above, flares in this number will occur during peak flow times such as weekends, the day before a holiday, the first business day after a holiday, and on most holidays except Thanksgiving and Christmas.

4. Ask the facility to provide the number and type of patient advocate complaints regarding any aspect of care in the Emergency Department. If the patient advocates are documenting patient complaints appropriately, those complaints are logged into tracking software and can be recalled by specific clinic name including "Emergency Department".

5. Ask the facility to report any ED complaints logged into the EPERS (Electronic Patient Event Record System). EPERS reports include actual bad outcomes as well as "near misses"

reported by ED staff. While not all staff use the EPERS system for fear of retaliation, the EPERS system may still contain valuable reports about ED problems. Ask for a briefing of how each ED EPERS investigation was handled. Please be aware that the Quality Management department may be months behind in investigating/uploading such EPERS reports to a national database.

6. Ask the facility's police department to provide the number of ED elopements each month. Elopements occur when mentally unstable or confused patients leave before receiving appropriate ED evaluation or treatment. Ask for a briefing of how the facility investigated the circumstances surrounding each elopement and what corrective actions were taken.

7. Ask constituents to report details of any negative experiences they have had within the local VA emergency departments. Constituent reports often mirror recurrent problems occurring in the ED but which may not be reported to the Patient Advocate Office. (Many veterans are so frustrated with the slow patient advocate system that they no longer bother to report significant complaints.)

The CHAIRMAN. Thank you, Dr. Mitchell.

I believe we are still waiting on Ms. Morris. If she arrives, you can please let her know that she can join the witness panel. We will submit her written testimony, which I have read, for the record for this hearing.

Now, what we would like to do is begin with some questioning of the witnesses to have a discussion of these issues. Out of respect for my colleagues from Arizona, I will defer my questions until after they begin. We will begin with Senator John McCain.

Senator MCCAIN. Thank you, Dr. Mitchell. Would you pull that a little bit closer so that we can hear you a little better? Thank you.

Dr. Mitchell, you have watched the evolution of events, legislation, the Choice card, and all of that since the beginning of the terrible scandal here at the Phoenix VA, as we all know. What would you say has been the degree of progress or lack of progress since that happened?

Dr. MITCHELL. The VA has made progress. It was so far down in the hole as far as being behind in its ability to care for patients that any improvements are greatly welcomed. However, there are still too many patients waiting to be seen.

It is very difficult to get appointments through the Choice program, now patients are no longer delayed waiting on the Phoenix VA waitlist, now they are delayed waiting on a Choice waitlist either through problems or difficulty reaching them.

There certainly has been more staffing across the board—physicians and other ancillary service personnel—so that is an improvement. However, there is still incredible difficulty getting things scheduled in the VA. Consults that are needed are delayed because they do not have adequate providers.

Senator MCCAIN. I do not often talk about my own involvement, but I negotiated with Senator Sanders for the VA reform legislation that was passed overwhelmingly by both houses of Congress. I wanted a Choice card for everybody, no matter what. In the nego-

tiations, I had to agree to the 40-mile distance or time on waiting list.

Do you believe that we should go back over the criteria with the Choice card and make it available for every veteran, no matter where they are geographically located or any amount of wait time?

Dr. MITCHELL. I think the Choice card is a great idea, especially for specialists for which the Phoenix VA and other VA's are short-staffed, and for which there are considerable delays in care.

The VA infrastructure is incredibly good. Although I am talking about the cracks in the VA care, the actual VA nationwide has millions of high-quality episodes in patient care every single year. The veterans who are able to get into the system, in general, are very happy with the care, and they get better care than they would in the community.

I do think that the Choice program needs to be restructured because veterans are still waiting, and whatever structure changes can be made to decrease the wait are important.

The other thing is that you need to look at the reimbursement for Choice providers. Part of the problem is not the fact that Choice cannot make appointments. It is that Choice cannot make appointments because they do not have providers signing up. The Choice reimbursement is much lower than the payments for non-VA care under other programs, and lower than Medicare. That should not be the case.

Senator MCCAIN. Mr. Byers, do you have a view on the Choice card?

Mr. BYERS. Yes, I actually concur, that we keep the Choice card and again remove some of those barriers that veterans are having difficulty with, and some of the language. The language is still not very clear to a lot of the veterans that we see.

When it works, it works well. I can say that because I used the Choice card with TriWest, and they were able to get me a provider that provided the services for me. Yet, I still feel that we should have the Choice card. It is an insurance policy for us veterans. I think it is important that we keep it.

Senator MCCAIN. Well, I thank you both for being here.

Dr. Mitchell, we will continue to rely on you.

I guess just one final question to Dr. Mitchell. Maybe this is not a fair question, but I feel compelled to ask it. Would you go to the Phoenix VA emergency room for care?

Dr. MITCHELL. Absolutely not. There is a reason for that. There are physicians in that ER that are the best in the State of Arizona. There are nurses that fill that ER who are the most professional I have ever worked with. The problem is that you have to get past nursing triage, and you have to get past the flood of patients.

Right now, the Phoenix VA health care system does not have a good way of dealing with urgent care patients, patients who do not need emergency care but certainly have issues that cannot wait until the next business day or the third business day or whenever the clinics can schedule them. As a result, you have a whole pool of people bearing down on this very small emergency room which dilutes getting care to people who are really sick, as opposed to getting care to people who can just wait.

There is no standardized triage training. Without that, it is the luck of the draw if you have a triage nurse who knows what they are doing.

Frankly, in my particular case, the nurses who retaliated against me by impeding my care for ill patients, most of them still work in the ER, and I do not trust their professionalism not to impede my care.

Senator MCCAIN. Thank you.

Mr. Chairman, I think I would like to just add a comment for the record.

We are deeply concerned, or we would not be having these hearings, we would not be passing legislation to try to fix it.

On Veterans Day, after the parade, I went down to Phoenix VA and people who are in the hospital there are well-treated. We do have many dedicated people who are working there. There has been some improvement.

Having said that, I think we should give credit to a lot of the outstanding men and women who are serving there. I think fundamental changes still have to be made in order to allow these dedicated men and women who are working at the VA to exercise their full capabilities. Right now, I do not think that is exactly the case.

If there is one issue I would like for us to continue, which you and I and Senator Flake have had numerous conversations with Chairman Isakson, is to make the Choice card completely available.

I thank the witnesses.

The CHAIRMAN. Thank you, Senator McCain.

Senator Flake?

Senator FLAKE. Thank you.

Mr. Byers, just to get an idea of how things have improved or have not improved, if you were to arrive today just like you did a few years ago from New Jersey, not knowing what you know now about how to navigate through the system, how long do you think your wait time would be for the same issues and needs that you had? What would be the change today from what it was before?

Mr. BYERS. I can answer that because I deal with a lot of veterans who come to me for eligibility and they need to get into the VA health care system.

They go through eligibility and at least within 30 days they are assigned a primary care doctor. That is what the appointment says, and that is where they go.

Senator FLAKE. That would have taken how long when you got here?

Mr. BYERS. I got here in August and I saw a doctor in November, but I was told it would be almost a year before I could even see a primary care doctor.

For the veterans today, at least in my CBOC, here in Gilbert, the eligibility works very well. If you are in the system, they can get you a primary care doctor within 30 days.

Now the problem is that you have a primary care doctor, but if you need any kind of specialty care or anything else that you have to have, that is where the bog-down occurs. I have some people who have to wait 6 months for an appointment.

Senator FLAKE. Thank you.

I should have mentioned in my opening statement, like Senator McCain, I appreciate what the city of Gilbert does, the programs that they have and the effort that they make to make sure that veterans here are treated well and receive the care that they can.

Dr. Mitchell, you mentioned that the culture has not changed at the VA. What will it take to have a change in culture? Is that a decades' long process? How can we expedite that to make sure it changes faster?

Dr. MITCHELL. In my opinion, the Central Office has the ability to stop whistleblower retaliation today. They just have not sent out the memo that specifically states the penalty for whistleblower retaliation.

For example, there is a significant amount of retaliation against physicians. There are sham professional standards boards, basically peer reviews where they say the physician is incompetent when they are not. These boards are held without notifying the physician of the accusations, without giving them access to the patient records, without having an impartial board given.

Then, the "not impartial" board makes a finding, says the physician is incompetent, and either fires them or fires them and reports them to their professional standards board. There are very clear policies about how professional standards boards are supposed to be done.

In the community, they are done only when there are there serious concerns that a physician is incompetent. I know of seven physicians in the VA system, either current or former, who have either undergone these sham peer reviews or are currently undergoing them. VA administrators have not followed the rules in each particular case.

All Central Office has to do, all the Under Secretary has to do, is send out a memo that says, at this point, all professional standards board reviews are to be on hold until you get the memo that is coming in 10 days. In that memo, we are going to specify that the rules need to be followed. Whatever findings your boards have, they have to be verified by an independent third party.

I think that is important because there are physicians who do not practice quality of care that need to be covered. Right now, it is a tool for retaliation. It is not considered a prohibited personnel practice, so the Office of Special Counsel will not get involved.

Because Phoenix administrators and administrators elsewhere have retaliated against physicians—this is becoming well known in the community—physicians are not applying for the jobs we desperately need them for. The Central Office needs to come through. It needs to declare that it stops today, and then give teeth to it so that every chief of staff, every service chief who is involved in a sham peer review is held accountable immediately instead of just letting the physician fight on their own, which can take years and can be financially and professionally devastating to the physician.

Senator FLAKE. Thank you, Senator Sullivan.

The CHAIRMAN. Thank you, Senator Flake.

Mr. Byers, I wanted to follow up on a couple questions.

Can you explain a little bit about the handoff when you went from New Jersey to Arizona. I am sure that is obviously common for a lot of veterans to be moving. How did that work?

Mr. BYERS. From New Jersey, you mean?

The CHAIRMAN. Leaving New Jersey. I know this is a beautiful State, so a lot of veterans are coming here, just like my great State of Alaska.

So, how does that work in terms of the handoff, in terms of the ability to just track veterans from one VA center to another? Are there lessons that you learned that we could focus on that could help improve that handoff?

Mr. BYERS. I think it should be seamless. OK, you are in a VA——

The CHAIRMAN. Was yours seamless?

Mr. BYERS. No. It was not. It was seamless for me to contact and work with the Philadelphia VA while I was here because I used My HealtheVet. My HealtheVet is a tool that we veterans can use to contact our primary care physicians, we can instant message them and be able to talk.

But, when they do not see you, or they cannot, they cannot prescribe medication. So, the medication was the main issue for me for that. That is why it was important for me to get a primary care physician.

I had the eligibility. I am priority one. I should not have any problems whatsoever going into the VA health care system. But the wait time, because they did not have a primary care doctor, that was the problem. That was not seamless at all.

Then when you get into the VA system, they do not seem to be talking to one another.

I understand that we have this great computer system, this CAPRI system, where everybody should be able to look at the medical records and see. It took quite a while for that to get transferred here to the Phoenix system. I am sure that that process, hopefully, has been improved.

The VA should be portable. It should be portable. If I have to go somewhere, I am in the VA health care system, I should be able to use it anywhere.

The CHAIRMAN. Another element about your testimony focuses on the delays—obviously, that is something that the Choice Act was focused on addressing is these lengthy delays.

In your written testimony, you noted that you waited over a year for your urology appointment. Did it actually take a year or did something intervene?

Mr. BYERS. I requested a urological appointment because I had to follow up. This is what the Phoenix VA said when I came to Phoenix, to please follow up.

So, I went to my primary care doctor. As we talked, I said I would like to have a referral for urology. I do not know at that time if urology was taking referrals. My understanding is that the urology department at the Phoenix VA were very, very thin. I understand there was probably one urologist at that time, and he was retiring. He was not taking any new patients.

I stayed in the process until finally I complained. How I had to complain? I had to change my primary care doctor. I changed my primary care doctor. I got a new doctor. Probably in all that time with all of what was happening here with the Phoenix VA, that is when the referral went out, and I got my TriWest appointment.

The CHAIRMAN. So, initially, they told you 1 year. You complained, and it took how long to get that appointment?

Mr. BYERS. It took me over a year to get my urological appointment.

The CHAIRMAN. I hope the panelists on our next panel are listening to all of these incidences, because I think that a lot of the explanations have to come from the officials, whether at TriWest or the VA, on why 1.5 years after the Choice Act, we still have veterans who are waiting a year—a year—for an appointment. It is unbelievable.

Mr. BYERS. Senator Sullivan, this was before the Choice Act.

The CHAIRMAN. Let me turn to Dr. Mitchell. I want to follow up on Senator Flake's comments about changing the culture.

Senator McCain mentioned, and I think we all agree, that the VA has many, many great employees who are very dedicated at the hospitals throughout the country. But, your written testimony actually ends by saying you do not think the culture has moved in terms of addressing it almost at all.

If you had a magic wand to address not only the facilities that you are familiar with here in Arizona, but the VA more broadly, how would you focus on starting to address the culture that you are still saying has not really moved a bit in terms of being able to address some of the huge systemic problems we have in the VA?

Dr. MITCHELL. I would make sure that everyone sees the consequences for whistleblower retaliation. Frankly, any leader who has been confirmed to have done whistleblower retaliation through an OSC investigation or an Office of Accountability investigation needs to be removed.

Right now, Senior Executive Service are held to a different standard of behavior than the rest of the frontline employees. The frontline employees are grossly aware of that. Things that senior administrators do and get away with are things that frontline employees would be fired for immediately on the spot. That needs to change.

It is not that there is a lack of people who are really good and dedicated to the VA, you are right. It is a problem that there are a few in positions of leadership who are making bad decisions for the entire VA.

I am appalled at the lack of accountability for leadership. Frankly, I am really disappointed in the Central Office, that they have not come down and truly held—Senior Executive Service, they should be held to a higher standard of behavior than the rest of us.

I would also like to state, although the Senior Executive Service, I certainly have known several that were less than stellar, there is one, Lisa Freeman out of Palo Alto, who rotated to the VISN office where I worked; she embodies some of the best characteristics of the Senior Executive Service I have ever met. The Central VA Office needs to take recognition of leaders like her and have them train the newest leaders coming up.

The CHAIRMAN. Let me ask you two follow up questions that relate to culture. You mentioned it. Senator McCain mentioned that the Choice Act does provide the Secretary of the VA with significant authority to remove officials who have underperformed or per-

formed in a way that should require their termination. Do you think that the VA is actually doing that or utilizing that authority? Is that a way in which to help change the culture, to hold more officials accountable?

Dr. MITCHELL. I do not think the VA is investigating the issues of retaliation seriously enough. In my particular instance, there was an Office of Accountability review investigation. I was interviewed last.

The team refused to interview any of my physician witnesses, which could describe clearly multiple episodes of retaliation. The administrator who was involved was found guilty of retaliation in one instance when actually he was guilty of retaliation in multiple instances that not only showed a lack of leadership skills but showed a lack of basic medical ethics.

Someone who refuses to investigate when six physicians tell him nurses are impeding care for ill veterans in the ER does not need to be in a leadership position, as he lacks basic medical ethics.

The CHAIRMAN. What about the issue of funding? Since the implementation, since the passage of the Choice Act, the VA has actually received an additional $15 billion to implement this new law on top of significant increases in the VA's budget over the last several years. Do you believe it is a lack of funding for the VA? Or is it another issue?

Some say it is a lack of funding. Others have actually said that might even be the problem, in terms of thinking the budget has been dramatically increased.

How do you believe that the funding issue, either too little or too much, relates to changing the culture?

Dr. MITCHELL. I think that the funding issue is part of the problem with the VA, but certainly not the entire problem.

The CHAIRMAN. Meaning that they are underfunded?

Dr. MITCHELL. That they are underfunded. The VA provides tremendous high-quality care. Every time we provide high-quality care to the veteran, it attracts another veteran.

Frankly, even in the ER, when they were able to get additional staffing to be able to care for veterans, once they had more staffing, more veterans came. It is the same across the Nation. There has been a 10 percent increase in appointments.

I do not think the public realizes how big the medical needs are for the veteran population.

What I do think needs to be done also is that some of the funding needs to be better managed. I, like other people, have listened to the media reports, where I find that funding is being spent on public relations that it should not be or other issues. To give any more detailed answer, I am not qualified, because this issue is too complex.

I do think there needs to be an expert panel looking at it, and a panel not of VA employees, but of outside people, such as Secretary McDonald gathering a panel to look at issues. I think that those would be invaluable to seeing where the improvements need to be made.

The CHAIRMAN. Thank you.

Ms. Morris, welcome. We are glad you are here. We would welcome the opportunity to hear your testimony. Please keep it to 5

minutes, then we will also have a few questions for you. So, welcome.

STATEMENT OF NICOLE MORRIS, U.S. NAVY VETERAN

Ms. MORRIS. Thank you. My name is Nicole Morris. I am a Navy veteran. I served overseas in Kuwait in 2004. When I came home, I was told I was eligible for VA benefits.

My first experience was a positive experience. There was a procedure that I needed done, which they did not do at the VA. They were able to get me to a civilian doctor and have the surgery paid for. So, it was a very positive experience.

However, a few years later, I was experience excruciating stomach pains. I did not have any other medical coverage. I went to the ER at the facility downtown at the VA, and I waited for 2 days in the ER to be seen.

The first day, I waited until about 1 in the morning. I was told I was not going to be seen anytime soon. Then I went home and came back. It was probably around 11 o'clock at night when I was finally seen.

When I was seen, it was very brief. They saw me in the back room for about 5 minutes, gave me some pain medicine, and told me to go on my way. There was not really an exam of what was going on with me physically. There was no follow-up. I was just given pain medication and told to go home.

There were other veterans in the ER at the time waiting that had more serious problems. I talked to some of the veterans who had strokes, seizures, who were waiting in the ER for a very long time.

I was told there was a priority list. It was not first come, first serve, but there was a priority list and I was down at the bottom of that priority list.

After that experience, I did not want to go back to the VA. I am a single mom. I am a student. I do not have any other health coverage. It was very disheartening for me.

I often have to pay out-of-pocket. If I have to go to the doctors, I have to pay hundreds of dollars out-of-pocket to go somewhere, to the urgent care, if I am sick.

I have tried scheduling appointments. I no longer have a primary care physician. I never saw my primary care physician. It takes a month, 2 months to get in, if I want to.

It is just very disheartening. It is very stressful to try to get an appointment. I am on the phone a long time waiting to get an appointment.

I have been talking to fellow veterans, and they share the same stories.

I appreciate having the VA coverage. I really do. I am thankful for it. But, I think that there are big improvements that could be done so I can be seen, I do not have to pay out-of-pocket, and that my fellow veterans can be seen as well.

[The prepared statement of Ms. Morris follows:]

PREPARED STATEMENT OF NICOLE MORRIS, NAVY VETERAN

Good morning. My name is Nicole Morris. I am a Navy veteran who deployed to Kuwait in 2004 for Operation Iraqi Freedom. Immediately after leaving active duty,

I was told I was eligible for VA health care. I needed to see a doctor and the VA actually referred me out to the private sector and paid the bill. It was a pretty positive experience. However, several years later and I was still eligible for VA health care and was experiencing severe stomach pains. I went to the VA emergency room at Phoenix at 8:30 a.m. and waited for someone to see me. Hours and hours went by without me being able to see a doctor. I ended up leaving that night because it was clear I wouldn't be seen by anyone. I came back the next day and ended up waiting again until 10 p.m. I was finally seen however it was extremely brief and I was not given the proper medical checkup to determine the issue. I was issued pain meds and released without knowing what my medical issue was.

There were other times I tried unsuccessfully to get appointments through the VA. It was always a hassle. Most of the appointments would be offered one to two months in the future. I'm not sure why I am supposed to stay sick for two months while waiting for a doctor to be available. Other times I would call and be put on hold for 30 to 45 minutes or more.

Another massive inconvenience was the policy that female veterans who needed specific health care specialists could only be seen on Wednesdays. I'm not sure who made that policy but it doesn't make sense to be the VA and only see female veterans one day a week. I work and go to school and also take care of my child and the VA's scheduling just does not meet my needs.

I also have a close friend from my unit who has more serious complications from our deployment than me. She also cannot get seen by the VA for her conditions and it is extremely frustrating and disappointing to hear how she struggles and how the VA is failing to take care of her.

I am sure the VA does provide for some military servicemembers' medical needs. But for me it just doesn't fit. It would be ideal for veterans like me to just have regular insurance that others have such as military retirees who are allowed to use TRICARE. That way I could call the doctor I choose when I am sick to schedule my appointment and not have to work through the VA. It would also help if my son/daughter and I could be covered on the same insurance policy.

Thank you for allowing me to share my experiences with the VA today. I hope that this will lead to reforms of the current system and improved care for those of us that served.

The CHAIRMAN. Thank you very much for that testimony, and thank you for your service. I will ask Senator McCain or Senator Flake if they have any questions for Ms. Morris.

Senator FLAKE. During that emergency room visit, I cannot imagine being there 2 days with just an intervening short time at home. What was said during that time? Did they come out and check on you?

Ms. MORRIS. Not at all, no. I often checked in with them.

Senator FLAKE. There were others in the same condition or similar condition?

Ms. MORRIS. Worse. There was a gentleman who had a stroke, a mild stroke, who I was sitting next to. He was there with his wife.

Senator FLAKE. Did it seem to be just too few personnel there? What seemed to be the issue, that you could tell?

Ms. MORRIS. I do not know. I do not know.

Senator FLAKE. Dr. Mitchell, is that typical of some of what you have talked about?

Dr. MITCHELL. Yes. What happens is that there is a priority list, so the sickest patients are supposed to be seen first. However, that depends on if the triage nurse is skilled enough to actually elicit the appropriate symptoms. If not, then you are not put in the correct order and priority, and you wait longer than you should.

There have been instances, which I have reported through the VISN office, the network office, even this year where strokes were being delayed in being evaluated, which there is this specific stroke protocol and that should never happen. There were strokes that the

nurse did not recognize as a stroke. There were strokes where a physician did not recognize it is a stroke, and the veteran was sent home only to return 3 days later with an inability to walk, a loss of vision, and having to be sent out to another facility that handles strokes.

The other problem is that the ER is physically very small. Originally, it was 11 beds, eight rooms. Now they have expanded, so there are 22 rooms, but there are still only approximately eight beds that have cardiac monitoring abilities. So, if the facility is backed up as far as admissions, then those patients have to be held in the ER, and then everything else gets backed up.

The facility does not allow us to close the ER, or at least it did not during the time I was there for 10 years. That means that although you can go on diversion and no ambulances show up, it does not stop very ill patients from coming to the ER. If they come to your ER and you do not have the capacity to care for the ill patient, our facility, at least at the time I was there, did not allow you to send them to another ER where they could get care quicker.

That is an issue that needs to be addressed because there are ill patients.

When you hear from panel two, you are going to hear a lot of really good statistics, and the statistics are good in some areas. But, there are certain things they are not going to want to mention. One of them is the greater than 6-hour waits in the ER. Those are calculated on a daily basis. Another thing that they are not going to want to mention are the extreme delays for non-VA care consults, which are outside the VA, that are greater than 90 days, and also the consult delays that are inside the VA that are greater than 90 days. Those numbers are huge. They are huge across the Nation. The VA is trying to figure out how to close them all and get people the appropriate care.

You are also not going to hear about statistics like the all-employee survey where the Phoenix VA was in the dumps, as far as confidence in leadership and psychological safety, which all play into fear of retaliation.

There are some serious problems in the ER that need to be addressed. There needs to be a way of managing these urgent care patients so that they get seen as well as the sickest patients.

Right now, you are ethically obligated to see the most sick patients. You rely on your triage nurse to be able to identify the sickest patients. If they make a mistake, then sick patients wait too long while their conditions deteriorate.

That has been an ongoing problem since I was there in 2003. It just got worse when our intake numbers increased.

Senator FLAKE. Thank you.

The CHAIRMAN. Ms. Morris, I had a question relating to your testimony where you talked about the limited hours available to receive gender-specific health care as a huge inconvenience for veterans. Can you talk a little bit more about that, your experience, and what you would recommend try to fix that?

Ms. MORRIS. Sure. For years, the Well Women's Clinic has only been open on a Wednesday. Once again, it was very hard to get into that, if I needed something right away. I would have to wait a month, 2 months.

Just recently, they actually changed it so the primary care physician can do the Well Women checkups, if they are designated to. However, they have to be accepting new patients in their network, they have to be your primary care physician, so not every woman probably has a primary care physician who can provide that service. Otherwise, you would have to wait on a Wednesday to receive that service. The waiting list is long.

I think the recent change is a step in the right direction to enable the primary care physician to give those services. Maybe if we could open it up so it is not just on Wednesdays at the VA downtown, that would be a good suggestion as well, as I cannot get in to see my primary care physician, because right now they are only there on Wednesdays.

The CHAIRMAN. Great. I want to thank the panelists very much. I want to thank you all for your service to our country, and, Dr. Mitchell, to the VA.

We will take a brief recess to move from panel number 1. I want to invite the witnesses for the second panel to please come to the witness table. Thank you again. [Recess.]

The CHAIRMAN. I want to welcome the second panel. The second panel will consist of Dr. David Shulkin, who is the Under Secretary for Health at the Department of Veterans Affairs. He is accompanied by Dr. Thomas Lynch, the Assistant Deputy Under Secretary for Clinical Health, and Ms. Kathleen Fogarty, Acting Director, Veterans Integrated Service Network (VISN) 18: Southwest Health Care Network.

We also have Dr. David McIntyre, Jr., who is the President and CEO of TriWest Healthcare.

Dr. Shulkin?

STATEMENT OF DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS; AND KATHLEEN FOGARTY, INTERIM DIRECTOR, VISN 18: SOUTHWEST HEALTH CARE NETWORK

Dr. SHULKIN. Good morning, Senator Sullivan, Senator McCain, Senator Flake. Thank you for the opportunity to discuss the improvement of access to and the timeliness of veterans' health care in the Phoenix VA health care system.

As you mentioned, Senator Sullivan, I am accompanied by Dr. Thomas Lynch to my left, who is the Assistant Deputy Under Secretary for clinical operations at VA, and Ms. Kathleen Fogarty, who is acting director of the VISN here in the Phoenix region.

I would like to thank Mr. Byers and Ms. Morris, for their service to the country and for their testimony today. I would also like to thank Dr. Mitchell for her testimony. We must depend on our employees to be vigilant about potential sources of harm to our patients and to voice their concerns, if patient safety is at risk, and they need to feel safe in doing so.

In September 2014, the GAO issued its report on managing the oversight of the consult process. VA concurred with all six recommendations and is taking actions to address the concerns raised by the GAO.

During this past year, VHA completed a national assessment of progress note completion and created the technical capability to assess and complete consults. Solutions were implemented by extensive national consult training within all the VISNs, weekly national consult calls, and the creation of a consult training module.

In October of this year, VA's OIG Office of Health Care Inspections delivered its evaluation of access to care concerns in the urology service here in Phoenix. It was determined that Phoenix suffered a significant urology staffing shortage, and its leaders did not have a plan to provide urological services during that shortage of providers.

To fill this need, VHA has hired six new urology employees since January 2013. As of December 7 of this year, the urology service had no patients waiting on its electronic waitlist. It had three consults waiting greater than 90 days. All three of those have now scheduled appointments. Now 99 percent of new patients are seen within 30 days.

Appointment volume doubled from the previous year, while the average wait time from the preferred date was at 3 days, 8 days lower than it was 1 year ago. Urgent care appointments in urology are available the same day.

VHA's efforts to issue disciplinary actions in Phoenix and to resolve the administrative leave status of two employees have been delayed by our inability to interview witnesses who have not been cleared by the U.S. Attorney's Office, and only recently were we given additional evidence by the VA OIG that we had been requesting for the last several months.

Until we have reviewed all of that relevant new evidence that we received, we have been unable to make a determination on what disciplinary action may be warranted related to the patient scheduling waitlist issues. These employees are going to remain on administrative leave.

VA has reached expedited settlements with the Office of Special Counsel on the whistleblower retaliation allegations made by three employees at the facility. Since some of the subject officials in these retaliation cases are the same as those in the patient scheduling wait time case, we have not issued disciplinary actions related to these retaliation allegations.

VHA is taking a number of actions in response to the events in Phoenix, such as: building partnerships with care in the community providers; reducing wait times; holding a national stand down for access this past November; and adding over 630 full-time equivalent employees to the medical center.

In November 2014, the former medical center director was terminated. On October 20, 2015, Ms. Deborah Amdur was appointed as the permanent director. Today is actually her first day.

VHA is continually monitoring wait times and making adjustments as needed to ensure that veterans have access to the best care they rightly deserve.

During fiscal year 2015, Phoenix VA increased completed primary care appointments by 7.72 percent, mental health appointments by 18.38 percent, and specialty care by 15.25 percent. During this period, Phoenix completed over 680,000 outpatient appointments. Overall, the Phoenix VA has completed 95 percent of all pa-

tient care appointments in fiscal year 2015 within 30 days of the date the veteran preferred and the average wait time for all patients in primary care has decreased to 6 days, as of December 7 of this year.

The average wait time for all patients in specialty care is 9.1 days, mental health 4.8 days, and urology 3 days.

On November 14, 2015, VA medical centers across the country, including Phoenix, participated in the first national access stand down. Prior to this stand down, there were 1,650 open priority one level consults at Phoenix open greater than 90 days. After this stand down, there were just 91 priority consults that still needed to be addressed and were authorized for care in the community.

I should say most of those we have been unable to contact. That is why there are 91 still left open.

Although the intent of this effort was to reach those veterans with the most urgent care needs, we will not rest until we fix our system in order to better serve the health needs of all veterans.

VHA is also improving access through extended hours into the evenings and weekends to leverage limited space and enhance convenience for veterans. Designated patient care teams perform extended hours on a rotational basis.

In October 2015, VHA delivered the new Veterans Choice program to Congress, proposing improvements for health care delivery to veterans. The plan addresses enhanced partnerships between VA and community providers to deliver care in the community more seamlessly. With the new Veterans Choice plan, enrolled veterans will have greater choice and ease in use of access to health care services at VA facilities in the community.

Through September 2015, contractors have added over 9,100 Choice authorizations for approximately 7,200 veterans in Phoenix. Additionally, the Phoenix VA created nearly 43,000 authorizations to veterans to receive care in the private sector between October 1, 2014, and September 30, 2015, a 45 percent increase in authorizations when compared to the previous year.

The VA is committed to providing the highest quality care to our veterans who have earned and deserve this care. Our work to effectively and timely treat veterans continues to be a top priority at the Phoenix VA health system and throughout VHA.

We really appreciate Congress' support and look forward to answering any questions you may have.

[The prepared statement of Dr. Shulkin follows:]

PREPARED STATEMENT OF DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Senator Sullivan, Senator McCain, and Senator Flake. Thank you for the opportunity to discuss this important topic regarding the improvement of access to and timeliness of Veterans' health care at the Phoenix VA Health Care System (PVAHCS). I am accompanied by Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health for Clinical Operations, Kathleen Fogarty, Acting Director, Veterans Integrated Service Network (VISN) 18, and Dr. Darren Deering, PVAHCS Chief of Staff.

PVAHCS

The Veterans Health Administration's (VHA) mission is to honor America's Veterans by providing exceptional health care that improves their health and well-being. By extension, this is also PVAHCS' mission and providing timely access to

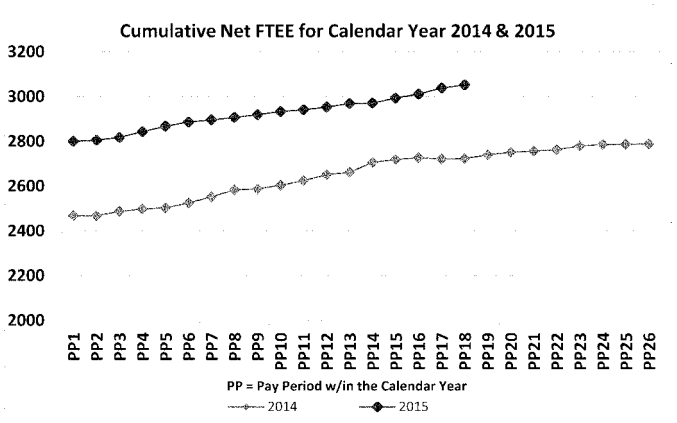
that care is critical. Access enables VHA to provide personalized, proactive, patient-driven health care; achieve measurable improvements in health outcomes; and align resources to deliver sustained value to Veterans.

VHA has taken a number of actions in response to events in Phoenix, such as building partnerships with Care in the Community providers, reducing wait times, holding a National Stand Down, and adding over 500 employees. In November 2014, the former Medical Center Director was terminated by VA and on November 20, 2015, Ms. Deborah Amdur was appointed as the permanent Director of PVAHCS. As previously mentioned, Ms. Kathleen Fogarty serves as the Acting Director for VISN 18 while VHA continues to recruit for a new VISN Director.

VHA is continually monitoring wait times and making adjustments, as needed, to ensure that Veterans have access to the best care they rightfully deserve. During Fiscal Year (FY) 2015, PVAHCS increased completed primary care appointments by 7.72 percent, mental health appointments by 18.38 percent, and specialty care by 15.25 percent. This means that during this period, PVAHCS completed over 680,600 outpatient appointments. Through September 2015, the contractors have created over 9,100 Choice authorizations for approximately 7,200 Veterans. Additionally, Phoenix created nearly 43,000 authorizations for Veterans to receive care in the private sector from October 1, 2014 through September 30, 2015—a 45 percent increase in authorizations when compared to the same period in previous years. Overall, PVAHCS completed 95 percent of all patient appointments in FY 2015 within 30 days of the date the Veteran preferred and the average wait time for all patients in primary care has decreased to 6 days (as of December 7, 2015). This means that PVAHCS is serving more Veterans and providing this service when they need it.

On November 14, 2015, VA medical centers (VAMC) across the country participated in the first ever National Access Stand Down. Prior to this Access Stand Down, there were 1,650 open priority level 1consults at PVAHCS (as of November 6, 2015). After the Access Stand Down, there were 91 priority level 1 consults that still needed to be addressed (as of November 16, 2015) and were authorized for care in the community. Although the intent of this effort was to reach those Veterans with the most urgent needs, we will not rest until we fix our system in order to better serve the health needs of those who need our help most.

PVAHCS opened a new Community-Based Outpatient Clinic (CBOC) in northeast Phoenix in May 2015. Additional CBOC locations have been identified in southwest and central Phoenix, with both activations planned for August 1, 2016, and reassigned specialty care clinic space to the second floor of the Community Living Center. Vacated space in the Ambulatory Care Center has been reallocated to primary care for additional exam rooms and future growth. PVAHCS is also improving access through extended clinic hours into evenings and weekends to leverage limited space and enhance convenience for Veterans. Designated Patient-Aligned Care Teams (PACT) perform extended hours on a rotational basis on Saturdays at the main facility and Southeast Clinic for a full shift. A limited number of PACTs also provide extended hours on Thursdays.



Since January 2014, PVAHCS has seen a net gain of 630 full time employee equivalents (FTEE), or an increase of 25.5 percent. As of October 2015, PVAHCS increased primary care staffing of physicians, nurses, and clerks by 77 additional full-

time employees from April 2014 to present. PVAHCS has approximately 160 FTEE on board, who are funded through the Veterans Access, Choice, and Accountability Act (Choice Act). The graph above shows a history and foundation for sustained high-production hiring for the local Human Resource (HR) office. We are confident that PVAHCS leaders are monitoring operations closely and are in position to continue making H.R. improvements throughout the facility.

VETERANS CHOICE PROGRAM (VCP)

Implementation of VCP, established by the Choice Act, has helped generate an 87-percent increase in the number of PVAHCS consults going out to the community for Veteran care from FY 2014 to FY 2015. PVAHCS is located in the same metro area as the TriWest Healthcare Alliance. PVAHCS has used this geographic access to develop strong working relationships with TriWest leadership and staff. As a result, PVAHCS has undertaken initiatives such as actively participating in the redesign of the TriWest Portal; enabling streamlined communication of records between the agency and vendor for all VAMCs served by TriWest; discussing potential new initiatives with TriWest to physically locate two to three TriWest staff members within PVAHCS to address Veteran/vendor issues more promptly; and holding periodic meetings and teleconferences between the leadership and staff of PVAHCS and TriWest to address issues raised directly from Veterans.

In October, VHA delivered to Congress a plan for how VA could consolidate all purchased care programs into one New Veterans Choice Program (New VCP) to deliver care in the community more seamlessly. With the New VCP, enrolled Veterans will have greater choice and ease of use in access to health care services at VA facilities and in the community. The New VCP will clarify eligibility requirements for care in the community, build on existing infrastructure to develop a high-performing network of community providers, streamline clinical and administrative processes, and implement a continuum of care to improve coordination of services. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve Veterans' experience and access to health care. As VA continues to refine its health care delivery model and examine how the Veterans Choice Program interacts with other VA health programs, we look forward to providing more detail on how to convert the principles outlined in the New VCP Plan into an executable, fiscally-sustainable future state. In addition, we plan to receive and potentially incorporate recommendations from the Commission on Care and other stakeholders.

VA OFFICE OF INSPECTOR GENERAL (OIG) REPORT

In August 2014, VA OIG published its final report, "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices, the Phoenix VA Health Care System," which noted delays in care and quality of care concerns. Of the 24 recommendations, OIG agreed to close three by the time the report was published and VHA has completed action leading to OIG closure on another 15 as of November 25, 2015. Six are still in progress. We will continue to focus on rebuilding employee commitment and morale and moving forward to provide accelerated, timely access to the high-quality health care Veterans have earned—when and where they need it.

U.S. GOVERNMENT ACCOUNTABILITY OFFICE (GAO) REPORT

In September 2014, GAO issued its report, "Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care." GAO found that VHA's management of the consult process had not ensured that Veterans always receive outpatient specialty care in a timely manner. VA concurred with all six recommendations and is taking actions to address the concerns raised by GAO. During the past year, VHA completed a national assessment of progress note completion and created technical capability to assess for incomplete consults. VHA implemented an interim consult standard operating procedure that standardizes consult management processes and developed a comprehensive compliance audit tool and protocol for robust oversight.

Additionally, VHA established business rules outlining appropriate use of cancellation and discontinuation and defined the circumstances requiring clinical determination and documentation of the reasons for discontinuation. VHA standardized the procedures for future care consults and authorized future care consults as the only approved method for managing consult requests for care intended to take place beyond 90 days from the date the consult was created. Facility level consult steering committees were established to identify and share best practices for managing consults. VHA also developed national guidance for management of patient no-shows and canceled appointments. Solutions were implemented by extensive na-

tional consult training with all VISNs, weekly national consult best practice/training calls, and creation of a consult training module.

Although VHA has greatly increased access through more hires and expanded clinic hours, demand has also significantly increased, resulting in Veterans waiting longer for care longer than VA's wait time performance standards. As mentioned above, on November 14, 2015, VAMCs across the country participated in the first ever National Access Stand Down. A team of clinical leaders, administrators and volunteers was on site at every VAMC to reach out to all Veterans identified as having the most important and acute needs to make sure that VHA is meeting their health care needs immediately. VHA's efforts to fix access issues will continue until our system can improve the health needs of those that need our help most.

VA OIG OFFICE OF HEALTHCARE INSPECTIONS (OHI) ACCESS TO UROLOGY REPORT

On October 15, 2015, VA OIG's Office of Healthcare Inspections (OHI) delivered its evaluation of access to care concerns in the Urology Service at PVAHCS. OHI determined that PVAHCS suffered a significant urology staffing shortage, and its leaders did not have a plan to provide urological services during the shortage of providers in the Urology Service. To fill this need, VHA has hired six Urology employees since January 2013.

OHI also determined that non-VA providers' clinical documents were not consistently available for PVAHCS providers to review in a timely manner. OHI concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to these Care in the Community clinical records. Even in the event that further recommendations were not needed, or there were no critical findings, this disconnect between the referring provider and the specialist compromised the overall management of the patient.

OHI also concluded that PVAHCS Urology Service and non-VA Care Coordination staff did not provide timely care or ensure that timely urological services were provided to patients needing the care. OHI identified 12 patients who experienced significant issues that may have affected their clinical outcomes. Two were quality of care issues and the other 10 were wait time issues. Such delays placed patients at unnecessary risk for adverse outcomes. Of these, VHA conducted further reviews and found eight requiring institutional disclosure, six of which are already complete.

VHA concurred with all three of OHI's recommendations and provided acceptable improvement plans. To address OHI's recommendation that PVAHCS ensures that resources are in place to deliver timely urologic care to patients, the facility has hired additional staff to provide urologic care. Currently, PVAHCS has a Chief of Urology, two full-time urologists, and one part-time urologist, a nurse practitioner, and three physician's assistants. Recruitment continues for another staff urologist, which is the only unfilled position in Urology Service. According to data on PVAHCS as of December 7th, the Urology Service has no patients waiting on an Electronic Wait List (EWL); 3 consults aged greater than 90 days (all with scheduled appointments); and 99 percent of new patients are seen within 30 days. Appointment volume doubled from the previous year while the average wait time from preferred date was at 3days—8 days lower than it was 1 year ago. Urgent appointments are available within 1 day.

To address OHI's recommendation that PVAHCS ensure that Care in the Community providers' clinical documentation is available in the electronic health records in a timely manner for PVAHCS providers to review, PVAHCS meets with TriWest leadership on a monthly basis to improve communication and assess the timely availability of records. PVAHCS developed a system by which patient records are downloaded from the TriWest portal on a daily basis. As the patient records are taken from the TriWest portal, they are placed in a facility folder where they are uploaded to Document Manager and linked to complete the Care in the Community consult in the Computerized Patient Record System (CPRS) in portable document format (pdf). The completion of the consult notifies the Ordering Provider automatically via CPRS Alert that the non-VA care consult results are available. All TriWest non-VA care providers are obligated by contract to provide medical records within 14 days. TriWest is obligated by contract to load those records into the portal within 48 hours of receipt so VA staff can retrieve the information.

To address OHI's final recommendation of ensuring that the cases identified in this report are reviewed and for patients who suffered adverse outcomes and poor quality of care, PVAHCS conducted in-depth quality of care reviews of the 12 identified cases and determined that 8 protected peer reviews and 8 institutional disclosures were warranted. Additionally, external reviews are being conducted to validate these findings.

HUMAN RESOURCES RESTORATION AND REVITALIZATION (HR3) SITE EVALUATION REPORT

As part of the H.R. 3 Report, VA conducted a needs assessment for the PVAHCS human resources (HR) team, and the resulting report focused on 65 actions needed for improvement. The most notable finding of the assessment was the poor state of the office culture which was having a negative impact upon H.R. operations, ultimately impacting their core mission of hiring those who could provide access to care. Action plans were developed and implemented locally which provided a framework for PVAHCS H.R. operations.

MYVA

At the enterprise level, the work that is underway to transform VHA operations also supports an effective response to past events in Phoenix. *MyVA* is our transformation from VA's past way of doing business to one that puts Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider. It will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. The *MyVA* vision provides a seamless, unified Veteran experience across the entire organization throughout the country.

One of the five pillars of *MyVA* is improving the Veteran's experience. At a bare minimum, every contact between Veterans and VA should be predictable, consistent, and easy. But we are aiming to make each touch point exceptional. This means that Veterans should be able to make appointments for timely treatment. Events such as the National Stand Down and practices such as extended care hours improve the accessibility of health care in Phoenix and the Veteran's experience.

Another of the five pillars is to enhance strategic partnerships that will allow us to extend the reach of services available for Veterans and their families. We are making it easier for Federal, state, and local government, as well as private sector organizations, to partner with VA by standardizing our partnership processes. This improves health care for enrolled Phoenix Veterans by making it easier for a Veteran to access Care in the Community, when VA care is inconvenient or unavailable.

CONCLUSION

VA is committed to providing the highest quality care our Veterans have earned and deserve. Our work to effectively and timely treat Veterans continues to be a top priority at PVAHCS and throughout VHA. We appreciate Congress' support and look forward to responding to any questions you may have.

LETTER OF REVISED DATA FROM HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

The CHAIRMAN. Mr. McIntyre?

STATEMENT OF DAVID MCINTYRE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TRIWEST HEALTHCARE ALLIANCE

Mr. MCINTYRE. Good morning, Senators Sullivan, McCain, and Flake. I appear before you today on behalf of TriWest Healthcare Alliance nonprofit owners led by Blue Cross Blue Shield of Arizona and our nearly 2,500 employees, most of whom are veterans or family members of veterans, to discuss the support that we are privileged to provide VA in 28 States and the Pacific, including the great States of Arizona and Alaska, as they execute their noble mission of caring for our Nation's warriors.

Our core job is to establish a provider network and make sure that care is placed with it when it is unable to be provided by VA because of wait times or the care exceeds 40 miles from their home.

I am pleased to appear alongside the team from VA, led by new Under Secretary for Health David Shulkin, with whom I have been very impressed in the short time I have had the privilege of working in support of his leadership. I would like to thank him for coming to the furnace and stepping in to lead the way.

Most importantly, I would like to say thanks to Chuck Byers and Nicole Morris and all the veterans in attendance today for their service. We are inspired and humbled by your presence. Know that we will not rest until the final refinements of Choice are in place and the program has achieved its potential.

Mr. Chairman, I ask that my written testimony be accepted into the record.

The CHAIRMAN. Without objection.

Mr. MCINTYRE. General George Patton once said, "A good plan violently executed now is better than a perfect plan executed next week."

I cannot speak to pre-April 2014, but all of us associated with the effort since to ensure that access exists for veterans when and where it is needed here in Arizona and elsewhere know firsthand the definition of a good plan violently executed. In fact, it was the result of a collaboration that we were able to collectively in Phoenix work off the waitlist of nearly 15,000 veterans, as the country was learning about Phoenix and the fact that it was not the only place where supply did not match demand.

Though the Department of Defense took nearly 3 years for the design and implementation of TRICARE, the situation post-April 2014 in VA called for a schedule for more aggressive, 2 months for design and 1 month for execution.

I would say that our fellow citizens who bore the costs of battle deserve such intensity. Senators, initial success was achieved with the design, production, and mailing of the Choice cards to veterans, with more than 9 million delivered. The phone systems were fully operational on day 1 and care began to be placed in the community.

Most in industry said it would take 12 to 15 months just to do that, but we all got it done in 30 days, a good plan violently executed. But, that was a year ago.

Since then, as you know, you and your colleagues in Congress have broadened the definition of an authorization so that cancer patients, pregnant moms, and post-surgical cases will no longer face a 60-day care authorization limit. You broadened the definition

of 40 miles, and you removed the pre-August 2012 enrollment limit.

For our part, we and VA have been collaborating fully, implementing a program to support the Phoenix VA medical center in its emergency room to ensure that when patients show up with mental health emergencies and cannot be handled directly by VA, then we are able to place them downtown. We placed 166 veterans in the last couple of months, providing them with needed protection.

We have identified and are working to close gaps in operation. We have developed and refined tools to better support the needs of veterans, providers, and our staffs. We have identified unmet demand and further expanded the provider network to bring care even closer to home. We are identifying resolutions to claims challenges that are needed, just like we did in the early days of TRICARE, on our road to becoming the fastest and most accurate payer in the marketplace.

While we are not done and we are not where we want to be, I think we are making progress. Today, there are more than 11,600 providers in the network in Arizona, more than 156,000 across the 28 States that we are privileged to serve. Three hundred to 500 are being added still daily.

Second, the number of appointments sought has grown from 2,000 in November 2014 to an expected 110,000 this month. For those of you who did your math quickly, that is an increase of 4,900 percent in that period. In Arizona, we will be delivering on more than 4,000 appointments this month.

Our staff has had to grow from March at 400 to now almost 3,000 individuals.

Third, we have handled 3.8 million veteran calls in that period, volume that has grown at 20 percent a month, with more than 690,000 in November alone.

Our abandonment rate is a mere 3 percent. We are not where we want to be yet. We do not like it at 3 percent. We would like lower. We want to be at the same industry-leading performance that we were in TRICARE, as validated by five successive J.D. Power awards.

Full success? Not yet. However, we believe that together we can get there faster than we did in TRICARE, and our Nation's veterans deserve no less.

So, what is the work that remains, from our perspective?

First, we are implementing major improvements in provider experience that was developed in collaboration with the providers from our network and our longtime partners at the Arizona State University (ASU) customer service institute.

Second, we are approaching the second round of demand forecasting with VA to determine where a network is optimally placed.

Third, we are soon going to train the behavioral health providers in our network on veteran experience in combat, just like we did in the early days of the war under TRICARE.

Fourth, we will soon be implementing the expansion and care authorizations for cancer, pregnancy, and post-surgical patients.

Fifth, we are going to be embedding staff at the VA facilities here in Phoenix and in Alaska to re-create the successful service center concept that we developed in TRICARE.

Sixth, we will be relentlessly focused at the start of next year on gaining feedback from veterans and partnering with ASU to improve veteran experience.

Senators Sullivan, McCain, and Flake, I believe the overall experience is getting better, but we have a lot of work to do before we achieve the vision that you and your colleagues had in the unprecedented action to both authorize and fund the Choice Act in one bill.

It is with deep humility and profound respect for our fellow citizens who put it all on the line for our freedom that we continue to lean forward. The same is true for our owners who by the end of March 2016 will have invested nearly $60 million of their own money in an effort to scale, stabilize, and ultimately refine our operation, so that we achieve our potential and honor the commitments we made when we stepped forward to be the high-performing partner to VA that we were to DOD in TRICARE.

We take our responsibility very seriously for VA, for veterans. This Committee can rest assured that our entire focus is on ensuring that our work in support of VA and the veterans who rely on them for care is fitting of the sacrifices of our heroes and is worthy of their trust.

It is for this reason that we will remain impatiently focused on the path of violently executing the plan until we achieve the success that we know is possible.

Mr. Chairman, this concludes my testimony.

[The prepared statement of Mr. McIntyre follows:]

PREPARED STATEMENT OF DAVID J. MCINTYRE, JR., PRESIDENT AND CEO, TRIWEST HEALTHCARE ALLIANCE

Introduction

Good morning, Mr. Chairman and members of this distinguished committee.

Thank you for the invitation to appear before you today at this field hearing in Gilbert, Arizona. I look forward to discussing our ability to achieve our collective potential in meeting the needs of those who deserve our very best – our nation's Veterans.

I am particularly pleased to be here alongside the team from the Department of Veterans Affairs (VA), led by Under Secretary for Health, Dr. Shulkin, Kathleen R. Fogarty, and Acting Director for Veterans Integrated Service Network 18, Dr. Darren Deering, Chief of Staff for the Phoenix VA Healthcare System and Dr. Thomas Lynch, Assistant Deputy USH for Clinical Operations and Management at the Veterans Health Administration. I would also like to welcome the new Phoenix VA Health Care System Director, Ms. Deborah Amdur, and look forward to working closely with her to best serve Veterans.

I am pleased to say of TriWest and VA that our two organizations are working closely together every day – hour by hour – to improve access to care for Veterans here in Arizona and across the 28-states and three U.S. territories in which we are privileged to support VA in meeting the health care needs of Veterans.

The purpose of this field hearing, as I understand it, is to review the implementation of the Veterans Choice Program (VCP) and to evaluate how the program is currently working in Arizona and the potential for its refinement.

It is a pleasure to be here with Senators McCain, Flake and Sullivan. On behalf of TriWest, I would like to thank you for your longstanding dedication to the health and wellbeing of the Veterans of our nation, and especially here in Arizona and in Alaska. Senators McCain and Sullivan, I would like to particularly thank you for your service in our nation's armed forces. As Veterans, you know the criticality of getting this right. Together with the Senate Veterans Affairs Committee, House Veterans Affairs Committee, the Veterans Service Organizations and the Department of Veterans Affairs, many strides have been made to enhance access to care for Veterans but more remains to be done to fulfill the promise of the nation to those who have borne the price of the battle.

TriWest Healthcare Alliance has a long and proud association with the health care community here in the state of Arizona and with our fellow citizens who have proudly worn the cloth of this nation. From 1995 to 2013, we worked alongside the Department of Defense (DoD). Today, we are privileged to lean forward shoulder to shoulder with VA, doing the same thing we have always done – facilitating the provision of private sector care to our nation's heroes when it is unavailable directly within the federal system. In order to assess TriWest's role in this effort, I believe it is important to provide a brief history of TriWest and how our history lead to the present efforts in support of VA, as we seek to assist VA in honoring this nation's commitment to those who have borne the battle.

A Historical Perspective

During TriWest's 20-year history, the company I was fortunate to help found with a group of non-profit health plans and university hospital systems and have been privileged to lead since as President and CEO, we have focused exclusively on providing access to needed care when it is not able to be provided by the federal systems on which those in uniform rely. Our first 17 years were spent helping the Department of Defense (DoD) stand-up and operate the TRICARE program in a 21-state area that included both Arizona and Senator Sullivan's home state of Alaska.

While we no longer support the DoD in that line of work, I'm proud of the work that we did to assist DoD in making TRICARE the most popular health plan in the country and meet the needs of millions across the TRICARE West Region who relied on us for that support. And, as those of us who were around in the early days of TRICARE can attest, we know it was neither an easy nor painless road. Now, working together with VA, while the challenges of implementing a new program have been similar to the early TRICARE days, due to the added layer of complication that led the Choice Program to be brought forth so quickly, I believe we can achieve the same results for Veterans who look to VA for their health care needs.

In our experience under the TRICARE program, we had nine months to focus solely on standing up the program before the demand for services arrived which allowed time to work through start up program issues. Today, I am proud to say that although we did not have the same implementation timeframe to stand up the Choice Program, we are maturing the program and we WILL achieve the expectations that you and your fellow members of Congress had when you mandated the creation of the Choice program to more optimally meet the health care needs of our nation's Veterans.

That said, I think it's important to consider the historical landscape of Veterans health care in this community in order to then speak to the present and future efforts for this program.

Where We Started: PC3

In September 2013, TriWest was awarded a contract to stand-up and implement the brand new Patient Centered Community Care (PC3) program across 28 states and the Pacific. TriWest rose to the occasion by leveraging the existing networks and strong relationships already in place due to our prior work under the TRICARE contract. Initial access to specialty care from our existing network providers began in January of 2014 with the ongoing expansion and addition of primary care providers coming online over the months that followed. That network building continues to this day as VA and we learn more about where demand exists that was otherwise not being met before this program began. And, we thank the nearly 150,000 providers from our communities of responsibility who have now stepped forward and said I will serve a few of my fellow citizens when VA is unable to do so directly.

PC3 was intended to be a nationwide program giving VA Medical Centers (VAMC) an efficient and consistent way to provide access to care for Veterans from a network of credentialed specialty care providers in the community – one of TriWest's primary missions as a TRICARE contractor. We are pleased to be sharing this work in support of VA with our long-time colleagues in the TRICARE space, Health Net Federal Services. Together we (along with VA) are working very collaboratively to leverage our collective knowledge with the common goal of optimizing VA's direct delivery system and supplement that care with access to care in the private sector when and where it is needed.

PC3 started well here in the State of Arizona and was available to VA to provide access to specialty care in the community when VA was unable to meet the demand directly. As we know, though, the true need for expanded access to care for Veterans was just about to come to light just shortly after the launch of PC3.

The Furnace Lights Off: A Historical Perspective of Choice Program

We all remember the article on the front page of the Arizona Republic in April 2014, which brought national attention to the significant issues faced by Veterans attempting to access care here in Phoenix. When the "furnace lit off" in Phoenix, it served as the catalyst for fueling a focus on VA reform throughout the nation. At that time, nearly 15,000 Veterans were discovered to be on waiting lists for care in Phoenix alone. It is but one example of the re-setting that was needed and has since begun under the leadership of Secretary Bob McDonald, Deputy Secretary Sloan Gibson, and Under Secretary for Health Dr. David Shulkin. Since then there have been a number of Office of Inspector General reports published outlining similar findings all pointing to the reality that Veterans were not getting the care they needed and deserved in a timely manner.

The recognition that further reform was needed to meet Veteran health care needs gave birth, as you know, to the Veterans Access, Choice and Accountability Act (VACAA) and ultimately to the Veterans Choice Program. In August 2014 Congress appropriately passed VACAA and, in

turn recognizing this program needed to be stood up fast in the marketplace, VA leaned on its two PC3 contractors, TriWest and Health Net, to help implement the new Choice Card Act. In fact, we had just over 30 days to go from the policy specs being received from Congress and interpreted by VA to having a program designed and stood up by November 5, 2014 – just 13 months ago.

Within record time, we created the infrastructure, hired and trained hundreds of staff, and mailed Choice Cards to the four million Veterans in our area of responsibility. TriWest stood up a contact center with a personalized message on its toll-free line from Secretary McDonald. This was the first greeting Veterans heard in calling the line and all accomplished within 30 days which was the timeframe mandated in the law.

I recall vividly sitting in a meeting that VA held with industry in mid-September 2014, as they were seeking to determine how to implement this necessary new program, and hearing many say that a program of this magnitude would take a minimum of 12-18 months to stand up and that DoD had been given about 36 months to design and then stand up a similar program with TRICARE.

However, that was not an option. Just as those who serve are not afforded such luxuries of time when our nation sent its Veterans to a place where they were needed. So, we swallowed hard and agreed to lean all the way forward to stand up the program knowing that it would be imperfect, just as TRICARE was in the early days, but that getting it in place and refining as we went forward would be critical to helping our fellow citizens who were standing in line because they were in need of care that was not available directly within VA.

So, we and Health Net stepped into the fire at the side of VA and did what others said could not be done and jointly stretched ourselves to stand up this critical new program in weeks (not months or years). And, in honor of those whom we are privileged to serve alongside VA, we did it. The phones worked, the cards went out, and care started to be rendered in the community when it could not be directly provided by VA.

The partnership between VA and TriWest has matured substantially over the past year. We continue to refine and strengthen operational processes and communication, both on our end and VA's end. Do we still have work to do? You bet we do! But, I am very proud of what we have all accomplished in such a short timeframe. And, I am confident that the trajectory on which we are all on to refine this much needed program will produce the same results as experienced with the refinements that came quickly within the TRICARE program.

One of the core challenges when the PC3 program was first implemented was that we didn't have a clear view of the demand for care. Thus, it made it difficult to ensure a precise supply of network and the subsequent infrastructure of systems and people needed to support that demand as a company. Additionally, we faced programmatic and statutory challenges with the new

Choice program when it was first launched (which is discussed in detail later). But, we had to start moving and then refine later … which is exactly what we have done and continue to do with intensity, and will continue to lean forward until you, Veterans and VA say that we can stand more upright and throttle back a bit. But, that will not be until the job is finished … and we are all comfortable that our fellow citizens are receiving that which was envisioned with the enactment of Choice!

Volumes were low in the beginning as program adoption was low. Care requests were about 2,000 for that first month of 2014. While volume increased each month, care requests under PC3 only reached their peak at about 20,000 per month by the end of that year when the Choice program came into the picture.

The second iteration of the program, beginning in January 2015 (the past 12 months), focused on implementing Choice and finding solutions to some of those challenges – both internally at TriWest, as well as within VA itself. We saw steady increases in care requests month by month with about 75,000 appointment requests per month by August. Just last week that number surpassed 110,000.

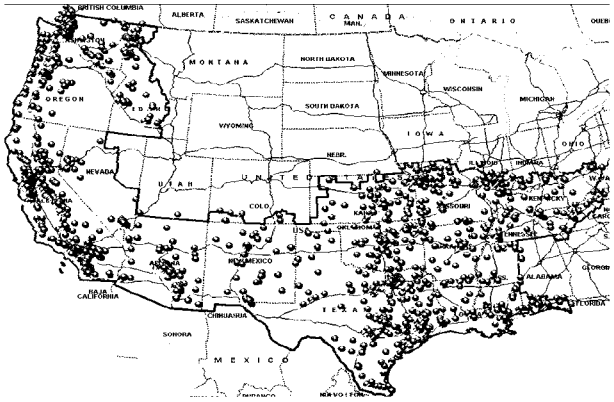
Network Growth

Foreseeing the likely increase in utilization, we initiated a process with the team from VA to sit and assess demand and determine the distribution and supply of network that would be needed in the community to support that demand. We call it the Demand Capacity Assessment Process which last summer was conducted with every VAMC within our service area. We met one on one with each medical center to assess which specialists were still required to meet the needs of that geographic area and the associated demand for those needs. This included not only the demand that was already known but that which seemed ready to materialize with the added policy decisions regarding Choice coming out of Congress. We then took the output of this data-driven process and turned to our owner/network subcontractors, including Blue Cross Blue Shield of Arizona, and started to grow the network on a tailored basis.

We birthed the tools for this process Memorial Day weekend of 2014 for the work that we were tasked with to assist the Phoenix VA in working off the backlog of nearly 15,000. Those tools allowed us to assess the demand and the needed provider and staff supply that resulted in the successful elimination of the backlog by the end of August 2014.

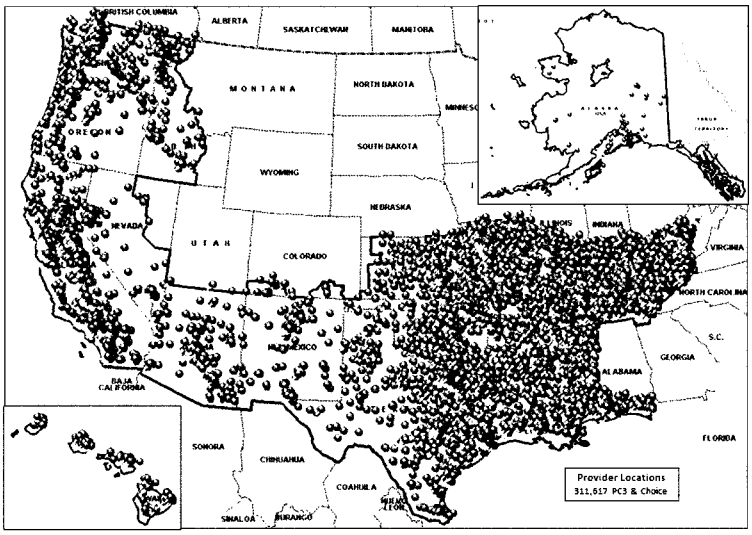
This month, will have us finishing Version 1.0 of the network build portion of the Demand Capacity Assessment Process. The first quarter of 2016, armed with the added changes to the program that have come from Congress, we will come back together for Version 2.0.

The map below highlights the results of this extremely targeted approach, which has resulted in a 23% increase in providers who have answered the call from July to October 2015 to join the network – responding to the jointly identified need.



Over the past 12 months, we tailored our network and expanded our base of 98,000 providers in January 2015 to 156,000 unique providers today (representing over 300,000 provider locations) – more than a 59% increase, and counting – to help ensure that we are available to help serve the VA health care system for their primary, specialty and behavioral health care needs. The map below shows the location of those providers.

December 2015 – All Providers



While expanding the provider network was of primary focus, we also recognized that assuring the quality of our provider network also deserved special focus. To that end, in August 2015, TriWest was awarded full health care network accreditation pursuant to the Health Network, Version 7.1 from URAC, a Washington, D.C.-based health care accrediting organization that establishes quality standards for the health care industry. TriWest demonstrated that we meet key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement, and consumer protection. The full accreditation is valid for three years. Receiving that accreditation this past summer helps ensure our nation's Veterans have access to the highest standard of quality health care providers available through our high quality network of providers.

And, as we continued to focus on the expansion of our network, this past Summer 2015, Congress refined the design of the Choice Program by enacting changes to help expand eligibility, and thus greater access to care for Veterans. And as a result, the number of care requests we received for private care has continued to grow dramatically.

Phoenix Initiatives

Now I would like to turn our focus to Phoenix – our hometown: the site in which the furnace lit off, leading to the focus on re-setting the largest health care system in the United States.

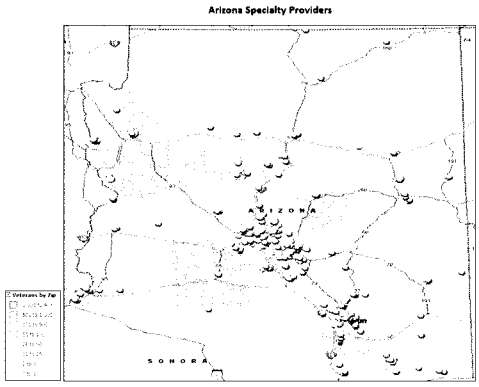
I will tell you that it was right after the revelation of the issues that I received an outreach from the Phoenix VA asking how we might partner with them to assess the backlogs and assist in resolving them. That effort, at the time, was led by Chief of Staff Darren Deering with the two of us on personal speed dial until the backlogs were resolved. That formed the foundational work for a strong partnership between the Phoenix VA and TriWest that continues to this day.

That collaborative work to resolve the backlog of nearly 15,000 Veterans, including 3,300 urology patients, has extended over the months to a full blown partnership with the Phoenix VA relying heavily on the Choice Program to ensure that care is accessed in the community for Veterans when it is not available within the VA Medical Center itself.

The entire team at TriWest, including our Arizona owner, Blue Cross Blue Shield of Arizona, would like to thank the nearly 7,000 providers in Maricopa County who stepped up and agreed to serve those Veterans standing in line. And, we would like to thank the team at VA for leaning forward since April 2014 and for allowing us the privilege of supporting you in this critical work of ensuring that our nation's heroes receive needed care when you are unable to deliver it yourself. We could not be more proud to be your partner.

With regard to our provider network in Arizona, in July 2015, we had 9,000 providers in the network. Just four months later, we have increased the Arizona network by 23%, and proudly have over 11,600 unique providers in the network who have stepped forward to provide care for

our nation's heroes. The following map shows the distribution of those providers, as of November 2015:



Yellow represents PC3; Green represents Choice

As most of us here today know, the providers in this community shoulder the increasing demand experienced as a result of our snowbird population during the winter months. Researchers estimate 300,000 snowbirds in Arizona during winter months, including many Veterans. Additionally, some of those visitors in Arizona arrive with care needs, or continuing care needs. It makes the challenge of access for all of us more difficult at this time of the year, and thus the necessity to share the privilege of serving Veterans between VA and community providers essential to meeting demand. I just don't think we can say thank you enough to those providers who have agreed to lean forward and help provide the needed care for Veterans, particularly during the winter surge months in Arizona.

Delivering an exceptional Veteran and provider experience with the Veterans Choice Program is our objective. It is important to Veterans, providers, VA and those of us at TriWest. In fact, it is exactly what we successfully accomplished nearly every time in TRICARE as we became the standard against which others were often measured. We didn't do it for ourselves. We stretched ourselves to that place for a reason… it was our way to honor those whom were privileged to serve and those providers who joined us in that noble cause. And, believe me when I assure you that we will not rest until we achieve the same in this work.

And, while we hear regularly from Veterans who are delighted with their experience, we also hear from those whose experience at this early stage of the program that leaves something to be desired. It is the latter group that has our attention as we want our work to be worthy of those whom we are honored to count as our customers.

As part of our commitment to achieving the same performance outcome as we produced in TRICARE, we turned to a 20-year partner of ours to repeat an effort we undertook in that work. Once we had a few months of experience under our belt at the side of VA, we started a very focused and intentional effort to assess and understand current experience, identifying gaps and opportunities for improvement by conducting in person, "blueprinting" sessions alongside the industry leading Arizona State University's world-renowned Center for Services Leadership (ASU CSL). In fact, it is they who train such industry leaders as Proctor and Gamble, Starbucks, Disney, and the like in the techniques of customer service mapping and process improvement.

One of the initial blueprinting sessions held this summer included Veteran representatives, Phoenix VAMC leaders, Veterans Service Organization leaders and TriWest stakeholders. As a result of the blueprinting effort, TriWest and VA made changes to processes, program materials, and training to improve the experience for Veterans. The very early indications are that this time-tested approach, mirroring that of the most highly regarded customer service brands in America, is beginning to yield results that matter. TriWest has also introduced the ASU CSL process known as "service recovery" to address customer service breakdowns identified in our complaints and grievance process for inquiries received from Veterans, providers, Congressional offices and VSOs. This process ensures that root causes are analyzed by the leadership so that process improvements to customer service can be made.

Similarly, the provider experience is critical to both TriWest's and our network subcontractors' ability to build and maintain networks to serve Veterans. We recognize that many of the requirements placed on providers to participate in the PC3 and Choice programs create a significant administrative burden, and often go beyond what is typically required of providers to treat patients. It is for this reason that we are making efforts to reduce this burden, where it can be controlled by TriWest, by streamlining our processes. As a result of the provider blueprinting effort, TriWest is now revising our provider letters and redesigning our *Provider* Portal (similar to what we did this past year with the VA portal) to improve the overall provider experience. We call this upgraded experience, "Provider 2.0" – as we take the provider experience to another level, for the 156,000 plus providers in our network who serve the health care needs of our nation's Veterans.

In an effort to lean forward further in the critical space of behavioral health here in our hometown, in response to an outreach from the Phoenix VA, we initiated a pilot project to care for Veterans in urgent need of behavioral health services, who present themselves to the VA emergency department. TriWest has committed to helping place such individuals into the private sector for their emergency behavioral health needs in a timely manner, and to date has ensured that more than 166 Veterans received the urgent behavioral health care they needed. That number represents saved lives. We want to thank the team at VA for having the confidence to turn to us as a teammate, so that together we might address a challenge they were facing.

Another example which illustrates the great partnership we have developed with VA – a partnership aimed at taking care of the Veterans that we are so privileged to serve – occurred right here in Phoenix (as well as nine other locations in the regions where we operate).

On Saturday, November 14th, TriWest stood alongside VA on a special initiative – "Stand Down Day" to advance efforts to reduce the number of Veterans with high-priority or urgent care problems waiting longer than 30 days and to learn together what should constitute our focus in the months to come as we seek to further refine the operation of Choice.

In a collaborative effort with VA, TriWest assembled a team to provide real-time, onsite support for the Stand Down efforts within 10 pre-determined VAMCs. Through this collaborative effort, TriWest worked 6,500 Choice Veterans and the associated referrals. On Saturday, November 14th, TriWest stood in support of the Stand Down with 868 employees working across all hub locations. The TriWest staff responded to inbound phone calls from Veterans and VAMC representatives, responded in real-time to VA comments posted through the shared web portal, data entered all new referral requests received on the 14th, and placed outbound phone calls to Veterans to initiate the appointment process. In addition, TriWest staff (including myself and other senior leadership) joined the VA staff in 10 specific VAMCs to provide real-time, onsite support.

As a result of VA initiating the Stand Down project, VA and TriWest were able to close the gap on outstanding health care service requests at VA and place a significant number of Veterans in the care of a community provider. The results for clinically urgent care were particularly strong as the large majority of care requests were appointed within 5 business days.

Right here in Phoenix, the Phoenix VA submitted a file to TriWest containing Choice referrals for approximately 298 Veterans. TriWest identified 502 referrals for this population. Beginning on November 14th (and scheduled to continue through December 11) TriWest staff researched all unresolved referral requests and initiated contact with Veterans, providers, and VA staff. Overall, TriWest has been successful in reducing the number of pending referrals to less than 30. The results for Phoenix demonstrate the growth of the network of community physicians as well as the tremendous collaboration between TriWest and VA to drive favorable outcomes in a timely manner.

In the area of educating Veterans, providers and others about this program and its operation, TriWest has shown its presence at a number of local town hall meetings around the state of Arizona, as well as attendance and support at a number of Congressional Veteran Resource Clinics. We have briefed government, non-profit and civic leaders on the program and efforts to improve the processes and will continue to do so as we move into 2016. We are also very active with our support of the Veterans Economic Community Initiatives program that was launched by Secretary McDonald in June 2015. This program is committed to providing employment opportunities for Veterans and their families through a network of support at the community

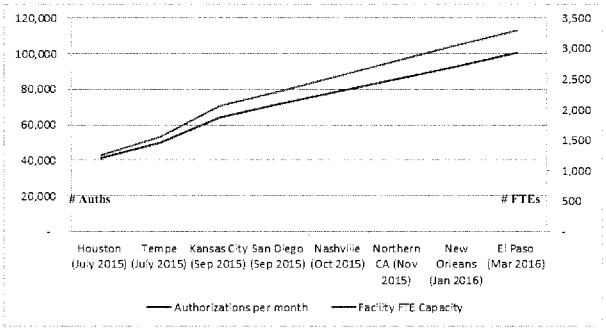
level. In fact, many of our operations centers we have opened throughout the country are located in VECI communities, to include Phoenix, where this program launched and where we had the opportunity of joining Mayor Stanton in the announcement of this program as one of the first companies in Phoenix to take up the mission of hiring America's Veterans.

At the end of the day, Phoenix is our hometown. Our company, which was formed here 20 years ago, remains headquartered here in Phoenix, and employs over 1,000 employees in both our Tempe and Phoenix locations – most of whom are either Veterans or family members of Veterans. This number represents a 150% increase in staffing and a significant job growth impact to these communities dating back to one year ago today. We essentially operated as a startup company when we began this work with VA back in 2013, and have ramped up quickly to keep pace with the increasing Choice program demand.

Operational Growth, Innovations and Program Improvements

Beginning in May 2015, TriWest responded to the growth in care requests by ramping up our workforce, expanding our footprint and our network, and working on operational efficiencies. To meet the increase in demand of care requests that is on pace to hit over 110,000 authorization requests by the end of this month, we have added six new operations centers across our geographic areas of responsibility and implemented a VISN-centric strategy with each of our locations, to better serve those geographic areas "on the ground". Over the past few months, TriWest has opened operations centers in: San Diego (225 employees), Kansas City (over 500 employees); Tempe, AZ (300 employees); Nashville (225 employees); Honolulu (50 employees); and Sacramento (225 employees). We are opening another location next month in New Orleans (250 employees) and a final location in March in El Paso, which will bring us to 10 total locations (including our Phoenix hub and our Puget Sound operations center which were already in place). My expectation is that once we are fully staffed at each of these sites (based upon the eligibility criteria that exists today), with all new staff online, that we will be able to adequately handle the increasing demand coming through this program, which frankly has continued to be a bit of a struggle, as demand has continued to exceed all of our projections!

The following chart outlines the growth in demand of authorizations; specifically, the number of authorizations per month and TriWest's approach to scaling to meet that demand – location by location, and within a very short timeframe.



At the same time, TriWest spent 2015 focused on innovations to help improve program operations across the enterprise. In addition to standing up contact centers, hiring thousands of new employees and building networks, a large focus has been on upgrading systems. We stood alongside our partners at the Phoenix VA almost one year ago today to obtain their requirements for a new portal – a region-wide system that enables VA staff to seamlessly order and track health care services between themselves and TriWest. We had a team of people working in shifts, around the clock for three months, to develop the upgraded portal, which was implemented in several phases beginning in May 2015. The new portal was available to every VAMC within our region by July 2015. Today, VA has over 2,500 trained users on the system, and they rely on this system to manage most aspects of community health care delivered through the Choice program.

Another major initiative TriWest implemented to help manage the surge in program volume and growth in usage among Veterans, and aimed at customer service, was a new Customer Relationship Management System. This new tool will ultimately assist our staff in delivering effective and efficient customer service encounters, just as we did in TRICARE and USAA for those who have served. The system also brings improvements to the user interface and the ability to document outbound and inbound calls with Veterans – all aimed at improving customer service.

And within the contact center, we recently have also implemented a Behavioral Analytics Call Monitoring System which helps improve staff interactions with customers, VA staff, providers and Veterans alike. Our contact centers are being built just as they were under our TRICARE contract – which was recognized for call center operation customer satisfaction excellence for five consecutive years under the J.D. Power and Associated Call Center Certification Program. That distinction acknowledges a strong commitment by TriWest call center operations to provide "An Outstanding Customer Service Experience." It is how we have always operated, and we are committed to that high level of customer service operations again under this program.

On the provider side, we have worked to streamline the claims payment process whereby providers submit their claims electronically and receive their payment within four days. This helps improve provider satisfaction as we approach a better place with claims processing. Today, we are two years ahead of the cycle over where we were in TRICARE. And, TriWest pays clean claims at a rate of 95% in less than 30 days.

With all of these initiatives, tools and expansions in mind, I would be remiss if I did not mention that all these needed upgrades that have been implemented over the past 12 months or so, do not come without cost. Our company's sole line of business is to care for Veterans – it's who we are; it's what we do. And from all we have done in dedicating ourselves to this mission, we have put the priority on getting this right for our nation's Veterans because our non-profit owners believe that is the right thing to do.

Investing around $60 million of our owners money thus far to further our and VA's joint objectives to develop more optimal tools, tailor networks, and scale and re-footprint the company to more optimally deliver customer service at the side of VA, we are pleased with the refinement that is starting to materialize. The fact is that we continue to work hard alongside VA to do whatever it takes to make this program meet the vision from which it was created!

Focus on Customer Service

At the end of the day, the most important tool and resource we have is the feedback from our customers – our nation's Veterans and our network providers – and that we take into account all input received, acknowledging that customer service breakdowns lead to service recovery opportunities as well. To that end, I would like to provide a few examples of Veterans who exemplify the work we are doing in this regard and how we are taking a "service recovery" perspective to fixing issues for these Veterans and those who will follow:

Case Study #1: When Contract Conflicts With Care

Under TriWest's contract with the government (and as prescribed by Congress for Choice-eligible Veterans), TriWest is limited to authorizing follow-up care for a period of 60 calendar days from the date of the original date of service. In some instances, such a timeframe is appropriate for the initial appointment, procedure and follow-up care. However, we have seen many examples of Veterans (and providers) who are unnecessarily stifled by this authorization limitation while in the midst of receiving treatment. Three examples of note:

1) TriWest has worked with a Veteran who requires a specific type of blood transfusion treatment for a chronic condition he contracted during his time in Vietnam. This treatment must occur on a monthly basis for the rest of his life. In the past, he has been able to secure an annual authorization for this treatment, but under Choice he and his

provider must now request six authorizations a year – a significant additional effort and expense for all parties involved.

2) We have a female Veteran in the community who is pregnant and was being seen by a community provider through the Choice program until a few weeks ago, then the facility indicated they were dropping all maternity patients because they did not want to deal with the "back and forth of getting authorizations…" In speaking with the office administrator for the facility, they indicated that their practice made the decision to no longer treat any patients related to the Choice program because they are unable to receive an authorization up front for the entire period. While TriWest was able to place her with another provider in the community and ensure the remaining authorizations are in place for the remainder of her pregnancy, changing a maternity provider mid-pregnancy is certainly not a desirable outcome for any Veteran.
3) TriWest has handled several cases of Veterans beginning or in the midst of cancer treatments where the same authorization challenges apply. In this and all other examples, the current model has TriWest "layering" authorizations in our system to track for coverage of when the next authorization will be necessary, but the requirement for the provider to request that next authorization prior to the end of the 60th day still remains.

TriWest and VA brought this matter to the attention of the congressional committees of jurisdiction earlier this year to explain this challenge to coordinating care for these types of long-term needs. We were successful in securing this needed legislative change, and are looking forward to this change taking place at the beginning of 2016.

Case Study #2: Growing Pains Lead to Systemic Customer Service Issues

1) As discussed earlier, the expedited timeframe for standing up this program has led to challenges for all parties involved (Veterans, providers, VA staff and TriWest staff), and in some ways those challenges have been magnified given that the growing pains of a new system (that is still frankly in its infancy) are far greater than those of a program that had time to work out the bugs before going live. We have seen many examples of those:
    a. We had a provider group in metro Phoenix contact us in March of this year, that had been having significant difficulties getting secondary authorizations approved for services dating back to October of the previous year. Our research identified that the provider had sent in multiple Secondary Authorization Requests (SARs) for care, some of which were the responsibility of TriWest, while others fell on the end of the Phoenix VAMC. Situations like this one led to our effort to collaborate with the Phoenix VAMC, and then seek the input of the other VAMCs across our area of responsibility, to create the next generation VA portal – streamlining both communications and workflow for both parties.
2) We received a written complaint from a Veteran in the Valley who was upset with the conduct of two patient service representatives that his wife had received calls from about

her husband, believing that the staff were "disrespectful and argumentative." The Veteran's wife was authorized to make and receive phone calls regarding all respect of her husband's care, as a signed authorization to release information form was on file with our Privacy Office, but the contact center staff were not identifying this information during the calls. In this case, the staff in question were subcontracted call center staff who were not well versed in TriWest's customer service protocols (which is standard for all of our new contact center staff) and who were unaware of the process for confirming this information. TriWest's CRM system mentioned earlier now provides an alert at the beginning of a call if such information is on file with TriWest, enabling our staff to speak with a Veteran's designated representative about their health care from the beginning of the communication.

3) Historically, we have experienced frustrations from some Veterans who have found themselves appointed to providers anywhere from 60-150 miles or more away from their residence, even though local providers or options much closer were available. Such was the case for an Arizona Veteran earlier this year who, while speaking with a contact center representative in Louisiana, was appointed for a colonoscopy provider located 90 miles from where the Veteran resides. Increases in the provider network across our region, combined with the VISN-centric approach to contact center operations (which enables us to train our staff on the state(s) they serve and better grasp the communities and referral patterns that exist in those states), has lessened these types of frustrations for Veterans.

While there are certainly other examples of breakdowns in the overall process – some VA-centric, some solely on TriWest's shoulders, some policy and contract-related and still others that are best described as "perspective-driven problems" given the attention to this program by the media and the heightened sensitivities to the way the system "should" work – we will continue to identify, research, resolve, track and trend these opportunities for program improvement for the benefit of those we serve and those providers who pledge to serve alongside us in this effort.

This work is intense and focused, just as should be… as we are trying to quickly address the processes we all know need attention in order to improve this critical program and meet the intended objective of Choice.

While I will submit that challenges still remain as the program continues to mature, the customer experience under VCP is getting better with each passing day. Information provided by TriWest staff is more consistent and more accurate; providers are more familiar with the program; and we have recently implemented an initiative that allows any provider in our region to register online with us to be a VCP provider. Knowing who is willing to treat a Veteran under VCP, even if they are not already a TriWest network provider, goes a long way towards speeding up the appointing process.

On a daily basis, our focus is on improving the program. I say this because each challenge presents an opportunity to make the system better and prove to Veterans that good can come from their utilization of this benefit bestowed on them by you and your fellow members of Congress. Whether it's the 95-year old Veteran in northwestern Arizona who used to drive three hours to Phoenix for care (and now gets his physical therapy 10 minutes from home) or the Veteran who spoke with one of our staff after his knee replacement, noting he's had 20 surgeries in his life and the process through Choice was "the easiest of them all" and "perfect", we know that Veterans are beginning to recognize the benefit of this program as utilization increases.

That said, I was honored to receive a copy of a letter received just this past week from a Veteran in Meadview, Arizona – one of the most remote and rural parts of northwestern Arizona – where the Choice program is often of greatest benefit to our Veterans. The letter reads as follows:

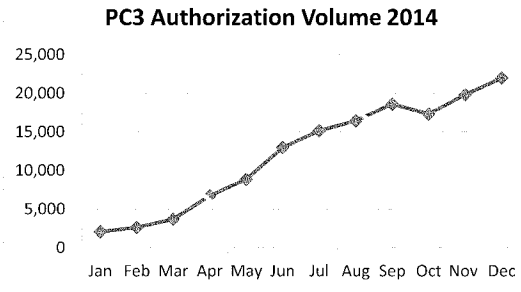
> "I am a Veteran, having served in the US Army from 1969 through 1971. Today I had the pleasure of calling the VA Choice Program and talking to Jocelyn. After 25 minutes, Jocelyn had understood my problem and solved it. She was knowledgeable, knew the right questions to ask, exhibited professionalism, patience and perseverance! I am very pleased at the outcome. This is only the second time I have used the VA Choice Program and both times there were no problems, just relatively easy solutions. I hope the government will make it a permanent program. It is really a blessing to Veterans I have talked to. Please make Jocelyn aware that she did a magnificent job! I also talked to her supervisor to get this address and she was friendly and appreciative. Thank you for hiring such good people to work with Veterans."
>
> "P.S. – Desiree just called with my appointment! Five hours to get it done! Simply wonderful. Thank them all for me."

This is but one individual Veteran, but such statements (which come with increasing frequency) reflect a belief that as this program is allowed to mature, more and more Veterans will find similar benefit in this choice afforded to them through your efforts. Such statements will also continue to charge our batteries as we work relentlessly to make this program into what Congress envisioned less than 16 months ago.

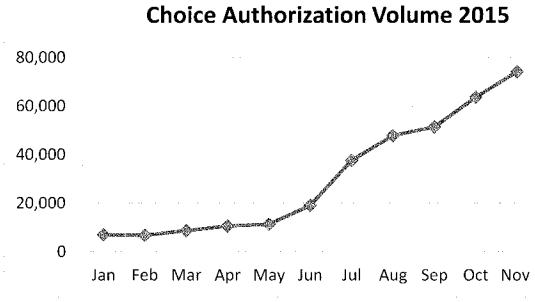
TriWest Performance – Becoming "the Answer" to VA

General George Patton said "a good plan violently executed now is better than a perfect plan executed next week". I think we now know personally the definition of "violently executed", as that has been required of us. We adopted this mindset to begin working off the significant care backlogs in place when we were awarded the contract. And while more time to implement the program would've been ideal, it was necessary to begin coordinating Veteran's health care immediately.

Beginning in 2014 when PC3 was implemented, the program started out slowly with a couple thousand care requests per month. Networks were being developed, and we phased our implementation by region beginning in January of 2014. Then, in April 2014, the furnace lit off in Phoenix, which ignited a rapid increase in program utilization nationwide. Over time, program adoption grew, and by the end of 2014, TriWest received almost 22,000 care requests from VAMCs throughout our regions, as displayed below:

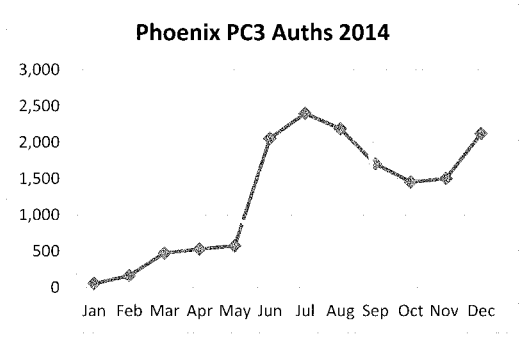


At the tail end of 2014, and moving into 2015, the Choice implementation was birthed. At the start of the Choice program, we received requests for only 2,000 Choice Card appointments for the entire month. This number has skyrocketed and expected to surpass 110,000 this month – just one year into the program. For those of us who are math minded, that's over a 4,900% increase in volume. The chart below shows the upward trajectory for the number of authorizations received per day in 2015:

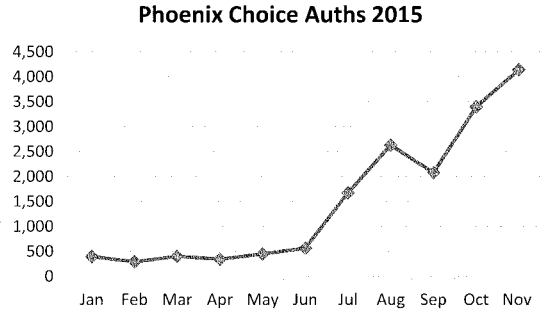


Although this massive growth is a positive indication that more and more Veterans are receiving the care they deserve, it does not come without operational challenges. Despite having added six operations centers over the past six months, increasing staffing by thousands, adding numerous innovations to systems and process, we are still not able to fully keep up with demand.

It should not be surprising then, that Phoenix experienced similar growth as a result of the furnace lighting off in April 2014, when the most significant growth occurred, as pictured below:



The next period of substantial growth in Phoenix occurred as the result of the several initiatives that Congress passed in the summer 2015 to help open eligibility for our nation's Veterans. As the following chart shows, Phoenix also underwent extreme growth in Choice program usage this past year:



This surge in demand over time is being tackled through several strategies, both on the policy side and also operationally, and progress is being made. For example, most recently VA implemented a change order to our contract in early October, which is aimed at lessening the wait lists and speeding the Veteran's access to care. That change involves using a more proactive approach to making health care appointments for Veterans, through the use of outbound calling. That is, through a streamlined process with VA, we now reach out to call the Veteran directly

versus waiting for the Veteran to call us. The new outreach processes we have developed jointly with VA keep the care requests moving rapidly through the system, so the Veteran receives care more expeditiously.

In addition, TriWest continues to scale to meet the demand. Our staffing will grow by another 500 employees over the next couple months, and we will assess any additional locations that may be needed – depending on volume – at that time. In the meantime, we are supplementing with using overtime and other external resources until the opening of our next facility in New Orleans in January and the facility in El Paso at which team we will have nearly 3,000 staff engaged in this critical work.

Further, we continue to collaborate arm-in-arm with 10 VA-identified VAMCs to research and respond to a significant number of authorizations, through the Stand Down Project. This ensures Veterans needing clinically and administratively urgent appointments receive them in a timely manner.

Finally, processes improvements continue to be worked as we implement additional operations centers to round out our presence in each of the VISNs within our regions. As with any new implementation or new job, there is a learning curve. Our employees will continue to become more efficient in their work, systems will continue to be tailored, and processes refined, ultimately resulting in a favorable outcome for the Veteran – which is meeting the overall goal of this program.

Refinements in Policy

At the outset of this program, Congress acted quickly to implement a program which provided enhanced access to Veterans health care. Since then, many legislative changes have occurred to address some nuances of this program that were unforeseen in the beginning.

The first of such changes began in January 2015, under the Omnibus Appropriations Act, when Congress addressed the rate issues present in the state of Alaska given the very unique area under Senator Sullivan's jurisdiction. This change helped align rates in the area with the marketplace – a key component to provider satisfaction and contracting in that state.

Several months later, in July 2015, to further improve the program from a policy perspective, the "Surface Transportation and Veterans Health Care Improvement Act of 2015" modified several requirements of the Veterans Choice Act of 2014.

First, the Act repealed the 60-day limit on follow up care. Instead, the authorization extends for the entire episode of care. When we receive the formal modification to implement this change, it will open doors for many Veterans who need urgent services lasting beyond 60 days, and will

help with certain provider groups who desire to provide care to Veterans, but are stifled by this 60 day authorization rule. We expect that this much anticipated change officially will be modified into our contract in early 2016. When this occurs, patients who face serious conditions (such as the case studies I shared with you earlier) will be able to receive the entire episode of care (chemotherapy treatment, maternity care, etc.) that is required to complete their treatment.

Second, the Act repealed the August 1, 2012 enrollment limitation on eligibility of Veterans in the patient enrollment system. This critical change removed the requirement that you have to be enrolled in VA prior to August 2, 2014, to be eligible for Choice Program. The impact was great to Veterans, allowing near instantaneous determination of eligibility by the VAMC.

Third, the Act extended provider eligibility to any health care provider meeting VA criteria – this change helped open the pool of providers who could provide health care to this deserving population.

Finally, the Act based the 40-mile distance requirement as the distance traveled from a VA medical facility instead of 'as the crow flies', including one offering primary care for a Veteran seeking primary care. This gave more Veterans access to the program, especially in complicating geographic areas.

Another program change last summer that was directed at improving access was the Administration's implementation of the Choice First program – which immediately expanded eligibility and opened the flood gates to care by giving a Veteran the ability to obtain services in the network, when such specialty was not available at all within their local VA medical facility.

Congress continued assessing necessary program modifications later into 2015. In September 2015, TriWest received a contract modification regarding outbound calls, and elimination of blind appointing, and were authorized to begin working these changes on October 1. This more proactive approach to making health care appointments for Veterans prevents an authorization from sitting and aging, awaiting a phone call from the Veteran. And as a result, more Veterans receive health care, and they receive it more timely.

This past month, Congress expanded access to private doctors where its Community Based Outpatient Clinics lacked sufficient provider access, expanding the number of patients who are eligible to seek care in the community under the Choice program. As a result, if VA has no primary care doctor on staff, a referral for private care is not required. This change alone should open the program up to about 160,000 more Veterans.

And finally, we recently received federal approval within our contract to allow TriWest to staff employees at VAMCs with the execution of an appropriate Memorandum of Understanding. Moving forward, TriWest will have several cells of embedded staff within a multitude of

medical centers, including right here Phoenix… where Veterans will be able to be walked right down the hall after a medical appointment that identified need for care in the community. In that office, they will get educated about the program, we will learn of their preferences, and we will start the process of securing them an appointment in the community. We know from our work during the TRICARE program that having staff embedded in a medical facility can go a long way toward making the use of the program a more seamless experience. Those TriWest staff got to know the government staff, the beneficiaries, and also the providers in the community. All of that helped speed the process of getting care provided in a timely manner downtown. We have that opportunity again here in Phoenix. TriWest staff working every day alongside their VA colleagues will identify process challenges quickly and implement solutions even faster. That structure will provide care authorized in a timelier manner and ensure better daily coordination at a personal level instead of faxes, phones, internet portals and emails. We have one such cell in a pilot phase at present at a VAMC within our service area, and will expand to several more facilities – including Phoenix – this year.

Overall, I commend Congress for all the steps it has taken this past year which have driven great program improvements. In addition to the changes that have already been modified into our contract, we are awaiting for the 60 authorization to change to an episode of care (as mentioned above) and we also anticipate a change in Medicare payment, whereby providers no longer have to be Medicare participating in order to see one of our nation's Veterans. This will be another piece to the puzzle of opening up more access to care for those providers who wish to provide care for Veterans nationwide.

The pace is swift and, as you can see, changes are plentiful, but we are implementing at lightening pace, changing programs and refining processes along the way, and MUCH has been done to set the groundwork to improve the overall program and enhance access to care for our nation's Veterans.

Looking Forward – the Art of the Possible

Now that we have had a glimpse into the past, let me take you to a very important part – the future and where this program will take us in the way of the 'next generation' of the program, so that Veterans get the best care they need and deserve. Here's what I see over the next six months that is part of the formula for success moving forward.

At this point, I can confidently say that the Choice program is well on its way to working. Veterans are receiving more of the care they need, when they need it. But there continues to be unmet need. And while the program is working, it's still not working fast enough.

One thing we know for certain is that through all of this, the VCP brought significant availability to health care for Veterans by making many community providers available to enhance access

when access to care in VA in sufficient to meet the need. As the Deputy Secretary, Sloan Gibson, stated during the House VA Committee hearing on November 18, there have been seven million more appointments scheduled this year, compared to last year. While not all of this has flowed through Choice, the volume is continuing to increase as we refine our capability and enhance our supply of network and staff to match demand. Despite all the maturation that still needs to occur to perfect the program, this to me, is great progress because millions more Veterans are receiving health care under this program than they were last year. Now, Veterans are demonstrating that they are gaining trust in the program, and TriWest, and are seeking the care they need.

Demand for health care will grow as Veterans who may have become discouraged and given up seeking care return as the backlogs across the system and we continue to work together to effectively address access issues. We expect that as Veterans continue to build trust in the Choice Program, they will continue to seek out this care when VA is unable to meet the need directly. It is for this reason that we will continue to expand our operations over the next six to nine months – and beyond.

The network will continue to expand and be high performing, so that the Veterans we serve – and the VAMCs we serve alongside – will continue to have the ability to access needed care in a timely fashion.

Additionally, Choice 1.0 will have been given more time to mature, allowing time for operational efficiencies to take hold. We are working daily and hourly with our partner, VA to get this right.

Legislative advances to help move this program forward will have taken a strong foothold. For example, the final contract modification will have been provided to us, giving us the ability to implement legislation that removed the 60-day authorization limitation and instead authorizes care for an entire episode of care. This will open doors for many areas, including those services that typically are needed for more than 60 days such as chemotherapy treatment.

We are also working arm-in-arm with our VA partners to encourage other legislative changes that will promote less hassle from a provider's point of view, which aligns with standard market practices in local communities. Most recommendations for standard care practices require additional review and authorization either by TriWest or VA. Those processes are frustrating to providers and to Veterans, delay care, and ultimately impact the cost and quality of the program. It is our hope that one day we might get to a position where providers are able to efficiently provide care to Veterans in an accepted standard of practice. Similar to the work we did under the TRICARE program, this will just take time for maturation, and we are working toward that end.

In summary, VA's health care system was originally designed to meet the needs of America's Veteran population when inpatient care traditionally was associated with long admission stays. The last major reform of the VA health care system occurred when Congressed passed the Eligibility Reform act of 1996. The result of this legislation was enhanced eligibility and access to care. Prior to that, the biggest change in delivery design occurred when Dr. Ken Kizer introduced his Vision and Journey for Change in the early 1990s.

In 2002, the VA system was re-examined and assessed changes in geographic concentrations of Veterans and ways in which medical treatment was provided. A process called CARES (Capital Asset Realignment for Enhanced Services) occurred to 'update' the VA health care system.

Now we are in the midst of another VA health care reform, and we have the opportunity to make the health care delivery model the most efficient it can be. In my opinion, the best system for Veterans is a VA public-private partnership that builds on what VA does best, while leveraging private sector provider networks and best business practices created by TriWest. But, VA must ultimately be the backbone, focusing on their core mission of taking care of its soldiers inside the four walls of VA. And VA must allow their private sector partners, TriWest, to do what we do best which is to build and enhance networks, process claims, schedule appointments, and help coordinate care for the best outcomes for the Veteran, with flexibility, effectiveness and efficiency. We must continue to work together for the betterment of VA health care, alongside VA and Congress, and we all must continue to build upon the core that we have already developed.

Conclusion

Mr. Chairman, I hope my testimony here has provided some useful information as to how TriWest became a part of this effort, where we are today, and where we are headed in the future. I also hope it has convinced you that the company I am proud to lead considers it an honor and privilege to work every day to provide access to care for those who have served this nation in uniform. We have always stood ready to implement VA health care needs within record speed and record time, and will continue to dedicate ourselves to this critical task, all in support of our nation's Veterans. It is an awesome responsibility and our owners, and we look forward to continuing to be a large part of the formula for future success, as we continue to be part of the "relief valve" for VA.

I want to conclude by thanking my fellow panel members, the leaders from the VA health care system at VA Central Office, the VISN, and the Phoenix VAMC, for their leadership, their commitment, their partnership, their tolerance of us as their partner, and their commitment to ensuring that our nation's heroes receive that which they have earned with their service … when and where it is needed. I want to thank the amazing providers of this community who have leaned forward and said I will serve a few when VA is unable to meet the need directly. And, I want to thank you, Senators McCain, Flake and Sullivan, for your leadership in working to

define the way ahead and partner with all of us to make enhanced access care possible for those who have worn the cloth of the nation!

Thank you again Mr. Chairman for this opportunity. I look forward to answering any questions you might have.

The CHAIRMAN. Thank you, Mr. McIntyre.

I know we have a number of questions. I will begin with Senator McCain.

Senator MCCAIN. Thank you for your testimony.

Dr. Shulkin, you have made a very favorable impression on those of us who have had dealings with you. I believe that you are working very hard, and I also appreciate your efforts to improve our communication and relations with Members of Congress, including the Veterans' Affairs Committee. I thank you and Dr. Lynch for coming out here to be at this hearing today.

Mr. McIntyre gives a rather optimistic view.

In front of you is a chart that shows that obviously veterans waiting over 30 days for appointments, it kind of contradicts what Mr. McIntyre said, because if TriWest was doing the great job that he claims, I would think that veterans waiting over 30 days for medical appointments would show a decline.

Maybe you can respond to that, whether you disagree with that chart, or what your comments are about that.

Dr. SHULKIN. Thank you, Senator.

First of all, I do want to thank you as well. I think that all three of you, your willingness to speak out on behalf of veterans and to work with us to improve the system is very much appreciated. As you know, Senator, I believe unless we do this together, we are not going to achieve the best results. I thank you again.

The wait times that currently exist are not acceptable to VA. That is why we are working so hard to make this better.

The way that we are working is really a dual approach. We are hiring additional staff in the Phoenix VA. We have hired over 600 new employees. We are adding space; we recently added some space and have additional plans to add significantly more space. We are improving our efficiencies, so we are working internally.

Most importantly—again, thanks to Congress, because of your leadership with the Choice plan, we have really utilized care in the community. We are about 80 percent in terms of care in the community from where we were.

Now we have a lot more to go, but I want to make one additional point.

As we have been saying recently—really I think Dr. Mitchell made this point—as VA gets better and veterans regain their trust in the VA, we are going to see more veterans coming back to get care in the VA system. So, our overall wait times are probably not going to go down.

What we are really focused on now is making sure that nobody who is waiting is being harmed. We are focusing on those veterans who need care with the highest priority, the most urgent care.

We can really tell you that is what our stand down was about, making sure that people who need care are getting in to see VA or getting into care in the community. We are not satisfied with that, Senator. So, we are making sure that people are not waiting and being harmed.

Senator MCCAIN. It seems to me, then, from what you are saying, that wait times will not go down anytime soon. That is an urgent call to make the Choice card universal.

Dr. SHULKIN. Senator, I think that is accurate. We are not saying that wait times overall are going to go down significantly or at all. In fact, as we improve the system, they may actually go up.

That does mean that we need to make sure that we are working better with providers in the community using the Choice program. We are focused on improving the Choice program. That is why we submitted a new plan to Congress that asks for your help in making sure that we can make this system work better for veterans.

We need legislation for new provider agreements. We need the flexibility to have funding for care in the community be in a single pot rather than separate programs. We want to make this program that you gave us work even better than it is working now.

Senator MCCAIN. Well, I do not want to belabor the point, but I think the prospect of veterans waiting over 30 days, no matter what their medical need, is not acceptable. If they had a Choice card, they would not have to wait 30 days. They could go out the next day and get an appointment with the physician of their choice.

Ms. Fogarty, do you have full confidence in your emergency room today?

Ms. FOGARTY. Senator, thank you. The emergency room has really experienced quite a lot of change over the past year and made several improvements. I would like to give you a sense of what those are.

We have increased the ER and mental health staffing. We have increased the space, as Dr. Mitchell identified, and we currently have a construction project underway.

We have added 24/7 social work coverage that was not there before. We have approved and recruited additional psychiatry to also have 24/7 coverage. We have added five mental health RNs to the ER. We have established a standard medical clearance protocol for patients that need to be admitted to our mental health.

We really thank our partners with TRICARE and TriWest because they do allow us, when we are full, to have care in the community, they would be allowed to take our patients that we could not.

We have had standardized training in documentation for patient safety, observers called sitters, who are sitting and watching any suicidal ideation patients that come in. We redesigned four of those exam rooms and a restroom to make them safer for suicide ideation patients, to help prevent a serious elopement.

Senator MCCAIN. You are aware of the Clay Hunt Suicide Prevention Act?

Ms. FOGARTY. Yes, Senator, very much.

Senator MCCAIN. Is that helpful?

Ms. FOGARTY. It is, and we thank you for that.

It is one of those that we worry the most about, those coming with suicide ideation. We really have to be the most diligent on those who come.

Senator MCCAIN. Do you have some examples of intervention that have saved some lives? I do not ask for them, but you do?

Ms. FOGARTY. Oh, absolutely.

Senator MCCAIN. Are physicians leaving the Phoenix VA?

Ms. FOGARTY. Are physicians leaving?

Senator MCCAIN. Are physicians leaving the Phoenix VA?

Ms. FOGARTY. No, sir.

Senator MCCAIN. They are not.

Ms. FOGARTY. As you saw here, of what we have netted of 600 FTE, we have hired over 160 on the Veterans Access, Choice and Accountability Act funding for us. I can give you some specifics on the physicians.

Senator MCCAIN. That is all right.

Ms. FOGARTY. We do have attrition, as you know, physicians who retire or do leave with family moves. We have had six.

Senator MCCAIN. You do not have physicians leaving the VA. Thank you.

Mr. McIntyre, what has been your experience with the Choice card? Does it need to be made universal?

Mr. MCINTYRE. I think it is starting to take hold in terms of its use. The fact that there are 110,000 appointments that are going to come our direction this month from 2,000 at the start of this indicates that we are on the right——

Senator MCCAIN. Mr. McIntyre, the fact that there were only 2,000 at the start is because they did not know about it. So, please do not keep throwing that one up at me.

I want to know whether you think the Choice card should be made universal or not.

Mr. MCINTYRE. I think the people's ability to access care downtown when it is not available in the VA and when it is not close to their home is exactly the right thing to be doing.

Senator MCCAIN. What impediments to you see to better usage?

Mr. MCINTYRE. I think that people understanding the program, first of all, from an education perspective, which we all can share in, is valuable. Second, I think changing the kinds of policies that have been changed will help smooth this out. Third, I think our operations need to continue to get stronger and more integrated in order to make this process work more effectively.

Senator MCCAIN. Thank you.

Dr. Shulkin, one of the sources of great frustration to many of us, especially here in Phoenix, is the fact that it is undeniable that there were really people who did not do their job. Otherwise, we would never have had 50 veterans who were on a nonexistent waiting list.

Yet, to our knowledge, maybe you can help us out, there is only one person—one person—that has been removed from office. People do not understand that when 50 people die on a nonexistent waiting list and there is only one person that is held responsible, and

many others are on "administrative leave" with full pay, paid for by the taxpayers. Please help us out on that one.

Dr. SHULKIN. Senator, we hear that frustration loud and clear. There is no question about that. We did remove the director, as you said. We placed two other officials on administrative leave.

Senator MCCAIN. That means paid. That means being paid.

Dr. SHULKIN. Paid administrative leave.

We would very, very much like to conclude our administrative and disciplinary actions against those two officials. The U.S. Attorney, as I said in my statement, has prohibited us from interviewing those individuals. The OIG just 30 days ago gave us 10,000 additional pages of evidence on these individuals, and last week an additional 1,000 pages. As soon as we can go through that evidence, we are committed to making an action.

On December 9, Deputy Secretary Gibson testified before the House committee and said we are no longer going to wait for the IG to act. VA will act independently as soon as we can.

We are committed not to putting additional people on administrative leave, but we will detail them to work. If the taxpayers are paying these individuals, they need to be working.

Those are changes in the way that we are going to be dealing with this in the future.

Senator MCCAIN. Well, I thank you, but I would remind you what you know, and that is the Senior Executive Service is a unique situation, as opposed to your average civil servant. The SES people are eligible for many benefits and rewards for excellent performance, but they are also liable or can be fired and removed from office with much less reason than an ordinary member of the civil service.

Many of these individuals who were in charge are members of SES, and yet that option has not been exercised. Maybe you can respond to that.

Dr. SHULKIN. Yes. Since Secretary McDonald was sworn in, July 2014, there have been eight SES removed by the Secretary. That option is available to him.

I think that we are all firm believers—the Secretary, the Deputy Secretary, and myself—in accountability. We have articulated that we believe we must do this principally based. There has to be evidence to match the actions or the punishment or the reward.

We are making sure that the evidence does match this. We hear you loud and clear, and VA is committed to moving quicker. We will not wait for IG actions in the future because it is very important that people understand that if people are not following our values, they do not belong in the VA.

Senator MCCAIN. Thank you.

I thank you, Senator Sullivan.

I just want to repeat again, Dr. Shulkin, you have been, I believe, admirably involved with Members of Congress in communicating with us and being frank in your assessments. That is appreciated by Members of this Committee. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator McCain.

I want to make a quick comment, just on what he mentioned to Ms. Fogarty. The Clay Hunt Suicide Prevention Act, which was the

first bill that I cosponsored in the U.S. Senate, named after a young Marine sniper who suffered through despair and did not get the service that he needed from the VA and ended up taking his own life.

The number 1 cosponsor of that bill in Congress, which passed unanimously, was Senator McCain. That is what he was referring to. Let us talk about an issue that really matters, veteran suicide, and the one member of the U.S. Senate who has led on that more than anyone is Senator McCain.

I am glad to see that is having an impact, because there is nothing worse—nothing worse—whether it is a Vietnam vet or a vet from Iraq or Afghanistan, coming back experiencing depression and despair and having nowhere to go. That is probably our highest responsibility, to take care of those veterans.

Senator Flake?

Senator FLAKE. Thank you.

Ms. Fogarty, if Ms. Morris were to go to the VA emergency room today like she did before and present the same symptoms, what would be her experience?

Ms. FOGARTY. First, I would like to acknowledge how disappointing to hear those statements of a veteran coming to our emergency room and having that wait. It just is not what our standard of care should ever be.

Today, I believe that she would have a very different experience in what we have approved and made. I would also believe that there is that opportunity with the Choice card that she could seek care in a private facility and have that reimbursed as well.

Senator FLAKE. If she were to go down to the ER, her wait time in the ER itself would be considerably shorter, and she would have a different experience than she had before?

Ms. FOGARTY. I would truly hope that is the experience, because that is what we are working on, always to have exceptional experiences, and have done great things in our emergency department to make that experience be——

Dr. SHULKIN. Senator Flake, let me just add, the average wait time in our Phoenix E.D., from the time that you register to when you see a physician or provider, the average is 35 minutes. That is an average.

You will still find times in an emergency department where there are critically ill patients and patients like Ms. Morris, that do not have a critical illness, will wait a lot longer than the patient wants to.

This is a national issue with emergency department overcrowding. So, we would not want to say that this would be her experience, but there would be times when patients will wait.

Senator FLAKE. All right. Thank you.

Dr. Shulkin, I, like Senator McCain, believe we need to get to a point where the Choice card is used universally and not with restrictions on mileage or whether there is a clinic or whatever else. But, that gets to the nut of the whole issue here, how much Choice can the VA withstand?

If a significant number of veterans choose that option, at what point does it impact the ability of the VA to have the funds and resources to operate at facilities and have the level of care that vet-

erans should expect? Are we close to that tipping point? Is that why we have the restrictions that we do?

Can you explain that conundrum that we are in?

Dr. SHULKIN. Sure. Senator, it is a very complex issue, as you said. First of all, as I previously said to Senator McCain, we are very grateful for Congress' leadership in providing us the Choice program. We think it was the right thing to do and we want to make this program work better for veterans. We know too many veterans have experienced the complexity of it, the confusion, the lack of knowledge about it, as has been mentioned. We are committed, as Mr. McIntyre said, to making this program work.

We have submitted what we think is a very thoughtful plan to Congress that we delivered approximately a month and one-half ago that lays out how we want to take the original Choice legislation and make it work better. We need your help.

We need provider agreements as soon as possible. We need the flexibility to make the spending easier for us to serve veterans and offer care in the community.

We are very much in support—VA has been providing care in the community for years. Over $10 billion of our dollars were spent for care in the community.

We think our plan is a very thoughtful balance of keeping the VA strong, because America needs a strong VA, and serving veterans by allowing them the ability to seek care in the community with the highest quality providers.

Senator FLAKE. Mr. McIntyre, has the VA done enough to advertise the Choice plan among veterans and to ensure that they understand their rights and ability to access private care?

Mr. MCINTYRE. I think the VA has done a remarkable job over the last couple of months of really stepping up the focus in that arena. Part of the thing we are all hampered by——

Senator FLAKE. Your comment implies that it is only a recent phenomenon?

Mr. MCINTYRE. No. At the very front end, we had 30 days to stand this up. It is hard to educate people internally and externally in an effective manner. There has been a real effort within the VA to figure out which populations need to be reached and how we do that collectively more effectively.

What I will tell you, though, is part of the challenge we all face is that the policies have not yet stabilized for how this all works and where you access and what the limitations are.

I would encourage that once that is done by, essentially, what is going to be the end of January, that there is dramatic new push by everybody, including the media and Members of Congress, ourselves, and the VA, to make sure that people really understand what it is that they have.

It is rather remarkable. We have providers all over this State, so that if you live in a rural area, the number of primary care providers that are accessible to you is rather dramatic. You have new rights under the Choice program to actually go and seek care in the ZIP Code in which you reside, not to have to drive a long distance in order to get that care.

Senator FLAKE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Flake.

I want to echo Senator McCain's comments about Dr. Shulkin. For the audience's knowledge, he came on board as the Under Secretary, the number 3 official at the VA, just in August. As I have said, he certainly did not cause these problems. He is someone from the private sector, an accomplished doctor who has run hospitals. He wants to do what is right to fix the problems, and he is aware that the Committee will not be standing by if we do not see the problems are being fixed.

So, Dr. Shulkin, I did want to follow up on what Senator McCain talked about on accountability. I think it is really important for Members of Congress but, more importantly, members of our veteran community across the country to see that something is being done.

You mentioned that we hear you loud and clear what you said to Senator McCain. I was disturbed by reading a recent article in *The Washington Post* on a House Veterans' Affairs Committee hearing just last week with Deputy Secretary Gibson not sounding like he is hearing us loud and clear at all.

He said, when asked about accountability of members of the VA, he was pushing back, saying, "You cannot fire your way to excellence. In my many years in the private sector, I have never encountered an organization where leadership was measured by how many people you fire."

"We will not administer punishment based on IG opinions, referrals to the Department of Justice, recycled and embellished media accounts, or external pressure. It is simply not right." He called some of these cases "failures of judgment, but not ethical breaches."

Last week, the number 2 guy in the VA sounded like he was pushing back against Congress' very legitimate questions about who is being held accountable in the VA. So, I think one of the things that we would want you to do is take back to the Deputy Secretary and the Secretary of VA that I certainly do not think that those kinds of statements are appropriate. It does not sound like he is getting the message at all loud and clear.

To go back to Senator McCain's question, how many VA officials in the last 2 years over all these scandals and wait times and our veterans not being treated the way they should be treated, how many VA officials have been terminated from their jobs?

You come from the private sector. You have a very, very stellar record in the private sector. I know that the hospitals you worked at would be firing a lot of people had things like this that happened in Phoenix.

What is the number?

Dr. SHULKIN. Senator, as you said, I have been in the system only a few months. I will tell you, I spend a fair amount of my time with Deputy Secretary Gibson and Secretary McDonald talking about these issues. I will tell you these are two of the finest leaders I have ever worked with in my career. They take this very seriously. I do not think that is an accurate representation of the Deputy.

The CHAIRMAN. I was simply quoting him.

Dr. SHULKIN. Yes, absolutely.

Where the Deputy stands on this, I know the Secretary as well, is that we are committed as leaders, and I stand right with them,

that we are going to take a look at the evidence and we are going to make decisions about who deviates from values and policies, and we are going to hold our employees accountable.

What we are not going to do, we are not going to have people tried in the press and tried through allegation. We are going to treat people fairly, because that is the way you run great organizations.

The data that you asked for, eight SES have been removed since the Secretary was confirmed in July 2014, and 2,100 employees have been terminated. We will continue to hold people up to these accountability standards and we are going to use the evidence.

What the Deputy said in that hearing was that he welcomes anybody else, a Member of Congress, to come and look at that evidence and show him if we are not making good decisions. But, he is going to uphold his leadership responsibility, and I stand with him on that.

The CHAIRMAN. Twenty-one hundred VA employees have been terminated for wrongdoing since these scandals?

Dr. SHULKIN. Since July 2014 when the Secretary was confirmed.

The CHAIRMAN. Perhaps for the record you can provide us the details on those and the eight that you mentioned.

Those have been fully terminated or, as Senator McCain mentioned, are on leave?

Dr. SHULKIN. No, those SES have left service. They have either been terminated, have resigned, or chosen to retire.

The CHAIRMAN. So, I would like, for the record, the detail on all of those for the Committee's review.

Dr. SHULKIN. Yes, sir. I will be glad to do that.

The CHAIRMAN. Thank you.

Another quick question is something that you and I saw in Alaska that I continue to see, which I think is something that we need to continue to work on. I still see veterans who come up to me talking about appointments they have had—you and I saw this when we were up there—that have been approved by the VA and somehow the reimbursement is not happening quick enough and these veterans are now being sent to collection agencies. I am still seeing that.

I would like to get your commitment to work with the Committee to put a halt to this. The idea that a veteran gets approved by the VA for an appointment, goes to it, the provider either through TriWest or the VA does not reimburse what has happened with regard to who is providing the service, and then a debt agency is collecting upon the veteran is outrageous.

You saw it when we were up in Alaska. I am still seeing it. I would like to get your commitment to work, both of you, Mr. McIntyre, on this issue, which just obviously adds enormous stress for our veterans, when a collection agency is calling them, saying they have a $50,000 bill.

Dr. SHULKIN. Yes. First of all, I heard this with you, absolutely. It is outrageous. We do not want that to be happening. If the VA authorizes care, the veteran should not be held accountable for that. You have my commitment. That should not be happening.

I would like to get the names and the specifics of anybody you are hearing about from any of your offices, and we will intervene to make sure that it does not happen.

The CHAIRMAN. Thank you.

Mr. McIntyre, you mentioned in your testimony that the relationship between the VA and TriWest has matured substantially. What more needs to be done to develop that relationship in a way that ultimately does what you are supposed to be doing, which is benefiting our veterans.

Mr. MCINTYRE. Senator, I would like to thank you for that question. I would also like to state that I, too, am committed to make sure that if you have cases where veterans are getting billed inappropriately by providers, that we would like to understand what they are so we can work those issues out, and we will do that in support of Dr. Shulkin.

With regard to the maturation of this program, we believe that the inner-threading relationship that is starting to develop at the ground level is really important. One of the things that we are going to be launching in Alaska, as you know, effective January 11, is the opportunity to have a joint service center at the ground level.

I will tell you that it is one thing for us to have policy-based discussions and operational-gap discussions up at the top, but it is quite another thing when you get down to the deck plate where veterans are being served on a day-to-day basis.

Your concept, which we are also going to be rolling out, Senators McCain and Flake, here in Phoenix of having an integrated service center that is located close in proximity to the veteran could not be more right on the money from the standpoint that you could walk a veteran down the hall after an appointment in the VA, educate them about Choice so that there is no lack of understanding, give them some materials, and find out what their preferences are in terms of appointments, how they would like to be contacted and the like. It is exactly what we ought to be doing.

Dr. Shulkin, our organization, and our entire teams are working to make sure that it is going to get prototyped in both Alaska and Phoenix.

The CHAIRMAN. Are you looking at, in terms of your call centers, which I know have been an enormous frustration for veterans across the country, because there is no localized component. So, a veteran from Arizona calls—I do not know where your call centers are located—but someone calls from Arizona or Alaska and they are having issues. Are you looking to start localizing and integrating those call centers throughout the country?

Mr. MCINTYRE. Great question. Thank you for the question, by the way.

When we started Choice, we had 30 days to go from a blank sheet of paper to full on operations on November 5. We had to hire 850 people, but we did not know the number until we were 10 days out. So, we turned to a third-party vendor that supports other organizations in managing backup in their contact center operations.

That was separate from how we were running our operation in PC3. We took all the calls, directed them to that organization. We have been weaning ourselves off of that when we came to the con-

clusion in the summer, when we were at 37,000 appointments a month, that we were going to face a meteoric rise in demand.

Tomorrow we will announce in El Paso the tenth operations center. Eight of them are now up and fully operational. The one that serves Arizona is right here near Gilbert. It is in Tempe, and we have a number of employees here. The operation for Alaska is served out of Puyallup, which very effectively served Alaska for PC3.

Then, what we are doing is we are inserting, on a test case to start with, these customer service staff at the local level, integrated with the VA staff, much like we did in TRICARE.

If you can think about it, it is a hub-and-spoke operation. You have a hub that is subgeographic in its location, and you have these nodes facility-by-facility-by-facility.

That is how we hit world-class service in TRICARE. Our intention is to roll out the same and be done with that by the beginning of March, which is the trajectory that we are on.

The CHAIRMAN. Thank you.

On the pilot program we talked about in Alaska, what is the date that it is going to be implemented?

Mr. MCINTYRE. There are three phases. The first phase was to take all calls and route them into Puyallup for Alaska. That happened right after the Alaska field hearing in August that you chaired.

The second phase is to place staff colocated in a service center within the Anchorage VA. We are also going to have other staff in Alaska on the ground in Fairbanks and probably in Southeast. That will go live January 11 and there, as we will do in every other location where we roll this out, we are taking seasoned staff that already know the market to go there first. Then, we will hire right behind that, so we can make sure we do not miss a beat.

The third phase, as you know for Alaska and unique to Alaska, is that the scheduling configuration will change. We will have more engagement between the VA staff in Alaska and the veterans and the providers in that community. We are in the process together of finishing the design with that, so that will next be able to roll out.

The CHAIRMAN. Let me ask a final question.

Mr. Byers talked about the problem with providers being reimbursed and how there was an issue with the lack of reimbursement, and then all the veterans who had appointments with that provider doing urological services were going to be dropped.

Have both of you been focused on making sure that those kind of things do not happen? That is a key element of the Choice Act. If the providers do not have any kind of clarity, it is going to be difficult for them to provide the services they need to our veterans.

Dr. SHULKIN. Senator, I will be glad to start, and then if Mr. McIntyre wants to add to this, that is fine.

Actually, TriWest does a very good job of paying its providers. I think, if I am not correct, you are close to 100 percent within 30 days. So, this is actually a problem for VA because TriWest pays the Choice bills. VA pays the care in the community bills.

We have not been doing as good a job as we need to, in my opinion, in paying our providers. Coming from the provider side where I spent my life, when you give a service, when you see a patient,

you deserve and expect to get paid. We are about 75 percent payment within 30 days.

We have antiquated roles and antiquated systems. We have asked for some help in this in simplifying the care in the community funds from Congress because we need this to get better.

Our new plan says that we are going to take a look at VA's ability to pay and make a build-by decision, because, quite frankly, we either need to invest and improve a lot better in our payment or we need to get out of the payment business and give it to people who know how to do this. The status quo is not acceptable.

Here in Phoenix, we, frankly, have too large of an accounts receivable for your big systems like Banner and Dignity and your other providers. We have our teams on site here in Arizona working out those payments right now because is it not acceptable to me that providers have to wait this long.

Mr. MCINTYRE. If I might follow that, and thank you for the kind comments, we have our own challenges from time to time in this space.

My dad was a doc. He served as an Army doc in Vietnam, and then went on to operate in private practice, including in the great State of Alaska as an ophthalmologist.

What I will tell you is that it is really important, as we discovered in TRICARE, to make sure that the payment is timely and accurate, because we are asking people to stretch themselves and take this patient population, which they very much want to do, make it the least bureaucratic as we can, and make sure that the timing of the payment works right.

What I will tell you is that we are gaining on where we want to be, but we are not there yet. We are spending a lot of time with providers trying to figure out where the gaps are so that we can make sure that we are able to give feedback to the VA on operations changes that we want to make and they might think about making. We are collaborating very closely on that.

The Banner situation, we own a part of it, the VA owns a part of it. We are working together very closely to try to resolve those issues. I am confident that we will.

Here is what I will tell you. We are at 95-plus percent for paying claims within 30 days. That is 1 year in. It took us longer to get there with TRICARE. What I am going to commit to all of you and to the veterans that we are privileged to lean forward for at the side of VA, and the providers in this community and elsewhere is we will get this right. We will get it right together. It is really important that it is right so that people do not feel like, "The bill is not going to get paid over here, so I am going to send the veteran to collections in order to be able to pay my bills."

The second thing is, in urology in Phoenix, AZ, when the furnace lit off in April, we ultimately came to find that of the 14,700 on a waitlist, 3,300 of them were urology patients. At the time, there were 72 urologists in Maricopa County. The VA had us on speed dial. We rolled up our sleeves together. We figured out how to design a demand capacity mathematical process together, which we are using to grow our network together across the 28 States and the Pacific. Then, we figured out what it would take to place providers, how to do it on a severity basis, and make that happen.

While Chuck was testifying, I had the information pulled with regard to his experience, because it was a while ago. I was having a hard time remembering it.

We received his care requests from VA on June 10. We had him appointed on June 17. The practice that saw him took more than 50 percent of the 3,300 urology patients and processed them within 7 weeks. They should be sainted. Their patients agreed to step aside in their own calendars and serve people like Chuck. Chuck got seen initially on the 20th, 3 days after he was appointed.

That is the way this should work. There are providers in this community and your great State and all over this country that said, "I do not want to replace the VA, but I will be there if I am needed. Just hand me a few; and, like what we did with TRICARE, let me take care of them and then make sure that I get paid properly for the work I have done and on time."

That is our commitment. I know from the work I have done with these three, that is our collective commitment in terms of where we want to be. We want to get there as fast as we possibly can.

The CHAIRMAN. Well, they should be sainted, but they are not going to continue to be committed to our veterans unless they are reimbursed. I think that is a key issue.

Senator McCain?

Dr. SHULKIN. They have been and they are still in the network.

Senator MCCAIN. I want to refer you, Dr. Shulkin, back to that chart that shows the veterans waiting over 30 days.

The Phoenix VA line is roughly double that of the national average. That, obviously, is very disturbing to anyone who represents the State of Arizona, that we should be almost double the percentage of people who are waiting over 30 days.

We are not proud of the fact that this whole thing really was ignited by what happened at the Phoenix VA. I would hope that extraordinary efforts would be made at least to bring that orange line down to the blue line. That part is really something that is not acceptable to those of us who care about our veterans in Arizona.

Dr. SHULKIN. Senator, it is not acceptable to me, as well. As you know, the country is experiencing a shift from VAs that were in the rustbelt down to areas like Arizona that are very attractive to veterans particularly who are retiring. We saw a 6 percent increase in unique veterans using the Phoenix VA last year, so we are growing. We have to plan for that. That is, in part, making this more difficult.

We will not rest until we can add capacity. We have 738 positions we are recruiting for today. We are adding new space. Our new director started today. We need stable leadership in order to make this work. I have extreme confidence in our new leader to be able to do this.

I can assure you, extraordinary efforts are what we are going to make to get this fixed.

Senator MCCAIN. Thank you.

I want to again thank the Senator from Alaska for being here, as one of the most important Members of Veterans' Affairs Committee, to conduct this hearing. I thank you, Senator Sullivan.

The CHAIRMAN. Thank you, Senator McCain.

I want to thank the witnesses from both panels. I want to thank my colleagues. It is an honor to be up here on the dais with Senator McCain and Senator Flake, two leaders in the entire U.S. Congress on these issues, as I mentioned earlier. Their names are on the legislation that we are talking about, and I think that is great not only for Arizona, but for the country.

Finally, I want to thank our veterans who joined us today. I assure you, as Dr. Shulkin said, this Committee and the entire U.S. Senate will not rest either until we have addressed these issues in a way that is faithful to the service you provided our great Nation.

I will mention one more time, if there are those of you in the audience who are interested in submitting written testimony to this hearing for the Veterans' Affairs Committee in the U.S. Senate, the email again is public_testimony@Sullivan.Senate.gov. You have 2 weeks to submit that written testimony, which would be Monday, December 28.

This hearing is now adjourned.

[Whereupon, at 11:08 a.m., the hearing was adjourned.]

CLARIFICATION OF TESTIMONY OF DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

January 8, 2016

The Honorable Johnny Isakson
Chairman
U.S. Senate Committee on Veterans Affairs
412 Russell Senate Office Building
Washington, DC 20510-6050

Dear Mr. Chairman:

Following the December 14, 2015 Committee on Veterans' Affairs field hearing in Phoenix, I asked staff to confirm my testimony regarding the particulars of our accountability investigation related to two senior Phoenix VA Health Care System managers who were on extended administrative leave.

I would like to clarify my testimony that "VHA's efforts to issue disciplinary actions in Phoenix and to resolve the administrative leave status of two employees have been delayed by inability to interview witnesses who have not been cleared by the U.S. Attorney's Office and only recently were we given additional evidence by the V.A. OIG that we had been requesting for the last several months." I reiterated these points when, in response to a question from Senator McCain, I testified "the U.S. attorney, as I've said in my statement, has prohibited us from interviewing those individuals and the OIG just 30 days ago gave us 10,000 additional pages of evidence on this individuals and last week and additional thousand pages."

These statements were correct with respect to the untimely delivery of evidence by OIG, which in fact has continued even into the new year with more than 20 new interview transcripts totaling more than 2000 pages delivered just this week.

With respect to the witness interviews, my testimony was consistent with the information provided to me regarding the administrative investigation conducted at Phoenix by the VA Office of Accountability Review (OAR), which is not part of my organization. However, I am informed that the information upon which I based my testimony was out of date, in that the OAR investigators were able to interview one of the subject senior managers in January and April 2015 and the other in October 2015.

I would ask that this letter be made an official part of the record.

Sincerely,

David J. Shulkin, MD

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