STATEMENT OF THE HONORABLE ROBERT A. McDONALD
SECRETARY OF VETERANS AFFAIRS
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
SEPTEMBER 9, 2014

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Senate Committee on Veterans' Affairs, thank you for the opportunity to discuss with you the Department of Veterans Affairs' (VA) response to the recent VA Office of Inspector General (OIG) report regarding wait times and scheduling practices at the Phoenix VA Health Care System (PVAHCS).

Let me begin by saying, I sincerely apologize to all Veterans who experienced unacceptable delays in receiving care at the Phoenix facility, and across the country. We at VA are committed to fixing the problems and consistently providing the high quality care our Veterans have earned and deserve in order to improve their health and well-being. We owe that to each and every Veteran that is in our care. We will continue to listen to Veterans, our VA employees, and Veterans Service Organizations (VSO) and use their feedback to improve access to quality care in Phoenix and across the country and we will work hard to rebuild trust with Veterans and the American public.

The VA OIG has released the final report of its review of issues with patient scheduling and access at PVAHCS. We have concurred with the recommendations in the final report and, in many cases, we have already taken action responding to the OIG's recommendations, improving processes and access to care for Veterans.

PVAHCS' Implementation of OIG Recommendations

The final OIG report is an update of the information previously provided by the OIG in its Interim Report issued on May 28, 2014, and contains final results from their independent review of the PVAHCS. In response to the report recommendations, we have outlined key action plans that expand access to care, improve staffing for primary care, and ensure accountability measures. All cases identified by OIG were reviewed,

and determinations regarding appropriateness of disclosures to patients and families are underway.

Currently at PVAHCS, we have a strong acting leadership team producing positive results. Glenn Costie is the Acting Medical Center Director and Elizabeth Freeman is the Acting Network Director. They are good people with a proven track record for serving Veterans and solving problems.

Based on the Interim report of the OIG, we began actions in Phoenix and across the country that have enhanced access for Veterans seeking care. In Phoenix specifically, we have taken the following actions:

Primary Care Staffing

PVAHCS leadership is increasing Primary Care staffing by 53 additional full-time equivalent employees. Aggressive recruitment and hiring processes have been implemented to speed this process. All services — physicians, nurses and clerks — have increased staffing in the clinics and Community-Based Outpatient Clinics (CBOC) and the facilities are securing contracts to utilize Primary Care physicians from within the community. Primary Care was recently added to the Patient-Centered Community Care contracts, and Health Net and TriWest are working to add Primary Care physicians to their networks nationwide including the Phoenix area.

Access to Care (wait lists)

PVAHCS, with support from the Veterans Health Administration's (VHA) Health Resource Center (HRC), has reached out to all Veterans identified as being on unofficial lists or the facility Electronic Wait List (EWL). PVAHCS completed 46,997 appointments in May, 48,970 appointments in June, and 50,629 appointments in July, for a total of 146,596 appointments completed at PVAHCS in three months.

As of August 15, 2014, there were 56 Veterans on the EWL at PVAHCS. PVAHCS is now scheduling the vast majority of patients directly into a Primary Care appointment when enrollment/registration occurs. Over 3,200 appointments have been made in Primary Care for new patients since this initiative began.

Access to Care (scheduling)

We announced on June 4, 2014, that the Department had reached out to all Phoenix, Arizona-based Veterans identified by the OIG as being on unofficial wait lists to immediately begin scheduling appointments for all Veterans requesting care. Nationally, VHA expeditiously deployed staff and resources from around the country to help PVAHCS identify patients waiting for care, clearing the way for them to get the care they needed. We have made progress and are publicly publishing data on our progress.

Access to Care (non-VA Care)

Clinical staff attempted to accommodate all appointments at PVAHCS. Where capacity did not exist to provide timely appointments, staff referred patients to non-VA community care in order to provide all Veterans timely access to care. From May 16, 2014 through August 28, 2014, PVHCS has made 14,622 referrals for appointments to community providers of non-VA care.

Since the Accelerating Care Initiative (ACI) began, resources have been provided to continue to work down the number of open consults even further. Since the beginning of the ACI, $24.9 million has been obligated as part of this initiative to provide community-based care for Veterans in the community.

Access to Care (new enrollees)

PVAHCS is hiring dedicated staff to complete on-line enrollment processing. VHA is developing an automated system for monitoring enrollment processing at PVAHCS and every VA facility. This monitor will track Veterans new to the VA and will assess the timeframe to their first appointment within the VA health care system. The data will be reviewed monthly with VISN 18 and PVAHCS leadership.

Locally, PVAHCS implemented process changes to ensure that Veterans receive appropriate care. To ensure continued success, patients waiting for care are reviewed daily and reported to facility and VISN leadership.

In July 2014, the Acting PVAHCS Director visited all CBOCs and local Clinics to observe the scheduling process and interact with scheduling staff to ensure all policies

are being followed to deliver Veterans the timely care they have earned. These interactions are now happening monthly across the country.

VA Nationwide

Since my confirmation as Secretary, I have traveled to VA facilities across the country speaking to employees and Veterans. I cannot overstate their enthusiasm for being part of the solution to our current challenges. Overwhelmingly VA employees are dedicated to serving Veterans. They are driven by strong institutional values that influence day-to-day behavior and performance: Integrity, Commitment, Advocacy, Respect and Excellence, I-CARE. On my first day as Secretary I asked all VA employees to join me in reaffirming our commitment to these core values and I directed VA leaders to do the same with the people that work for them. As we continue to move forward, our values help cultivate a climate where all employees understand what the right thing is and then does it. VA's way of doing business must conform to how we expect employees to treat Veterans and how we expect employees to treat one another. It is clear that somewhere along the line, some people's behavior was at odds with VA's mission and core values. It is up to the Department to reaffirm its worth and regain Veterans' trust. Over the past months, we have been forced to take a hard look at ourselves and the way we do business, listening to Veterans, employees, Congress, VSOs and other stakeholders.

Using their input, VA is in the process of rapidly deploying and instituting an array of changes aimed at fixing VA's problems. Beyond culture issues, demand outstripped supply. This contributed to an environment that led to violations of our mission and our values. Demand was increased by new presumptive conditions, twelve years of war, the economy and significant VA outreach and education efforts. Peak application of care for wars is decades after the conflict ends as Veterans age. This issue will be with us a long time. We have to build the appropriate capacity now.

We have initiated development of a more robust process for continuously measuring patient satisfaction at each site, and we will expand our patient satisfaction survey capabilities in the coming year, to capture more Veteran experience data

through telephone, social media, and on-line means. Additional VA-wide actions include:

Access to Care

- As of August 15, VHA has reached out to over 266,000 Veterans to get them off wait lists and into clinics.

  VA has re-doubled its efforts to provide quality care to Veterans and has taken steps at national and local levels to ensure timely access to care. VHA has developed the Accelerating Care Initiative (ACI), a coordinated, system-wide initiative designed to increase timely access to care for Veteran patients; decrease the number of Veteran patients on the EWL waiting longer than 30 days for their care; and standardize the process and tools for ongoing monitoring and access management at VA facilities. As of August 15, VA has decreased the number of Veterans on the EWL 57 percent. As we continue to address systemic challenges in accessing care, we are providing regular data updates to enhance transparency and provide the immediate information to Veterans and the public on improvements to Veterans' access to care. Data updates can be found on the following link: http://www.va.gov/health/access-audit.asp
- VA health care facilities nationwide continuously monitor clinic capacity in an effort to maximize VA's ability to provide Veterans timely appointments appropriate for their clinical conditions.
- Where VA cannot increase capacity, VA is increasing the use of care in the community through non-VA medical care. From May 16, 2014, through August 24, 2014, 975,741 total referrals to non-VA care providers have been made. That is 203,637 more non-VA care referrals than the same time period in 2013.
- Each of VA's facilities continuously reaches out to Veterans waiting longer than 90 days for care to coordinate the acceleration of their care.
- Facility clinical staff continuously evaluates Veterans currently waiting for care to ensure the timing of their appointment is medically appropriate for their individual clinical conditions.

- VA is decreasing the number of Veterans on the EWL by standardizing the process and tools for ongoing monitoring and access management at VA facilities.
- VHA utilizes call monitoring in its large national call centers. These monitoring practices require adequate telephony systems. VHA will introduce new monitoring practices through the VA Health Resource Center to assess scheduling practices performed by VA staff.

Scheduling

- The 14-day access measure was removed from all employee performance plans to eliminate any incentive for inappropriate scheduling practices or behaviors. In the course of completing this task, over 13,000 performance plans were amended.
- VA has suspended the use of Desired Date Performance Accountability Report (PAR) performance plans. VA is currently evaluating the use of Desired Date as a mechanism to assess patient preferred appointment timeframes.
- The VSOs are actively engaged in the process. We are updating the antiquated appointment scheduling system, beginning with near-term enhancements to the existing system and ending with the acquisition of a comprehensive, state-of-the-art, “commercial off-the-shelf” scheduling system.

Accountability

- At VA, we depend on the service of employees and leaders who place the interests of Veterans above and beyond self-interest. Accountability, delivering results, and honesty are key to serving our Veterans.
- Where willful misconduct or management negligence is documented, appropriate personnel actions will be taken—this also applies to whistleblower retaliation, which is unacceptable and intolerable at VA.

- VA Medical Center Directors and VISN Directors are completing face-to-face audits of their facilities' scheduling practices. The first round of face-to-face audits will be completed by September 30, 2014. So far, we have conducted 2,450 of these visits nationwide.
- On July 8, 2014, the Deputy Secretary announced that he ordered a restructuring of the Office of the Medical Inspector (OMI) to better serve Veterans and create a strong internal audit function. This restructuring will result in revisions to the policies, procedures, and personnel structure by which OMI operates and establish an internal audit group that will validate VHA's critical national performance measures.
- On August 7, 2014, I asked all VA employees and leadership to reaffirm their commitment to both our mission and "I CARE" values – Integrity, Commitment, Advocacy, Respect and Excellence. I intend this reaffirmation to be the first of many, to be repeated by each employee each year in March, on the anniversary of our establishment as a Department.

Patient Satisfaction

- We are building a more robust, continuous system for measuring patient satisfaction to provide real-time, site-specific information on patient satisfaction. We will augment our existing survey with expanded capabilities in the coming year to capture more Veteran experience data using telephone, social media, and on-line means. Our effort includes close collaboration with VSOs to plan our efforts. We are learning what other leading healthcare systems are doing to track patient access experiences.

Whistleblower Protections

We have made great strides in improving care and services to Veterans in Phoenix and nationwide because employees in Phoenix and elsewhere had the moral courage to do the right thing. They made their voices heard about what they saw

happening. Those employees are examples of I-CARE at its best. Our collective ability to deliver the best services and care to Veterans is inextricably linked to sustaining an organizational culture that protects and empowers the voices of all employees and leverages the diverse talent of all our human resources. This includes creating a climate that embraces constructive dissent, welcomes critical feedback and ensures compliance with legal requirements. As part of our commitment towards embracing this culture we have reinforced our commitment to whistleblower protections to all employees and VA recently registered for and published an implementation plan to receive certification from the Office of Special Council's Section 2302(c) Certification Program.

Accountability

We will continue to work with IG and other stakeholders to take appropriate action, but accountability is about more than personnel actions. We must focus on sustainable accountability. Sustainable accountability means ensuring all employees understand how daily work supports our mission, values and strategy. Sustainable accountability is about more than top-down, hierarchical behavior modification. It is collaborative. Supervisors provide feedback, every day, to every subordinate to recognize what is going well and identify where improvements are necessary. In that same spirit, employees fulfill their responsibility to Veterans and to the Department to provide feedback and input on how we can better serve Veterans.

To achieve sustainable accountability we will do a better job training leadership, flatten our hierarchical culture to encourage innovation and collaboration and we will rate the relative performance of employees because everyone cannot be *the* best. We have strong institutional values: I-CARE. These are mission-critical ideals that must profoundly influence our day-to-day behavior and performance. In performance that mission, guided by those values, we will judge the success of our efforts against a single metric – customer outcomes, Veterans' outcomes. We hold ourselves accountable to these standards. We do not want VA to meet a standard. We want VA recognized as *the* standard in health care and in benefits.

Conclusion

Mr. Chairman, the health and well-being of the men and women who have bravely and selflessly served this Nation remains VA's highest priority. By recommitting, as a Department, to our values, I know we can fix the problems and utilize this opportunity to transform VA to better serve Veterans. This concludes my testimony. Dr. Clancy and I are prepared to answer questions you or the other Members of the Committee may have.