STATEMENT OF

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BEFORE THE

VETERANS' AFFAIRS COMMITTEE
UNITED STATES SENATE

WITH RESPECT TO

"The State of VA Health Care"

WASHINGTON, D.C. May 15, 2014

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Chairman Sanders, Ranking Member Burr and members of the committee, I wish I did not have to be here today, but I want to thank you for the opportunity to share the Veterans of Foreign Wars' concerns on the Department of Veterans Affairs' (VA) health care delivery.

Simply put, the VFW is outraged over the allegations that have surfaced in recent weeks that VA denies care to veterans. What is more frustrating is that nearly a month after these allegations surfaced, we still do not have all the facts. We do not know who the veterans are who died waiting for care in Phoenix. We do not know if other hospitals are cooking the books in appointment scheduling to keep up appearances, while veterans either wait for care, or pay for it out of their own pockets.

Regardless of the forensic facts in Phoenix, Wyoming, Atlanta, Chicago, or Jackson, Mississippi, the VFW knows that veterans have died waiting for care. This in and of itself is inexcusable. VA is supposed to have protocols in place to make sure this never happens. So, what happened?

VA tells us the situation is improving, but to the veterans' community, this is not good enough. VA's obligation is to provide our veterans with the best health care our nation has to offer. Over the last month, we can clearly see that VA is not living up to this obligation.

Veterans want and deserve the truth, but instead we are fed vague platitudes about quotas, wait times, waiting lists, and ongoing investigations. The VFW has been vocally frustrated at the situation, but we have been reticent to condemn individuals because of these "ongoing investigations." We are here today to say that enough is enough. Whistleblowers first brought

the problems in Phoenix to the attention of VA and Congress as early as 2010. CNN broke the doors off this story in April. Why are we still waiting?

Last week, the VFW grew tired of waiting and told veterans to call our help line, 1-800-VFW-1899, to voice their concerns about VA health care, and connect with our service officers for help. While some said they were satisfied, or acknowledged improvements, most veterans painted a picture of a VA health care system that is overburdened, under-resourced, and many times paranoid:

In Durham, North Carolina, an Iraq veteran told us that he can see his primary care doctor only once a year, and that he has sought care elsewhere after 10 years of misdiagnoses.

In Denver, a veteran told us that when he moved to the city in 2011, it took a year and a half to book an appointment, and now he cannot get in for treatment of his service-connected conditions.

In Florida, a veteran who was diagnosed with prostate cancer told us that he had to wait five months to see his primary care doctor.

In Nevada, a veteran who was diagnosed with skin cancer tells us he is waiting eight months for an appointment after the hospital's dermatologist quit.

And finally, in Phoenix, a veteran told us that he has been waiting three years for a surgical consult, and was told that if his condition gives him problems, he should just come to the emergency room.

If one veteran is not receiving the care he or she needs, it is one too many. This is only a small sample of the hundreds of concerns we heard from veterans at VA facilities from coast to coast, but the outpouring of concerns was alarming, and seemingly systemic. So, what is causing this failure? Is it a lack of resources? Is it personnel? Is it leadership?

As a result, the VFW will also conduct a series of veterans' Town Hall meetings, talking to veterans face-to-face, allowing them to voice their concerns. Once we have finalized locations and dates, we invite this committee to attend and observe, hearing directly from the veterans about VA care delivery.

Although we are still waiting for the full reports to be issued on the latest allegations, recent preventable deaths at other VA facilities have already been confirmed. In South Carolina and Georgia, we learned that 23 veterans died due to recent consultation errors. Last year, VA's Inspector General released a report detailing the improper handling of an outbreak of Legionella at the Pittsburgh Veterans Affairs Medical Center (VAMC) which took the lives of at least five veterans. Another report revealed the mismanagement of inpatient mental health care at the Atlanta VAMC, costing at least four veterans their lives. The Jackson, Mississippi VAMC has been plagued by multiple problems which endangered veterans' safety and lead to preventable deaths, including chronic understaffing, failure to sterilize instruments, and thousands of unread radiology images leading to missed diagnoses. Most recently, the VFW learned that as many as

19 veterans died nationwide in 2010 and 2011 due to unacceptably long wait times for routine cancer screening procedures.

In the past three weeks, whistleblowers in Phoenix, Colorado, Wyoming, Texas and North Carolina have alleged that these locations have "gamed" their patient appointment schedules to make it appear these facilities are achieving their appointment wait times. VA's assertion that wait times for primary care appointments in Phoenix have decreased from more than a year to 55 days on average is unacceptable. Mental health access also continues to be an issue. VA has hired more than 1,000 mental health care providers, but they still are not sure how many providers they need to fulfill the current demand.

The lack of timely care for veterans is unacceptable. The VFW certainly hopes that VA would never intentionally deny care to veterans, but there have to be reasons why care takes so long to be delivered. We know capacity is an issue. The VFW, in partnership with the Independent Budget, has highlighted for years the need to increase VA medical facility capacity. Even VA's own 10-year Strategic Capital Investment Plan (SCIP) identifies capacity as an issue. In 2004, VA's medical center capacity was 80 percent. It peaked at 122 percent capacity in 2010, and in 2013 capacity remained unacceptably high at 119 percent. Since FY 2010, appropriations for major construction projects have decreased from $1.2 billion annually to an FY 2014 appropriation of less than $350 million for the same account. Access to care can be directly linked to capacity. VA's major lease authority is also placing a burden on capacity, which directly effects access. Since FY 2012, Congress has not authorized VA major medical lease authority. That is 27 facilities in 18 states, most of which should be providing direct care to veterans.

These allegations are causing veterans and their family members to lose faith and confidence in a system that is supposed to care for them. VFW members and their families are outraged. They want answers, and they want those responsible for any substantiated allegations held accountable from the lowest to the highest level of leadership. With this in mind, it may be time to commission an independent review of VA's health care system. We must all work together to ensure that the culture across VA is one of placing veterans' needs first, and when veterans' care suffers because of one of these reasons, those responsible must be held accountable to the fullest extent of the law.

To provide timely access to care, VA must use all available tools, including purchasing non-VA care when necessary. Ideally, VA would have the capacity to provide timely, quality direct care to all those who need it, but it has become apparent to the VFW that they do not. Although we support expanding VA infrastructure and hiring enough health care professionals to meet demand at VA facilities, we recognize that this will not happen overnight. In the meantime, it is absolutely unacceptable for veterans to suffer. Non-VA care must be used as a bridge between full access to direct care and where we are now.

If it appears that certain facilities are not making proper outside referrals due to improper training, lack of standards, or institutional resistance, VA must move swiftly to correct those problems. If VA's new fee basis care model, PC3, is not being used to its full potential due to

insufficient funding at the local level, we will call on VA and Congress to give them the resources they need.

When there is a lack of resources, there is a tendency to make trade-offs, whether it is delaying care or manipulating scheduling systems to satisfy quotas.

It appears that the culture of leadership, management and accountability is focused on making the funding fit at every level. If this is the case, this culture must change. Leadership at every level must have the confidence that if they have a need, they can ask for that need to be addressed. VA, the Administration and Congress must resolve to make the true need the priority, not the need to make budget lines fit.

There is no question that the Veterans Health Administration (VHA) faces significant challenges in efficiently and effectively running the largest health care system in the United States. Successfully executing its four major missions of providing care to veterans, conducting medical and prosthetic research, training this nation's physicians, and providing medical support to the public during domestic emergencies is a massive undertaking. When failures are identified, it must be the responsibility of VA, Congress, veterans service organizations, and all of America to swiftly correct those problems with better oversight, sufficient funding, and accountability of those responsible.

In doing so, however, we must resist any suggestion that VHA is a fundamental failure which should be dismantled in favor of an alternative model. Such suggestions not only serve to relieve VA of its responsibilities, but fail to take into account the contributions that VHA makes to veterans, their families, and the medical community as a whole.

The VA health care system was commissioned to care for those who served and bled for our nation. The men and women who are chosen as stewards of the VA health care system have been entrusted with a mission that cannot fail under any circumstances. If the system is failing, it is their duty to fix it. It is their duty to hold underperforming employees accountable. Most importantly, if they are unwilling to perform this mission, it is their duty to either ask for help or step aside.

Last year, when the President met with then-VFW Commander-in-Chief John Hamilton at the White House, he promised that he would not leave the problems within VA for his successor to deal with. Today we ask not only the President to live up to his word, but we implore Congress to do the same.

We absolutely cannot sit on our hands and wait for the system to slowly improve. Every day we hear of new allegations in another VA facility. The situation that is unfolding in VA facilities across the country demands immediate, decisive action. The mission of the VA health care system is far too important, and as a society that cares for the men and women who volunteer to defend our way of life, we cannot allow it to fail.

Mr. Chairman, this concludes my testimony, and I am prepared to take any questions you or the committee members may have.