S. HRG. 115–323

GAO'S HIGH-RISK LIST AND THE VETERANS HEALTH ADMINISTRATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

MARCH 15, 2017

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C O N T E N T S

MARCH 15, 2017

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WITNESSES

GAO'S HIGH-RISK LIST AND THE VETERANS HEALTH ADMINISTRATION

WEDNESDAY, MARCH 15, 2017

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

The Committee met, pursuant to notice, at 2:30 p.m. in room 418, Russell Senate Office Building, Hon. Thom Tillis, presiding.

Present: Senators Boozman, Rounds, Tillis, Tester, Murray, and Brown.

OPENING STATEMENT OF HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. I call the hearing to order. Thank you all for being here. Senator Isakson is out today and I will be standing in. Senator Boozman is at a meeting where he should be joining us and taking the gavel shortly.

We all continue to wish the very best for Senator Isakson who is recovering from back surgery. He submitted a statement in a prior meeting. Although the reality is I am wearing this bow tie, which is a University of Georgia bow tie, because I am repaying a bet that I lost, but since I am sitting in his chair for a little bit today I am going to say I am doing it in honor of Senator Isakson.

I would like to welcome the witnesses. Then, we are going to defer to Senator Tester to allow him to make his opening statement. He has a meeting outside, in the anteroom, which we will let him move to. I want to thank the witnesses on the panel today.

Senator Tester, I will wait until after your opening statement, in the interest of time, to introduce the witnesses.

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

Senator TESTER. Thank you, Chairman Tillis. I very much appreciate the hospitality, and thank you all for being here today.

As many of you know, we had a hearing on GAO's High-Risk List a few weeks ago at the Homeland Security and Government Affairs Committee. During the questioning of the Comptroller, Gene Dodaro, who is a guy that I like a lot, who works really tirelessly to help agencies work more effectively and save taxpayer dollars, he told me that he was very concerned about the VA's reaction to its inclusion on the list.

Chief among his concerns is that the VA did not seem to move—did not seem overly interested in doing what it takes to be removed from that High-Risk List. Now that is something that should con-

cern the panelists and something that should concern everybody. Dr. Clancy, I would love to hear from you whether the VA is being productive in addressing those GAO concerns and whether there is an appropriate sense of urgency, because, I want to tell you, the fact that the VA has not fully met the action plan for getting off the list is worrisome in and of itself.

Meanwhile, recent reports from the VA Inspector General, including one about VA in Montana that was released late last week, indicate that the problems that caused GAO to add it to this list are still occurring. According to that report—and the IG is here—according to that report, the IG found that steps have been taken to improve consult time, in addition, and address factors that contribute to future delays at Fort Harrison in Montana, but that is little solace to the four veterans who are identified in that report as being potentially harmed by the consult backlog.

On behalf of them and the veterans seeking care at facilities across this country, we need to do better, the VA has to do better. I think you guys realize that, but I want you to know.

I will hold everybody at the VA accountable for this. Secretary Shulkin knows this, and he also knows we will hold everybody in the leadership team accountable too, including the team at Fort Harrison.

If done right, VA's action and response to the GAO concerns can leave that agency and, more importantly, the veterans of this country in a better place, which is what we want. We want the best services and care for our veterans.

I want to thank you again for calling this hearing. It is always good to work with the good Senator from North Carolina. This is an important topic and I think it has bipartisan support.

Senator TILLIS. Thank you, Senator Tester.

We are welcoming to the panel today Debra Draper, Ph.D., Director, Health Care Team, Government Accountability Office; Michael Missal, Inspector General, Department of Veterans Affairs. I think that he is accompanied by Dr. John Daigh—did I pronounce that correctly?—Assistant Inspector General for Healthcare Inspections, Office of the Inspector General; Carolyn M. Clancy, M.D., Deputy Under Secretary for Health for Organizational Excellence, Department of Veterans Affairs; Jennifer Lee, M.D., Deputy Under Secretary for Health for Policy and Services, Department of Veterans Affairs; and Amy Parker, Executive Director of Operations, Office of Management, Department of Veterans Affairs.

If you all would like to begin with your opening statements; we will just go from left to right. If we can keep those tight so we can get to questions I would appreciate it.

STATEMENT OF DEBRA A. DRAPER, Ph.D., DIRECTOR, HEALTH CARE TEAM, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DRAPER. Chairman Tillis, Ranking Member Tester, and Members of the Committee. I appreciate the opportunity to be here today to discuss the status of veterans' health care as a high-risk area. In my testimony today, I will focus on the concerns that led to this designation, what actions VA has taken in response, and what additional actions are needed to ensure progress and eventual removal from the list.

Veterans' health care was added to GAO's High-Risk List for the first time in 2015, because of concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of the care provided to veterans. In designating veterans' health care as high risk, we categorize our specific concerns into five categories: (1) ambiguous policies and inconsistent processes; (2) inadequate oversight and accountability: (3) information technology challenges; (4) inadequate training for VA staff; and (5) unclear resource needs and allocation priorities.

At the time, we were also concerned that VA had not implemented more than 100 GAO recommendations related to veterans' health care, and many had been open for three or more years.

Last month, as we do every 2 years, at the start of each new Congress, we updated our High-Risk List and reported on progress made by each area on our list, including veterans' health care. We assess progress and potential for removal from the list based on five criteria: leadership commitment; capacity, in terms of people and resources; an action plan; monitoring; and demonstrated progress.

Our assessment is that VA has taken some, albeit exceedingly limited actions, to address the concerns that led to its high-risk designation. For example, some leadership actions have been taken, including the establishment of a task force, working groups, and a governance structure to address the concerns. Additionally, VA leadership provided us with an action plan in August, in which they acknowledged the deep-rooted nature of the concerns and stated that addressing these would require substantial time and work.

Based on these actions, we concluded that VA had partially met the high-risk removal criteria of leadership commitment and an action plan, and had made no progress with regard to the other three criteria: capacity; monitoring; and demonstrated progress.

I want to be very clear that even in the areas where VA has made some progress, there is a long path toward fully meeting the criteria. For example, the action plan submitted to us lacked many critical elements, including an analysis of the root causes for each of the categories of concern, a critical step to better understanding why the problem exists, and what specifically needs to be addressed; reasonable timelines, given the significant scope of the efforts needed; clear metrics necessary for measuring and monitoring progress; and finally, the plan lacked an assessment of the resources needed for implementation.

We also continue to be concerned about the large number of open recommendations, and while VA has taken actions to address some of these, considerable work remains. As I noted at the time of its high-risk designation in 2015, VA had more than 100 open GAO recommendations related to veterans' health care. Seventy-four new recommendations have been added since then. Currently, there are still more than 100 open recommendations and about a quarter of these have been open for three or more years.

It is critical that VA resolve our recommendations in a timely manner, not only to remedy the specific weaknesses identified but because they may be symptomatic of larger underlying problems that also need to be addressed.

There are a number of actions that VA needs to immediately take to move forward. The most important of these are ensuring strong, department-level leadership support; developing a robust action plan that provides a clear roadmap for what needs to be done, when it will be done, how progress will be measured, and what resources are needed to ensure successful implementation; integrating VA's response to its high-risk designation with other initiatives such as the Secretary's 10-point plan; and resolving open recommendations in a timely manner.

We are very concerned about VA's exceedingly slow pace of progress. Unfortunately, as of today, VA is not much further ahead at addressing the concerns that led to its high risk designation than it was 2 years ago. The lack of progress raises several important questions, including how seriously VA is taking this, whether the right people with the right skills are being tasked to address the high risk concerns, and whether the overall responsibility for achieving removal from the High-Risk List is at the right organizational level within VA.

Mr. Chairman, this concludes my opening remarks. I would be happy to answer any questions.

[The prepared statement of Ms. Draper follows:]

PREPARED STATEMENT OF DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

GAO Highlights

Highlights of GAO-17-473T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

March 15, 2017

VETERANS' HEALTH CARE

Limited Progress Made to Address Concerns That Led to High-Risk Designation

Why GAO Did This Study

VA operates one of the largest health care delivery systems in the nation, including 168 medical centers and more than 1,000 outpatient facilities organized into regional networks. Enrollment in the VA health care system has grown significantly, from 7.9 million in fiscal year 2006 to almost 9 million in fiscal year 2016. Over that same period, VA's Veterans Health Administration's total budgetary resources have increased substantially, from $37.8 billion in fiscal year 2006 to $91.2 billion in fiscal year 2016.

Since 1990, GAO has regularly updated the list of government operations that it has identified as high risk due to their vulnerability to fraud, waste, abuse, and mismanagement, or the need for transformation to address economy, efficiency, or effectiveness challenges. VA health care was added as a high-risk area in 2015 because of concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of veterans' health care. GAO assesses High-Risk List removal against five criteria: (1) leadership commitment, (2) capacity, (3) action plan, (4) monitoring, and (5) demonstrated progress.

This statement, which is based on GAO's February 2017 high-risk report, addresses (1) actions VA has taken over the past 2 years to address the areas of concern that led GAO to designate VA health care as high risk, (2) the number of open GAO recommendations related to VA health care, and (3) additional actions VA needs to take to address the concerns that led to the high-risk designation.

View GAO-17-473T. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) has taken action to partially meet two of the five criteria GAO uses to assess removal from the High-Risk List (leadership commitment and an action plan), but it has not met the other three (agency capacity, monitoring efforts, and demonstrated progress). Specifically, VA officials have taken leadership actions such as establishing a task force, working groups, and a governance structure for addressing the issues that led to the high-risk designation. VA provided GAO with an action plan in August 2016 that acknowledged the deep-rooted nature of the five areas of concern GAO identified: (1) ambiguous policies and inconsistent processes; (2) inadequate oversight and accountability; (3) information technology challenges; (4) inadequate training for VA staff; and (5) unclear resource needs and allocation priorities. Although VA's action plan outlined some steps VA plans to take over the next several years, several sections were missing analyses of the root causes of the issues, resources needed, and clear metrics to measure progress.

Managing Risks and Improving VA Health Care

Source: GAO analysis. | GAO-17-473T

Also of concern are the more than 100 open recommendations GAO has made between January 2010 and February 2017 related to VA health care, almost a quarter of which have been open for 3 or more years. Since February 2015, GAO has made 74 new recommendations relating to the areas of concern.

To address its high-risk designation, additional actions are required of VA, including: (1) demonstrating stronger leadership support as it continues its transition under a new administration; (2) developing an action plan to include root cause analyses for each area of concern, clear metrics to assess progress, and the identification of resources for achieving stated outcomes; and (3) implementing GAO's recommendations, not only to remedy the specific weaknesses identified, but because they may be symptomatic of larger underlying problems that also need to be addressed. Until VA addresses these serious underlying weaknesses, it will be difficult for the department to effectively and efficiently implement improvements addressing the five areas of concern that led to the high-risk designation.

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE: I am pleased to be here today to discuss the status of the Department of Veterans Affairs' (VA) actions to address the concerns that led to the high-risk designation we made related to VA health care. We added managing risks and improving VA health care to our High Risk List in 2015 due to our concern about VA's ability to ensure the cost-effective and efficient use of resources to improve the time-

liness, quality, and safety of health care for veterans.[1] We expressed continued concerns about VA health care in our 2017 high-risk report.[2]

VA's Veterans Health Administration (VHA) operates one of the largest health care delivery systems in the Nation, with 168 medical centers and more than 1,000 outpatient facilities organized into regional networks. VA has faced a growing demand by veterans for its health care services—due, in part, to servicemembers returning from military operations in Afghanistan and Iraq and the needs of an aging veteran population—and that trend is expected to continue. The total number of veteran enrollees in VA's health care system rose from 7.9 million to almost 9 million from fiscal year 2006 through fiscal year 2016. Over that same period, VHA's total budgetary resources have increased substantially, from $37.8 billion in fiscal year 2006 to $91.2 billion in fiscal year 2016.

Although VA's budget and enrollees have substantially increased for at least a decade, there have been numerous reports during this same period—by us, VA's Office of the Inspector General, and others—of VA facilities failing to provide timely health care.[3] In some cases, the delays in care or VA's failure to provide care at all reportedly have resulted in harm to veterans. In response to these serious and longstanding problems with access to VA health care, the Veterans Access, Choice, and Accountability Act of 2014 was enacted, which provided temporary authority and $10 billion in funding through August 7, 2017 (or sooner, if those funds are exhausted) for veterans to obtain health care services from community (non-VA) providers to address long wait times, lengthy travel distances, or other challenges they may face accessing VA health care.[4] Under this authority, VA introduced the Veterans Choice Program in November 2014, which offers veterans the option to receive hospital care and medical services from a non-VA provider when a VA facility cannot provide an appointment within 30 days, or when veterans reside more than 40 miles from the nearest VA facility.[5]

In addition to concerns about timely access to care, VA faces challenges regarding the reliability, transparency, and consistency of its budget estimates for medical services, as well as weaknesses in tracking obligations for medical services and estimating budgetary needs for future years. These challenges were evident in June 2015, when VA requested additional funds from Congress because agency officials projected a fiscal year 2015 funding gap of about $3 billion in its medical services appropriation account.[6] The projected funding gap was largely due to administrative weaknesses that slowed the utilization of the Veterans Choice Program in fiscal year 2015 and resulted in higher-than-expected demand for VA's previously established VA community care programs.[7] To address the projected funding gap in fiscal year 2015, the VA Budget and Choice Improvement Act provided VA tem-

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[1] GAO, High Risk Series: An Update, GAO 15 290 (Washington, DC: Feb. 11, 2015).

[2] GAO, High Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others, GAO 17 317 (Washington, DC: Feb. 15, 2017).

[3] See, for example, GAO, VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care, GAO 16 328 (Washington, DC: Mar. 18, 2016) and GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO 16 24 (Washington, DC: Oct. 28, 2015). See also, for example, Department of Veterans Affairs, Office of Inspector General, Veterans Health Administration, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, Report No. 14–02603–267 (Washington, DC: Aug. 26, 2014) and VA, Department of Veterans Affairs Access Audit, System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014.

[4] Pub. L. No. 113–146, 128 Stat. 1754. The $10 billion is meant to supplement VA's medical services budget and is funded through a separate appropriations account, the Veterans Choice Fund. The 2014 law also appropriated $5 billion to expand VA's capacity to deliver care to veterans by hiring additional clinicians and improving the physical infrastructure of VA's medical facilities.

[5] VA has purchased care from non-VA community providers through its care in the community programs since as early as 1945. VHA has numerous programs, including the Veterans Choice Program, through which it purchases VA care in the community services.

[6] See GAO, VA's Health Care Budget: In Response to a Projected Funding Gap in Fiscal Year 2015, VA Has Made Efforts to Better Manage Future Budgets, GAO 16 584 (Washington, DC: Jun. 3, 2016). In our 2016 report, the projected funding gap refers to the period in fiscal year 2015 when VA's obligations for medical services were projected to exceed its available budget authority for that purpose for that year. The Antideficiency Act prohibits agencies from incurring obligations in excess of available budget authority. 31 U.S.C. § 1341(a). An evaluation of whether an Antideficiency Act violation occurred in fiscal year 2015 was outside the scope of our work.

[7] In particular, VA officials expected that the Veterans Choice Program would absorb much of the increased demand from veterans for health care services delivered by non-VA providers, but instead the slow utilization resulted in veterans continuing to receive care through previously established VA community care programs that drew funds from VA's medical services appropriation account.

porary authority to use up to $3.3 billion from the Veterans Choice Program appropriation for obligations incurred for other specified medical services.[8] In our June 2016 report on VA's health care budget, we reported that VA officials anticipated requesting another increase in funding for health care services in the budget request for fiscal year 2018.[9] Over the course of fiscal year 2016, utilization of the Veterans Choice Program increased considerably, and the Veterans Choice Fund had a $4.5 billion remaining balance at the start of fiscal year 2017 to cover community care services.[10] However, in February 2017, a VA official told us that VA would need an estimated $2 billion in addition to its fiscal year 2018 advance appropriation of about $70 billion to continue providing services.[11]

My statement today, which is based on our February 2017 High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others, will address (1) actions VA has taken over the past 2 years to address the areas of concern that led us to place VA health care on our High-Risk List in 2015, (2) the number of open GAO recommendations related to VA health care, and (3) additional actions VA needs to take to address the concerns that led to the high-risk designation. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

BACKGROUND

Since 1990, we have regularly reported on government operations that we have identified as high risk due to their vulnerability to fraud, waste, abuse, and mismanagement, or the need for transformation to address economy, efficiency, or effectiveness challenges. Our high-risk program—which is intended to help inform the congressional oversight agenda and to guide efforts of the administration and agencies to improve government performance—has brought much-needed focus to problems impeding effective government and costing billions of dollars. In 1990, we designated 14 high-risk areas. Since then, generally coinciding with the start of each new Congress, we have reported on the status of progress to address previously designated high-risk areas, determined whether any areas could be removed or consolidated, and identified new high-risk areas.

Since 1990, a total of 60 different areas have appeared on the High-Risk List, 24 areas have been removed, and 2 areas have been consolidated. On average, high-risk areas that have been removed from the list remained on it for 9 years after they were initially added. Our experience has shown that the key elements needed to make progress in high-risk areas are top-level attention by the administration and agency leaders grounded in the five criteria for removal from the High-Risk List, as well as any needed congressional action. The five criteria for removal that we issued in November 2000 are as follows:[12]

- Leadership Commitment. The agency demonstrates strong commitment and top leadership support.
- Capacity. The agency has the capacity (i.e., people and resources) to resolve the risk(s).
- Action Plan. A corrective action plan exists that defines the root cause and solutions, and provides for substantially completing corrective measures, including steps necessary to implement solutions we recommended.
- Monitoring. A program has been instituted to monitor and independently validate the effectiveness and sustainability of corrective measures.
- Demonstrated Progress. The agency is able to demonstrate progress in implementing corrective measures and in resolving the high-risk area.

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[8] Pub. L. No. 114–41, Tit. IV, § 4004, 129 Stat. 443, 463–464 (2015). Specifically, VA was authorized to use the Veterans Choice Program appropriation to cover obligations incurred for the other specified medical services starting May 1, 2015, until October 1, 2015.

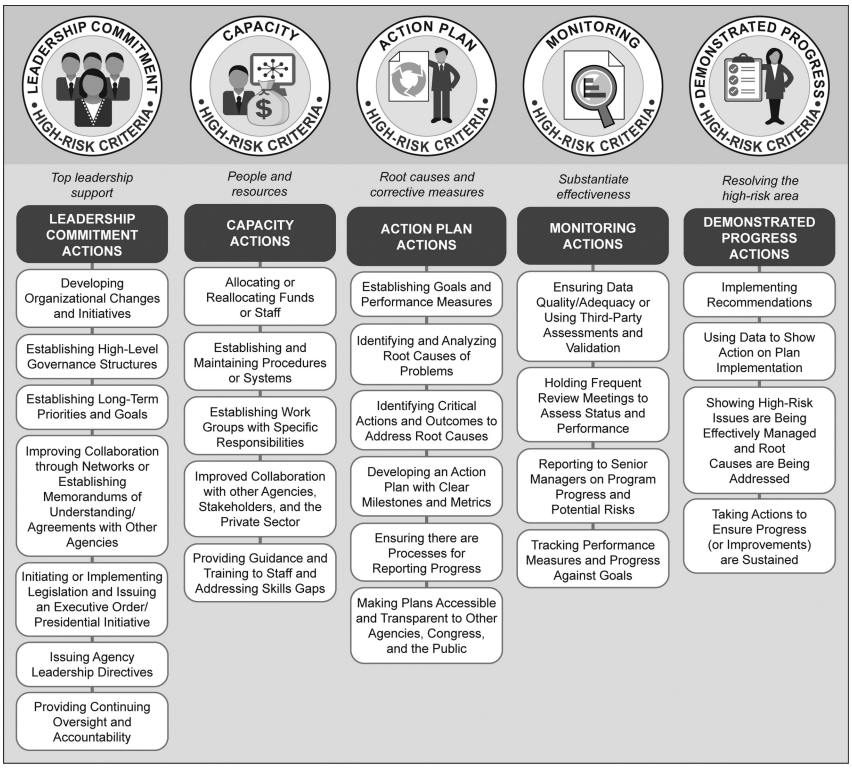
[9] See GAO 16 584.

[10] At the start of fiscal year 2016, VA issued a policy memorandum to its VAMCs requiring them to offer eligible veterans referrals to the Veterans Choice Program before they authorize care through VA's previously established community care programs.

[11] Each year, Congress provides funding for VA health care through the appropriations process. Specifically, Congress provides appropriations for the coming fiscal year (which begins October 1 of that year), as well as an advance appropriation for the following fiscal year. VA's advance appropriation for fiscal year 2018 was enacted on September 29, 2016. Pub. L. No. 114–223, 130 Stat. 857, 869 (2016).

[12] GAO, Determining Performance and Accountability Challenges and High Risks, GAO 01 159SP (Washington, DC: November 2000).

These five criteria form a road map for efforts to improve and ultimately address high-risk issues. Addressing some of the criteria leads to progress, while satisfying all of the criteria is central to removal from the list. In our April 2016 report, we provided additional information on how agencies had made progress addressing high-risk issues.[13] Figure 1 shows the five criteria for removal for a designated high-risk area and examples of actions taken by agencies as cited in that report.



Source: GAO-16-480R. | GAO-17-473T

Importantly, the actions listed are not "stand alone" efforts taken in isolation from other actions to address high-risk issues. That is, actions taken under one criterion may also be important in meeting other criteria. For example, top leadership can demonstrate its commitment by establishing a corrective action plan including long-term priorities and goals to address the high-risk issue and using data to gauge progress—actions which are also vital to monitoring criteria.

VA HAS MADE LIMITED PROGRESS IN ADDRESSING THE CONCERNS THAT LED TO THE 2015 VA HEALTH CARE HIGH-RISK DESIGNATION

VA officials have expressed their commitment to addressing the concerns that led to the high-risk designation for VA health care. As part of our work for the 2017 high-risk report, we identified actions VA had taken, such as establishing a task force, working groups, and a governance structure for addressing the five areas of concern contributing to the designation: (1) ambiguous policies and inconsistent processes; (2) inadequate oversight and accountability; (3) information technology (IT) challenges; (4) inadequate training for VA staff; and (5) unclear resource needs and allocation priorities. For example, in July 2016, VA chartered the GAO High Risk List Area Task Force for Managing Risk and Improving VA Health Care to develop and oversee implementation of VA's plan to address the root causes of the five areas of concern we identified in 2015.

[13] GAO, High-Risk Series: Key Actions to Make Progress Addressing High-Risk Issues, GAO 16 480R (Washington, DC: Apr. 25, 2016).

VA's task force and associated working groups are responsible for developing and executing the department's high-risk mitigation plan for each of the five areas of concern we identified. VA also executed two contracts with a total value of $7.8 million to support its actions to address the concerns behind the high-risk designation. These contracts—with the MITRE Corporation and Atlas Research, LLC—are intended to provide additional support for actions such as developing and executing an action plan, creating a plan to enhance VA's capacity to manage the five areas, and assisting with establishing the management functions necessary to oversee the five high-risk-area working groups.

On August 18, 2016, VA provided us with an action plan that acknowledged the deep-rooted nature of the areas of concern, and stated that these concerns would require substantial time and work to address. Although the action plan outlined some steps VA plans to take over the next several years to address the concerns that led to its high-risk designation, several sections were missing critical actions that would support our criteria for removal from the High-Risk List, such as analyzing the root causes of the issues and measuring progress with clear metrics. In our feedback to VHA on drafts of its action plan, we highlighted these missing actions and also stressed the need for specific timelines and an assessment of needed resources for implementation. For example, VA plans to use staff from various sources, including contractors and temporarily detailed employees, to support its high-risk-area working groups, so it is important for VA to ensure that these efforts are sufficiently resourced.

Overall Rating for Managing Risks and Improving VA Health Care

As we reported in the February 2017 high-risk report, when we applied the five criteria for High-Risk List removal to each of the areas of concern, we determined that VA has partially met two of the five criteria: leadership commitment and an action plan. VA has not met the other three criteria for removal: capacity to address the areas of concern, monitoring implementation of corrective actions, and demonstrating progress. It is worth noting that although both criteria were rated as partially met, the department made significantly less progress in developing a viable action plan than it has in demonstrating leadership commitment. Specifically, VA partially met the action plan criterion for only one of the five areas of concern—ambiguous policies and inconsistent processes—whereas VA partially met the leadership commitment criterion for four out of five areas of concern.

The following is a summary of the progress VA has made in addressing the five criteria for removal from the High-Risk List for each of the five areas of concern we identified.[14]

Ambiguous Policies and Inconsistent Processes

Summary of concern. When we designated VA health care as a high-risk area in 2015, we reported that ambiguous VA policies led to inconsistent processes at local VA medical facilities, which may have posed risks for veterans' access to VA health care. Since then, we highlighted the inconsistent application of policies in two recent reports examining mental health and primary care access at VA medical facilities in 2015 and 2016, respectively.[15] In both reports, we found wide variation in the time that veterans waited for primary and mental health care, which was in part caused by a lack of clear, updated policies for appointment scheduling; therefore, we recommended that VA update these policies. These ambiguous policies contributed to errors made by appointment schedulers, which led to inconsistent and unreliable wait-time data. For mental health, we also found that two policies conflicted, leading to confusion among VA medical center staff as to which wait-time policy to follow. In 2015, VA resolved this policy conflict by revising its mental health handbook, but other inconsistent applications of mental health policy have not yet been addressed, such as our recommendation to issue guidance about the definitions used to calculate veteran appointment wait times, and communicate any changes to those definitions within and outside VHA.

2017 assessment of VA's progress. Based on actions taken since 2015, VA has partially met our criteria for removal from the High-Risk List for this area of concern for leadership commitment and action plan. VA has partially met the leadership commitment criterion because it established a framework for developing and reviewing policies—with the goal of ensuring greater consistency and clarity—and set

[14] For more detailed analysis of VA's actions in each of the five areas of concern, see GAO 17 317.

[15] See GAO, *VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care*, GAO 16 328 (Washington, DC: Mar. 18, 2016); and GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO 16 24 (Washington, DC: Oct. 28, 2015).

goals for making the policy-development process more efficient. VA has partially met the action plan criterion for this high-risk area of concern because its action plan described an analysis of the root causes of problems related to ambiguous policies and inconsistent processes, an important aspect of an action plan. However, VA has not met our criteria for removal from the High-Risk List for capacity, monitoring, and demonstrated progress for this area of concern because it has not addressed gaps that exist between its stated goals and available resources, addressed inconsistent application of policies at the local level, or demonstrated that its actions are linked to identified root causes.

Inadequate Oversight and Accountability

Summary of concern. In our 2015 high-risk report, we found that VA had problems holding its facilities accountable for their performance because it relied on self-reported data from facilities, its oversight activities were not sufficiently focused on compliance, and it did not routinely assess policy implementation. We continued to find a lack of oversight in our October 2015 review of the efficiency and timeliness of VA's primary care. For example, we found inaccuracies in VA's data on primary care panel sizes, which are used to help medical centers manage their workload and ensure that veterans receive timely and efficient care.[16] We found that while VA's primary care panel management policy required facilities to ensure the reliability of their panel size data, it did not assign responsibility for verifying data reliability to regional- or national-level officials or require them to use the data for monitoring purposes. As a result, VA could not be assured that local panel size data were reliable, or know whether its medical centers had met VA's goals for efficient, timely, and quality care. We recommended that VA incorporate an oversight process in its primary care panel management policy that assigns responsibility, as appropriate, to regional networks and to VA's central office for verifying and monitoring panel sizes.

2017 assessment of VA's progress. VA has partially met the leadership commitment criterion for this area of concern because it established a high-level governance structure and adopted a new model to guide the department's oversight and accountability activities. However, VA has not met our criteria for removal from the High-Risk List for capacity, action plan, monitoring, or demonstrated progress for this area of concern because the department continues to rely on existing processes that contribute to inadequate oversight and accountability.

Information Technology Challenges

Summary of concern. In our 2015 high-risk report, we identified limitations in the capacity of VA's existing IT systems, including the outdated, inefficient nature of certain systems and a lack of system interoperability as contributors to VA's IT challenges related to VA health care. We have continued to report on the importance of VA working with the Department of Defense to achieve electronic health record interoperability. In August 2015, we reported on the status of these interoperability efforts and noted that the departments had engaged in several near-term efforts focused on expanding interoperability between their existing electronic health record systems. However, we were concerned by the lack of outcome-oriented goals and metrics that would more clearly define what VA and the Department of Defense aim to achieve from their interoperability efforts. Accordingly, we recommended that the departments establish a timeframe for identifying outcome-oriented metrics and define related goals for achieving interoperability. In February 2017, we reported that VA has begun to define an approach for identifying outcome-oriented metrics focused on health outcomes in selected clinical areas, and it also has begun to establish baseline measurements.[17] We intend to continue monitoring the departments' efforts to determine how these metrics define and measure the results achieved by interoperability between the departments.

2017 assessment of VA's progress. VA has partially met our leadership commitment criterion by involving top leadership from VA's Office of Information & Technology in this area of concern, but it has not met our four remaining criteria for removing IT challenges from the High-Risk List. For example, VA has not demonstrated improvement in several capacity actions, such as establishing specific responsibilities for its new functions, improving collaboration between internal and external stakeholders, and addressing skill gaps. VA also needs to conduct a root

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[16] GAO, *VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care*, GAO 16 83 (Washington, DC: Oct. 8, 2015).

[17] GAO, *Veterans Affairs Information Technology: Management Attention Needed to Improve Critical System Modernizations, Consolidate Data Centers, and Retire Legacy Systems*, GAO 17 408T (Washington, DC: Feb. 7, 2017).

cause analysis that would help identify and prioritize critical actions and outcomes to address IT challenges.

Inadequate Training for VA Staff

Summary of concern. When identifying this area of concern in our 2015 high-risk report, we described several gaps in VA's training, as well as burdensome training requirements. We have continued to find these issues in our subsequent work. For example, in our December 2016 report on VHA's human resources (HR) capacity, we found that VA's competency assessment tool did not address two of the three personnel systems under which VHA staff may be hired.[18] We recommended that VHA (1) develop a comprehensive competency assessment tool for H.R. staff that evaluates knowledge of all three of VHA's personnel systems and (2) ensure that all VHA H.R. staff complete it so that VHA may use the data to identify and address competency gaps among H.R. staff. Without such a tool, VHA will have limited insights into the abilities of its H.R. staff and will be ill-positioned to provide necessary support and training.

2017 assessment of VA's progress. VA has not met any of our criteria for removing this area of concern from the High-Risk List. VA intends to establish a comprehensive health care training management policy and a mandatory annual training process; however, as of December 2016, VA officials said they had not begun drafting a new policy to replace an outdated document from 2002 that contains training requirements that are no longer relevant. The high-level nature of the descriptions in the action plan and lack of action to update outdated policies and set goals for improving training shows that VA lacks leadership commitment to address the concerns that led to our inclusion of this area in the 2015 high-risk report.

Unclear Resource Needs and Allocation Priorities

Summary of concern. In our 2015 high-risk report, we described gaps in the availability of data needed for VA to identify the resources it needs and ensure they are effectively allocated across VA's health care system as contributors to our concern about unclear resource needs and allocation priorities. We have continued to report on this concern. For example, in our September 2016 report on VHA's organizational structure, we found that VA devoted significant time, effort, and funds to generate recommendations for organizational structure changes intended to improve the efficiency of VHA operations.[19] However, the department then either did not act or acted slowly to implement the recommendations. Without robust processes for evaluating and implementing recommendations, there was little assurance that VHA's delivery of health care to the Nation's veterans would improve. We recommended that VA develop a process to ensure that it evaluates organizational structure recommendations resulting from internal and external reviews of VHA. This process should include documenting decisions and assigning officials or offices responsibility for ensuring that approved recommendations are implemented. We concluded that such a process would help VA ensure that it is using resources efficiently, monitoring and evaluating implementation, and holding officials accountable.

2017 assessment of VA's progress. VA's actions have partially met our criterion for leadership commitment but not met the other four criteria for removing this area of concern from the High Risk List. VA's planned actions do not make clear how VHA, as the agency managing VA health care, is or will be incorporated into VA's new framework for the strategic planning and budgeting process.[20] It is also not clear how the framework will be communicated and reflected at the regional network and medical center levels. VA also has not identified what resources may be necessary to establish and maintain new functions at the national and local levels, or established performance measures based on a root cause analysis of its unclear resource needs and allocation priorities.

MORE THAN 100 GAO RECOMMENDATIONS FOR IMPROVING VA HEALTH CARE REMAIN OPEN

Since we added VA health care to our High-Risk List in 2015, VA's leadership has increased its focus on implementing our prior recommendations, but additional work

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[18] GAO, *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges*, GAO 17 30 (Washington, DC: Dec. 23, 2016).

[19] GAO, *VA Health Care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed*, GAO 16 803 (Washington, DC: Sept. 27, 2016).

[20] In its action plan, VA reported adopting a framework in 2016 called "Managing for Results" to better connect VA's requirements setting process (that forecasts veterans' needs) with its process for developing the department's budget. VA stated that full implementation of the framework will take place over several budget cycles.

is still needed. Between January 2010 and February 2015 (when we first designated VA health care as a high-risk area), we made 178 recommendations to VA related to VA health care. When we made our designation in 2015, the department only had implemented about 22 percent of them.[21] Since February 2015, we have made 74 new recommendations to VA related to VA health care, for a total of 252 recommendations from January 1, 2010 through February 15, 2017 (when we issued the 2017 high-risk report).[22] VA has implemented about 50 percent of these recommendations. However, there continue to be more than 100 open recommendations related to VA health care, almost a quarter of which have remained open for 3 or more years.[23] We believe that it is critical that VA implement our recommendations not only to remedy the specific weaknesses we previously identified, but because they may be symptomatic of larger underlying problems that also need to be addressed. Since the 2015 high-risk report, we have made new recommendations to VA relating to each of the five areas of concern. (See table 1.)

Table 1: GAO Recommendations to the Department of Veterans Affairs (VA) Related to VA Health Care from January 1, 2010 through February 15, 2017, by Area of Concern

VA health care area of concern	Number of recommendations prior to GAO high-risk designation (Jan. 1, 2010 through Feb. 11, 2015)*	Number of recommendations added since GAO high-risk designation (Feb. 11, 2015 through Feb. 15, 2017)*	Cumulative number of GAO recommendations Jan. 1, 2010 through Feb. 15, 2017*	Cumulative percentage of GAO recommendations VA has implemented, Jan. 1, 2010 through Feb. 15, 2017
Ambiguous policies and inconsistent processes	42	21	63	52%
Inadequate oversight and accountability	63	36	99	51
Information technology challenges	11	2	13	44
Inadequate training for VA staff	6	8	14	43
Unclear resource needs and allocation priorities	48	6	54	66
Not assigned to an area of concern	8	1	9	44
Total	178	74	252	50%

Source: GAO. GAO 17 473T.
*Recommendation counts listed include both implemented and not implemented recommendations as of the dates indicated.

SUSTAINED LEADERSHIP SUPPORT AND STRATEGIC FOCUS NEEDED TO MEET HIGH-RISK REMOVAL CRITERIA

VA has taken an important step toward addressing our criteria for removal from the High-Risk List by establishing the leadership structure necessary to ensure that actions related to the High-Risk List are prioritized within the department. It is imperative, however, that VA demonstrate strong leadership support as it continues its transition under a new administration, address weaknesses in its action plan, and continue to implement our open recommendations.

As a new administration sets its priorities, VA will need to integrate those priorities with its high-risk-related actions, and facilitate their implementation at the local level through strategies that link strategic goals to actions and guidance. In its action plan, VA separated its discussion of department-wide initiatives, like *MyVA*, from its description of High-Risk List mitigation strategies.[24] We do not view high-risk mitigation strategies as separate from other department initiatives; actions to address the High-Risk List can, and should be, integrated in VA's existing activities.

VA's action plan did not adequately address the concerns that led to the high-risk designation because it lacked root cause analyses for most areas of concern, as well as clear metrics and identified resources needed for achieving VA's stated outcomes. This is especially evident in VA's plans to address the IT and training areas of con-

[21] Of the 178 recommendations, 134 were open because VA had not yet implemented them. Additionally, 39 had been closed because VA implemented them, and 5 had been closed without VA implementing them. We close recommendations without agencies having implemented them primarily if the recommendation is no longer valid because circumstances have changed.

[22] See GAO 17 317.

[23] Specifically, 112 recommendations are open because VA has not yet implemented them, 25 of which have been open for 3 or more years. In addition, 127 recommendations were closed because VA implemented them, and 13 were closed without VA implementing them.

[24] According to VA, *MyVA* intends to make changes to VA's systems and structures to (1) improve the veteran experience, (2) improve the employee experience, (3) achieve support services excellence, (4) establish a culture of continuous performance improvement, and (5) enhance strategic partnerships.

cern. In addition, with the increased use of community care programs, it is imperative that VA's action plan include a discussion of the role of community care in decisions related to policies, oversight, IT, training, and resource needs. VA will also need to demonstrate that it has the capacity to sustain efforts by devoting appropriate resources—including people, training, and funds—to address the high-risk challenges we identified. Until VA addresses these serious underlying weaknesses, it will be difficult for the department to effectively and efficiently implement improvements addressing the five areas of concern that led to the high-risk designation.

We will continue to monitor VA's institutional capacity to fully implement an action plan and sustain needed changes in all five of our areas of concern. To the extent we can, we will continue to provide feedback to VA officials on VA's action plan and areas where they need to focus their attention. Additionally, we have ongoing work focusing on VA health care that will provide important insights on progress, including the policy development and dissemination process, implementation and monitoring of VA's opioid safety, Veterans Choice Program implementation, physician recruitment and retention, and processes for enrolling veterans in VA health care.

Finally, we plan to also continue to monitor VA's efforts to implement our recommendations and recommendations from other reviews such as the Commission on Care.[25] To this end, we believe that the following GAO recommendations require VA's immediate attention:

- improving oversight of access to timely medical appointments, including the development of wait-time measures that are more reliable and not prone to user error or manipulation, as well as ensuring that medical centers consistently and accurately implement VHA's scheduling policy.
- improving oversight of VA community care to ensure—among other things—timely payment to community providers.
- improving planning, deployment, and oversight of VA/VHA IT systems, including identifying outcome-oriented metrics and defining goals for interoperability with DOD.
- ensuring that recommendations resulting from internal and external reviews of VHA's organizational structure are evaluated for implementation. This process should include the documentation of decisions and assigning officials or offices responsibility for ensuring that approved recommendations are implemented.

Moreover, it is critical that Congress maintain its focus on oversight of VA health care to help address this high-risk area. Congressional committees responsible for authorizing and overseeing VA health care programs held more than 70 hearings in 2015 and 2016 to examine and address VA health care challenges. As VA continues to change its health care service delivery in the coming years, some changes may require congressional action—such as VA's planned consolidation of community care programs after the Veterans Choice Program expires. Sustained congressional attention to these issues will help ensure that VA continues to improve its management and delivery of health care services to veterans.

Chairman Isakson, Ranking Member Tester, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

Senator TILLIS. Thank you.
Mr. Missal.

[25] The Veterans Access, Choice, and Accountability Act of 2014 established the Commission on Care to examine, assess, and report on veterans' access to VA health care and to strategically examine how best to organize VHA, locate health resources, and deliver health care to veterans during the next 20 years. The Commission's June 2016 report to the President included 18 recommendations to improve veterans' access to care and, more broadly, to improve the quality and comprehensiveness of that care. On September 1, 2016, the President concurred with 15 of the 18 recommendations and directed VA to implement them.

STATEMENT OF MICHAEL J. MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN D. DAIGH, JR., M.D., CPA, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL

Mr. MISSAL. Senator Tillis and Members of the Committee, thank you for the opportunity to discuss the work of the VA Office of Inspector General and how we provide effective oversight of VA programs and operations through independent audits, inspections, and investigations. I am accompanied by Dr. David Daigh, the Assistant Inspector General for Healthcare Inspections.

The OIG seeks to prevent and detect fraud, waste, and abuse and make meaningful recommendations to drive economy, efficiency, and effectiveness throughout VA's programs and operations. Our goal is to undertake impactful work that will assist VA in providing the appropriate and timely services and benefits that veterans so deservedly earned and ensuring the proper expenditure of taxpayer funds.

I have had the great privilege of serving as the Inspector General since May 2, 2016. Since that time, I have fully immersed myself in the work, priorities, and policies of the OIG. We have made a number of enhancements since I started, in an effort to do more impactful work in a timelier manner.

The OIG shares a similar mission with GAO. It is important that we have a strong relationship with GAO, to ensure we avoid duplication of effort as much as possible. To that end, one of the first things I did when I started was to meet with Comptroller General Dodaro, Dr. Draper, and his other senior staff. Our offices have had a number of communications since that time to promote coordination and more effective oversight of VA.

GAO added VA health care to its biannual High-Risk List in 2015, and it remains on the High-Risk List that was just issued in 2017. GAO focused its concern in five broad areas. While our work is determined by what we believe is the most effective oversight of VA, a number of our reports addressed concerns in these same five areas. My written statement includes examples of OIG work in each of the areas that resulted in GAO placing VA health care on its High-Risk List. It should be noted that many of the OIG's reports could fit into more than one area. I will highlight a few of those reports now.

We have issued a number of reports in the past few years that include VA's ambiguous policies and inconsistent processes. For example, our review of the Health Eligibility Center determined that VA had not effectively managed its business processes to ensure the consistent creation and maintenance of essential health care eligibility data.

Proper oversight by management would ensure that programs and operations would work effectively and efficiently. Our September 2016 report on the Denver replacement medical center is an extremely costly example of the result of inadequate oversight. Through all phases of the project, we identified various factors that significantly contributed to delays and rising costs. This occurred due to a series of questionable business decisions and mismanagement by VA senior officials, resulting in a project years behind

schedule and costing more than twice the initial budget of $800 million.

We have frequently identified VA struggles to design, procure, and/or implement functional IT systems. IT security is continually reported as a material weakness in VA's consolidated financial statements. Moreover, VA has a high number of legacy IT systems needing replacement. Furthermore, after years of effort focused on replacement of VA's legacy scheduling software, a new scheduling system is still not in place. VA's issues with scheduling software are related to the inability to define its requirements and determine if a commercial solution is available or if it must design the system.

One prevailing theme of the OIG's work related to wait times and scheduling issues was the inadequate, lack of, or incorrect training provided to VA staff responsible for scheduling appointments. As we have stated in reports that have been issued since the allegations at the Phoenix VA health care system surfaced in April 2014, the lack of training for schedulers, the lack of understanding of the process by their managers, and, in some cases, the disregard of VA scheduling policies created a system where services have not been provided timely, and in some situations, wait times were not accurately portrayed. VA needs to accurately forecast the demand for health care services in both the near term and the long term.

In conclusion, the OIG is committed to providing effective oversight of the programs and operations of VA. We will continue to produce reports that provide VA, Congress, and the public with recommendations that we believe will help VA operate its programs and services in a manner that will effectively and timely deliver services and benefits to veterans and spend taxpayer money appropriately.

Senator Tillis, this concludes my statement. Dr. Daigh and I would be happy to answer questions that you or other Members of the Committee may have.

[The prepared statement of Mr. Missal follows:]

PREPARED STATEMENT OF MICHAEL J. MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

MR. CHAIRMAN, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, Thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG) and how the OIG provides effective oversight of VA programs and operations through independent audits, inspections, and investigations. The OIG seeks to prevent and detect fraud, waste, and abuse, and make meaningful recommendations to drive economy, efficiency, and effectiveness throughout VA programs and operations. Our goal is to undertake impactful work that will assist VA in providing the appropriate and timely services and benefits that veterans so deservedly earned, and ensuring the proper expenditure of taxpayer funds. I am accompanied by John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections.

I have had the great privilege of serving as the Inspector General since May 2, 2016. Since that time, I have fully immersed myself in the work, priorities, and policies of the OIG. We have made a number of enhancements since I started, including issuing a Mission, Vision, and Values statement; increasing transparency; creating a Rapid Response team in our Healthcare Inspections directorate; expanding our data analytics capabilities; and being more proactive in our review areas. I believe that these changes, as well as other enhancements we will make, will enable us to do additional impactful work in a more timely manner.

The OIG shares an analogous mission with the Government Accountability Office (GAO). It is important that the VA OIG has a strong relationship with GAO to en-

sure that we avoid duplication of effort as much as possible. To that end, one of the first things I did when I started was to meet with Comptroller General Dodaro and some of his senior staff. Our offices have communicated regularly since that time to promote coordination and more effective oversight of VA.

In February 2015, GAO added Managing Risks and Improving VA Health Care to its biannual High Risk list. It focused its concerns in five broad areas:

- Ambiguous policies and inconsistent processes,
- Inadequate oversight and accountability,
- Information technology challenges,
- Inadequate training for VA staff, and
- Unclear resource needs and allocation priorities.

While our work is determined by what we believe is the most effective oversight of VA, a number of our reports address concerns in these same five areas. I will highlight a sampling of OIG work in each of the areas that resulted in GAO placing VA Health Care on its High Risk list. However, it should be noted that many of the OIG's reports could fit in more than one area.

AMBIGUOUS POLICIES AND INCONSISTENT PROCESSES

We have issued a number of reports in the past few years that include VA's ambiguous policies and inconsistent processes. Our recent report [1] on wait time in one specific Veteran Integrated Service Network (VISN), we assessed the reliability of wait time data and timely access within VISN 6 which includes VHA facilities in North Carolina and Virginia. The objective of the audit was to determine whether VISN 6 facilities provided new patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 facilities appropriately managed consults. We reported that veterans who were authorized Choice care in VISN 6 did not consistently receive the authorized health care within 30 days as required by Health Net's contract with VA.

We reviewed a statistical sample of 389 Choice authorizations provided to Health Net by VISN 6 medical facility staff during the first quarter of Fiscal Year (FY) 2016. Based on our sample results, we estimated that for the approximately 34,200 veterans who were authorized Choice care in VISN 6, approximately 22,500 veterans who received Choice care waited an average of 84 days to get their care through Health Net providers. We estimated it took VA medical facility staff an average of 42 days to provide the authorization to Health Net to begin the Choice process and an additional 42 days for veterans to receive the medical service through Health Net providers. We identified delays related to authorizations for primary care, mental health care, and specialty care. VHA's Chief Business Officer addressed a potential cause for delay in creating appointments by executing a contract modification effective November 1, 2015. This change allowed Health Net to initiate phone contact with a veteran to arrange a Choice appointment, rather than require the veteran to contact Health Net as previous required. Our analysis showed that, while still untimely, this change lowered the percentage of veterans who waited more than 5 days for Health Net to create an appointment from 86 percent to 69 percent.

The Under Secretary for Health concurred with our 10 recommendations and provided a responsive action plan and milestones to address the recommendations regarding monitoring controls over scheduling requirements, wait time data, and access to health care and consult management. Our recommendations will help ensure staff use clinically indicated and preferred appointment dates consistently, medical facilities conduct required scheduler audits, and staffing resources are adequate to ensure timely access to health care. The report's recommendations remain open.

Another example, in September 2015, we reported in *Review of Alleged Mismanagement at the Health Eligibility Center* that VA's Chief Business Office (CBO) had not effectively managed its business processes to ensure the consistent creation and maintenance of essential health care eligibility data. Due to the amount and age of the Enrollment System (ES) data, as well as lead times required to develop and implement software solutions, a multiyear project management plan was needed to address the accuracy of pending ES records and improve the usefulness of ES data. We offered 13 recommendations in the report including one focused on controls to ensure that future enrollment data are accurate and reliable before being entered into the Enrollment System. VA concurred with the recommendations and provided sufficient information to close all recommendations in October 2016. We have an ongoing review of the Health Eligibility Center focusing on the alleged lack of effective

[1] *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, March 2, 2017

governance over the Veterans Health Administration's (VHA) execution of the health care enrollment program at its medical facilities. We expect to issue our report in late spring 2017.

Another program that operates nationwide also had issues related to inconsistent implementation of policies is the Homeless Grant Per Diem Program. In a June 2015 report, *Audit of Homeless Providers Grant and Per Diem Case Management Oversight*, we determined VA needed to clarify eligibility requirements across the program to ensure that all homeless veterans have equal access to case management services. Historically, homeless veterans ineligible for VA health care have not been excluded from the program. However, we questioned the application of the program's eligibility criteria, and found the criteria were unclear and inconsistently applied. This was confirmed in our interviews of VA's Office of General Counsel, program directors, network homeless coordinators, and liaisons, which revealed confusion occurred at all program levels. We made five recommendations, three of which involved establishing a definitive legal standard on program eligibility and ensuring that policies and controls matched that standard and were applied across the program. The recommendations dealing with policies and controls remain open.

INADEQUATE OVERSIGHT AND ACCOUNTABILITY

Proper oversight by management ensures that programs and operations would work effectively and efficiently. Our September 2016 report, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System*, on the management of the construction of a new VA medical center in the Denver area, is an extremely costly example of the result of inadequate oversight. We confirmed the project to build a new medical center in the Denver area has experienced significant and unnecessary cost overruns and schedule slippages. Originally estimated for 2013 completion, it will not be ready before mid-to-late 2018, about 20 years after its need was identified.

Through all phases of the project, we identified various factors that significantly contributed to delays and rising costs, including:

- Inadequate planning and design,
- Initiation of the construction phase without adequate design plans,
- Changing the acquisition strategy mid-stream, and
- Untimely change request processing.

This occurred due to a series of questionable business decisions and mismanagement by VA senior officials. The report summarizes the significant management decisions and factors that resulted in a project years behind schedule and costing more than twice the initial budget of $800 million. We made five recommendations and VA management concurred with all recommendations. We recently requested information from VA on the implementation status of the recommendations and will keep them open until VA provides satisfactory evidence of implementation.

In June 2016, we issued a report on allegations related to appointment cancellations at the Houston VA Medical Center, titled *Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas*. We substantiated that two previous scheduling supervisors and a current director of two outpatient clinics instructed staff to input clinic cancellations incorrectly as canceled by the patient. We also confirmed that a current director of two CBOCs instructed staff, as recently as February 2016, to record an appointment as canceled by the patient if clinic staff at one CBOC offered to reschedule a veteran's appointment at a different CBOC situated about 17 miles away and the veteran declined the appointment. The CBOC Director noted this was appropriate since the CBOC was still offering the patient an appointment. However, when interviewed regarding these cancellations, the CBOC Director acknowledged she instructed staff to cancel appointments by the patient if the veteran declined an appointment in the alternate location. We made six recommendations, including referring the matter to VA's Office of Accountability Review (OAR), to determine what, if any, administrative actions should be taken based on the factual circumstances developed in our report.

In December 2014, we released an audit related to VA's National Call Center for homeless veterans, titled *Audit of The National Call Center for Homeless Veterans*. We reported that homeless and at-risk veterans who contacted the Call Center often experienced problems accessing a counselor and/or receiving a referral after completing the Call Center's intake process. We reported:

- Veterans could leave a message on an answering machine only 27 percent of the time period reviewed,
- Veteran messages were not referred to VA medical facilities due to inaudible messages or no contact information in 16 percent of the time period reviewed,

• Veterans were not referred to VA medical facilities despite providing all the necessary information in 4 percent of the time period we reviewed.

Moreover, the Call Center closed approximately 47 percent of referrals even though the VA medical facilities had not provided the Homeless veterans any support services. These missed opportunities occurred due to lapses in the Call Center's management and oversight. We made seven recommendations, including implementing effective performance metrics to ensure homeless veterans receive needed services. We closed our report in September 2015 based on information received that all recommendations had been implemented.

INFORMATION TECHNOLOGY CHALLENGES

As we reported in our list of VA's Major Management Challenges within VA's Annual Financial Report, we have frequently identified VA's struggles to design, procure, and/or implement functional information technology (IT) systems. IT security is continually reported as a material weakness in the Consolidated Financial Statement audits that are conducted annually by the OIG's independent auditing firm, CliftonLarsonAllen (CLA).

VA has a high number of legacy systems needing replacement including the Financial Management System; Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system; Veterans Health Information Systems and Technology Architecture, and the Benefits Delivery Network; After years of effort focused on replacement of VA's legacy scheduling software, a new scheduling system is still not in place. VA's issues with scheduling appointments are related to the inability to define its requirements and determine if a commercial solution is available or if it must design a system. Replacing systems has been a major challenge across the government and is not unique to VA. We have issued a number of reports outlining access issues and our work in this area is continuing.

While the difficulties between VA's electronic health record (EHR) and the Department of Defense's EHR are well documented, the increased utilization of care in the community will present further IT challenges. To ensure that medical providers both inside and outside VA have the most complete and up-to-date information, VA needs to find a more effective method for sharing patients' EHRs. We reported on the possibility of delays in care because of the difficulties in sharing medical records in the Urology Clinic at the Phoenix VA Health Care System in our October 2015 report, titled *Healthcare Inspection, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona*. Specifically, we identified approved authorizations for non-VA care coordination (NVCC) urological care and a notation that an authorization was sent to the non-VA provider. A scheduled date and time of an appointment with the non-VA urologist was often documented. However, we were unable to locate scanned documents from non-VA providers in these patients' EHRs verifying that the patients had been seen for evaluations, and if seen, what the evaluations might have revealed. This finding suggested that the Phoenix VA Health Care System (PVAHCS) did not have accurate data on the clinical status of the patients who were referred for the specialty care.

Further, with respect to scanning and reviewing outside clinical documents (for example, clinic notes, labs, or imaging results), when the services were provided by TriWest Health Care Alliance (TriWest), the treating providers' office submitted this data to the TriWest Portal. To access that information, an NVCC staff member was required to log into the TriWest Portal to print and scan these records into the patients EHRs. This process was delayed because of the NVCC staffing shortages, which could have resulted in important clinical information not being reviewed for several months. We made three recommendations, including one specifically related to ensuring that non-VA care providers' clinical documentation is available in the EHRs in a timely manner for PVAHCS providers to review. We closed our report in June 2016 after VA provided information that addressed the recommendations.

In the area of IT security, VA uses personally identifiable information (PII), protected health information (PHI), and other sensitive information to deliver benefits to veterans and their dependents. Employees and contractors must safeguard this information. As we reported in our September 2015 report, *Review of Alleged Data Sharing Violations at VA's Palo Alto Health Care System*, the VA Palo Alto Health Care System (VAPAHCS) did not ensure that contract staff had the appropriate background investigations or proper security and privacy awareness training before being granted access to VA patient information. Additionally, facility Information Security Officers were not involved prior to the contractor placing its software on a VA server. We made three recommendations to VAPAHCS management and a fourth recommendation that VA's Office of Information Technology implement controls to ensure that unauthorized software is not procured or installed on VA net-

works without a formal risk assessment and approval to operate. We closed our report based on information provided that the recommendations were implemented.

INADEQUATE TRAINING FOR VA STAFF

One prevailing theme of the OIG's work related to wait times and scheduling issues was the inadequate, lack of, or incorrect training provided to VA staff responsible for scheduling appointments. We conducted extensive work related to allegations of wait time manipulation through FY 2015 and FY 2016 after the allegations at the PVAHCS surfaced in April 2014. As we have reported in more than 90 Administrative Summaries of Investigation and other reports that have been issued, the lack of training for schedulers and the lack of understanding of the process by their managers created a system in which long wait times were not accurately portrayed to management.

In October 2016, we reported again that some confusion persists regarding appointments. The focus for this report was on consult management. In our report, *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, we substantiated that in 2015, PVAHCS staff inappropriately discontinued consults. We determined that staff inappropriately discontinued 24 percent of specialty care consults we reviewed. This occurred because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result, patients did not receive the requested care or they encountered delays in care. This report offered 14 recommendations including ensuring that staff are hired and trained appropriately. We are tracking VA's progress on implementing all the recommendations.

In January 2016, we determined that VHA did not provide medical facilities with adequate tools to reasonably estimate non-VA care (NVC) obligations in our report, *Audit of Non-VA Medical Care Obligations*. The facilities we visited used a combination of methods that were ineffective at ensuring NVC cost estimates were reasonable. The methods used to calculate estimated costs included Medicare or contract rates, historical costs, and the optional cost estimation tools provided by CBO. The accuracy of estimates varied widely among these methodologies. We made five recommendations including for VA to improve the cost estimate tools so that NVC cost estimates are produced consistently. The recommendations related to cost estimate tools remain open.

UNCLEAR RESOURCE NEEDS AND ALLOCATIONS PRIORITIES

In March 2017, we published *Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, MT*. We assessed the extent that patients experienced delays in obtaining consults, and the impact of any delays on patient outcomes. We reported that, for system consults ordered through VA Montana Healthcare System in FY 2015, there were apparent delays [2] for:

- 11,073 of 26,293 patients (42 percent) with at least one in-house consult;
- 11,863 of 21,221 patients (56 percent) with at least one non-VA care consult; and
- 2,683 of 4,427 patients (61 percent) with at least one Choice consult.

We found that delays among consults ordered in FY 2015 may have harmed four patients. Beginning in July 2015, system leadership initiated a focused effort to identify and resolve factors that contributed to consult delays, including hiring additional support staff to process consults. Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). We also noted that system leadership initiated ongoing reviews to determine if patient harm occurred due to delays in care.

We made two recommendations to the VA Montana Director to ensure that an external (non-system) source review the care of patients we identified who were potentially harmed by consult delays and that VA staff provide institutional disclosures, as appropriate. We also made a recommendation regarding ongoing efforts to improve consult timeliness. The VA Montana Director and the VISN 19 Director concurred with our three recommendations and provided a responsive action plan and milestones to address the recommendations.

The OIG has repeatedly reported on VA's legacy systems and how they impair VA operations. A key element to accurate planning is a financial system that provides timely information to VA leadership. As was reported in *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015*, VA's complex, disjointed, and legacy financial management system architecture continues to deteriorate over time and no

[2] We considered delayed consults to be those that were not completed, canceled or discontinued within the expected timeframe.

longer meets the increasingly stringent and demanding financial management and reporting requirements mandated by the Department of the Treasury and the Office of Management Budget. VA continues to be challenged in its efforts to apply consistent and proactive enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems. VA announced in October 2016 that it selected the Department of Agriculture as its Federal shared service provider to deliver a modern financial management solution to replace its existing core financial management system. When completed, this will be a major and critical effort for VA in modernizing its system architecture for financial management.

The audit of VA's FY 2016 Consolidated Financial Statements also identified Community Care obligations, reconciliations, and accrued expenses as a material weakness. Lack of tools to estimate non-VA Care costs, lack of controls to ensure timely deobligations, and the difficulty in reconciling non-VA Care authorizations to obligations in VA's Financial Management System, make the accurate and timely management of purchased care funds challenging. In addition, the Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities were not integrated with VA and VHA Chief Financial Officer (CFO) responsibilities under Public Law (P.L.) 101–576, the Chief Financial Officers Act of 1990, to develop and maintain integrated accounting and financial management systems and provide policy guidance and oversight of all Community Care financial management personnel, activities, and operations.

To address the difficulties in estimating costs, VA requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone—i.e., obligating funds at the time of payment—would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls to monitor accounting, reconciliation, and management information processes to ensure they effectively manage funds appropriated by Congress.

VA needs to accurately forecast the demand for health care services in both the near term and the long term. The OIG is required by Section 301 of Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014, to review VHA occupations with the largest staffing shortages. We have issued three reports at this time and under the statute we will report for another two years. In our most recent report issued in September 2016,[3] we identified (i) medical officer; (ii) nurse; (iii) psychologist; (iv) physician assistant; and (v) physical therapist/medical technician as five critical occupations with the largest staffing shortages. In our initial review[4] and our subsequent reviews,[5] we continue to recommend VHA create a staffing model that considers demand and complexity, and matches that to budget requests and allocations. While VHA has continually concurred with the recommendation, their planned completion date is September 2017. Further delay will potentially result in missed opportunities to request appropriate funding when planning for the FY 2019 budget.

CONCLUSION

The OIG is committed to providing effective oversight of the programs and operations of VA. A number of our reports address the five broad areas noted by GAO in placing VA Health Care on its High Risk list. We will continue to produce reports that provide VA, Congress, and the public with recommendations that we believe will help VA operate its programs and services in a manner that will effectively and timely deliver services and benefits to veterans and spend taxpayer money appropriately.

Mr. Chairman, this concludes my statement and we would be happy to answer any questions that you or other Members of the Committee may have.

Senator TILLIS. Thank you, Mr. Missal.

Dr. Clancy.

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[3] https://www.va.gov/oig/pubs/VAOIG–16–00351–453.pdf, September 28, 2016

[4] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, January 30, 2015

[5] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, September 1, 2015

STATEMENT OF CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH AND ORGANIZATIONAL EXCELLENCE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JENNIFER LEE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES; AND AMY PARKER, EXECUTIVE DIRECTOR OF OPERATIONS, OFFICE OF MANAGEMENT

Dr. CLANCY. Good afternoon, Senator Tillis, Members of the Committee. Thank you for the opportunity to discuss VA's efforts to improve the issues identified by the GAO when they placed VA health care on the High-Risk List in 2015. As you noted, I am accompanied by Dr. Jennifer Lee and Amy Parker.

In its High-Risk List update, GAO identified managing risks and improving VA health care as a high-risk area and noted five associated issues, which we have detailed in our written statement, and Debra Draper just reiterated.

On March 3, 2017, Secretary Shulkin met with Comptroller General Dodaro to convey VA leadership's commitment to accelerating the changes required to meet all of GAO's criteria for removal from the High-Risk List. Secretary Shulkin acknowledged the significant scope of the work that remains and committed to better integrate its high risk-related actions with the President's priorities and ongoing VA transformation efforts.

We immediately began working with GAO to follow through on Secretary Shulkin's commitments and to ensure continued VA collaboration with our GAO colleagues. We take GAO's work and the Inspector General's very seriously and appreciate the advice and feedback we have received from them. We are pleased to have the opportunity to report on our progress to date and our plan to ultimately be removed from the list.

Addressing these risks will provide a sustainable foundation for continued transformation of the Veterans Health Administration. We have made progress since being placed on the High-Risk List. Two years ago, VHA had over 800 policies and over half of these had expired. On average, it took about 340 days to produce national policy, and VHA lacked a consistent process for their development. Since that time, we have established a workgroup of all outcome executives, meeting every 2 weeks, tracking all policies and development, examining every step of the process, addressing barriers, and piloted and established a new lean process that would be completed within 120 days.

There are now approximately 650 active policies. New policies are created and reviewed promptly, and essential policies on access, scheduling, and consultations have been completed, published, and widely disseminated. We have committed to completing GAO's recommendations to ensure medical facility controlled substance inspection programs meet our requirements by October of this year.

VHA also instituted a significant organizational transformation that aligned key offices, including offices of compliance and business integrity, medical audit, a new internal audit function, the management review service, and ethics, under a single combined Office of Integrity, led by a new leader, Assistant Deputy Under Secretary for Health, Dr. Gerard Cox, who reports to me.

The newly established Office of Internal Audit and Risk Assessment uses reports from VA's Office of Inspector General, GAO, and the Office of Special Counsel to conduct further assessments into potential weaknesses in VA health care programs or care quality.

During the past 2 years, in partnership with GAO, we conducted a comprehensive inventory of open recommendations and instituted a regular process for adjudicating closure based on documentation of completed actions, and linked them quite specifically to the risk areas identified by the GAO. Now, more than 45 percent of open recommendations were made, just in a year or less, and we have requested closure on 18 percent of the open recommendations.

We have learned that integrating with or updating our veterans health information systems and technology architecture, known as VistA, is difficult and costly. We must be able to consistently access veteran information to succeed. We certified our interoperability with the Department of Defense on April 8, 2016. Today the Joint Legacy Viewer is available to all clinicians in every one of our facilities across the country, and we are also actively onboarding private sector partners into our health information exchange, because that is absolutely imperative for community care to work well.

Mr. Chairman, transformation is a marathon, not a sprint. It takes several years to turn any organization around and we are acutely aware that most of the candidates on GAO's High-Risk List have taken multiple years to meet that requirement. Secretary Shulkin is absolutely dedicated that we do this as rapidly as possible.

While I am proud of the progress we have made in a short time, I am also acutely aware that we have much more work to do. I am grateful for the subject matter advice and consultation provided by Dr. Draper and her colleagues, and reiterate my commitment to working more closely with them.

We look forward to working with you and Members of this Committee and to better serve our veterans, and to have committed to quarterly briefings to your staff.

Thank you for the opportunity to testify and I look forward to your questions.

[The prepared statement of Dr. Clancy follows:]

PREPARED STATEMENT OF CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) efforts to improve the issues identified by the Government Accountability Office (GAO) that placed VA health care on the 2015 GAO High Risk List. I am accompanied today by Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services, and Amy Parker, Executive Director of Operations, Office of Management.

INTRODUCTION

In its 2015 High Risk List Update, GAO identified "Managing Risks and Improving VA Health Care" as a high-risk area and noted five associated high-risk issues:

- Ambiguous policies and inconsistent processes;
- Inadequate oversight and accountability;
- Information technology (IT) challenges;
- Inadequate training for VA staff; and,
- Unclear resources needs and allocation priorities.

We take GAO's work seriously and appreciate the advice and feedback we have received from our colleagues. We are pleased to have the opportunity to report on our progress to date and our plan to be removed from the list. Addressing these risks will provide a sustainable foundation for continued transformation of the Veterans Health Administration (VHA).

PROGRESS TO DATE BY RISK AREA

Ambiguous Policies

• Two years ago, VHA had over 800 policies, and more than half had expired. On average, it took over 340 days to produce national policy, and VHA lacked a consistent process for policy development. Since that time, we have established a workgroup comprised of all outcome executives that meets every two weeks and tracks all policies in development. We examined every step of the process, addressed barriers, and piloted and established a new, lean process with an aspirational timeline of 120 days. Our new process incorporated review and comments from medical centers and administrative offices—something that had never been formally required in the past, and which addressed many of the gaps identified by GAO. We funded seven full-time contractors to support transformation. We identified and rescinded 112 expired policies and 20 additional policies that were no longer relevant. We completed work updating many policies imperative to addressing then-Under Secretary for Health Dr. David Shulkin's five priorities, and are eliminating handbooks and manuals in an effort to simplify and streamline national policy. There are now approximately 650 active policies, including essential policies on access, scheduling, and consultations that were completed, published, and widely disseminated. We are also beginning to experience the unquantifiable benefits of culture change, as people in VA Central Office and the field become aware of these new processes, and the response has been overwhelmingly positive.

Inadequate Oversight and Accountability

• VHA instituted a significant organizational transformation that aligned several key offices including the Office of Compliance and Business Integrity, the Office of the Medical Inspector, the Office of Internal Audit and Risk Assessment, the Management Review Service, and the National Center for Ethics in Health Care. These offices are led by a newly established Assistant Deputy Under Secretary for Health for Integrity, Dr. Gerard Cox, who reports to the Deputy Under Secretary for Organizational Excellence. VHA also established a new Office of Internal Audit and Risk Assessment that uses reports from VA's Office of Inspector General (OIG), GAO, and the U.S. Office of Special Counsel to conduct further assessments into potential weaknesses in VA health care programs or care quality. The expected outcomes from VHA's integration of oversight and accountability activities are that: 1) VHA program offices, Veterans Integrated Service Networks (VISN), and facilities will possess a common understanding of how their oversight authorities, roles, and responsibilities align, 2) VHA will have a workforce well trained in oversight standards, 3) program offices, VISNs, and facilities will uniformly oversee policy implementation, and 4) VHA will have a culture that incorporates both values and process to solve policy concerns.

• During the past two years VA, in partnership with GAO, conducted a comprehensive inventory of open recommendations and instituted a regular process for adjudicating closure based on documentation of completed actions. This adjudication process resulted in closure of 91 recommendations, and we have requested closure on 18 percent of open recommendations. We have systematically cleared out the backlog of old recommendations so that currently over 45 percent of our open recommendations were made during the past 12 months. An additional 30 percent of open recommendations are between 1- and 3-years old.

INFORMATION TECHNOLOGY CHALLENGES

• VA has learned that integrating with or updating the Veterans Health Information Systems and Technology Architecture (VistA) is difficult and costly. VistA Evolution is a joint VHA and Office of Information and Technology project intended to improve the efficiency and quality of Veterans' health care by modernizing VA's health information systems, increase data interoperability with the Department of Defense (DOD) and network care partners, and reduce the time it takes to deploy new health information management capabilities. VistA Evolution funds have enabled critical investments in systems and infrastructure; supported interoperability, networking and infrastructure sustainment; continuation of legacy systems; and other efforts that are critical to maintenance and deployment. These investments will deliver value for Veterans and VA providers regardless of whether our path for-

ward is to continue with VistA, shift to a commercial Electronic Health Record (EHR) as DOD is doing, or some combination of both.

• Access to accurate Veteran information is one of our core responsibilities, and today the Joint Legacy Viewer (JLV) is available to all clinicians in every VA facility in the country. VA certified VA/DOD interoperability on April 8, 2016, in accordance with section 713(b)(1) of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113–66). However, JLV is a read-only application. Leveraging this JLV interoperability infrastructure, the Enterprise Health Management Platform (eHMP) will ultimately replace JLV. eHMP is a cornerstone of the VistA Evolution Program, building on the capability for clinically actionable, patient-centric data pioneered by JLV. eHMP will fill clinical gaps in VA's current tools, bridge the EHR modernization effort, and simplify VHA's overall clinical user experience. Upon completion, eHMP will offer robust support for Veteran-centric health care, team-based health care, and quality driven health care while improving access based on clinical need.

Inadequate Training for VA Staff

• Training is vital to maintain a competent workforce and ensure that Veterans consistently receive timely, safe, high quality care. Training also requires a substantial investment of time and resources. From March to June 2016, then-Under Secretary for Health Dr. Shulkin directed a temporary moratorium on all Talent Management System (TMS) assignments not assigned by law or Executive Order. A detailed listing of previous training requirements was built to review all assignments, and comprehensive recommendations from across the organization were collected on existing training assignments. The VHA training policy was revised based on the results of this training review and is currently under evaluation.

• As a result, all 32,326 VHA employee TMS assignments were reviewed, and more than 700,000 hours of training were targeted for potential removal along with possible savings of over $38.7 million in hourly equivalent staff salary. To continue this improvement, VHA's new Mandatory Training Policy will be implemented this year in a phased rollout, with additional steps for review of content and comment from field-based experts.

Unclear Resource Needs and Allocation Priorities

• Key accomplishments for connecting strategy, requirements, programming, budgeting, and execution (since June 2015) include:

• Completion of the Quadrennial Strategic Planning Process (QSPP)—Strategic Options and Alternative of Analysis Phases. Outputs from the QSPP informed our planning guidance.

• Selection of the U.S. Department of Agriculture as a Federal Shared Service Provider to support the migration of a new financial management system (FMS). VA established a Financial Management Business Transformation program office and an Executive Steering Committee to manage the multi-year effort to improve VA's financial management accuracy and transparency.

• Issuance of FY 2019–2023 Programming Guidance as the disciplined framework to develop, assess, and prioritize multi-year requirements. VA successfully implemented two Managing for Results Programming cycles, which enhanced the connection of requirements and resources to support more defensible budget justifications. This included conducting Program Review Boards with senior leadership to assess gaps, impacts, and mitigations in advance of budget formulation.

• Publication of the FY 2018–2022 Programming Decision Memorandum (PDM) to capture decisions from the Program Review Boards and inform budget formulation guidance. The PDM included senior leadership decisions for resource prioritization and enterprise-wide mitigations to garner efficiencies and optimize strategic outcomes.

• Publication of a VA Cost Estimating Guide as a new financial policy outlining procedures for developing lifecycle estimates for programs that meet requirement thresholds.

PATH FORWARD

On March 3, 2017, Secretary Shulkin met with Comptroller General Gene Dodaro to convey VA leadership's commitment to accelerating the changes required to meet all of GAO's criteria for removal from the High-Risk List. Secretary Shulkin acknowledged the significant scope of the work that remains and committed to better integrate its high-risk related actions with the President's priorities and ongoing performance improvement initiatives.

VA immediately began working with GAO to follow through on Secretary Shulkin's commitments to Comptroller General Dodaro and to ensure continued VA collaboration with our GAO colleagues.

As we did in 2016, we will continue to place priority on implementing GAO's and VA OIG's recommendations using our new adjudication process. We have committed to completing GAO's recommendations to ensure medical facility controlled substance inspection programs meet VA requirements by October 2017. VHA's new office of Internal Audit and Risk Assessment will lead this work and will harmonize the policy, its implementation, training, and internal controls for required corrective actions to ensure consistent enterprise-wide management of controlled substances.

We will buildupon our accomplishments for same-day access for Veterans with urgent problems in primary care or mental health, develop and disseminate a policy that builds on current guidance to the field, further improve our oversight of access to ensure all VA medical facilities consistently prioritize the needs of Veterans with urgent problems today, and transition to rely on Veterans' reports in how we display information to the public on wait times.

VA will work with GAO and Congress to redesign the Veterans Choice Program so it works for Veterans and community providers, improve oversight of VA community care to ensure Veterans receive the care they deserve, and ensure our community partners are paid in a timely fashion.

VA needs Congressional action to extend the current Choice Program beyond August 7, 2017. VA also needs new legislation to: (1) provide standardized, clear eligibility criteria for Veterans to get care closer to home; (2) facilitate building a high-performing network of community care providers, which includes our DOD, other Federal, and academic affiliate partners as the foundation and reimburses for care using contemporary payment models; and (3) better coordinate benefits for Veterans, allowing VA to work directly with third-party insurers. We look to Congress and our stakeholders to help enact these changes for Veterans within six months so that once all the Choice funds are depleted, there will be a plan in place for Veterans to continue receiving uninterrupted community care.

As described above, VA's patient scheduling and EHR system requires significant improvement, and VA will take steps this year to address these needs. In addition, VA will improve oversight of the systems, to include establishing outcome-oriented metrics. VA's relationship with DOD and our community providers is complex and evolving. We will work closely with DOD to improve interoperability of VA and DOD record systems, and with our community providers to ensure continuity of care for Veterans. VA will implement a process to develop, document, implement, and oversee organizational structure recommendations to ensure approved recommendations are implemented, outcomes are measured, and plans are adjusted as necessary.

VA is a complex "system of systems," and this is reflected in the root cause analysis work we have accomplished thus far. We will complete this analysis in 2017, integrating the health care high-risk area actions with the President's priorities, the Secretary's 10-Point Plan, and with VA's ongoing performance improvement initiatives. We will use the results of the analysis to fine tune and speed up VA's progress in managing its health care high-risks.

VA efforts will buildupon each other across a period of years to develop a sustainable solution to each high-risk issue, as well as to put in place systems that dramatically reduce the chance that high-risk issues will reemerge.

CONCLUSION

Mr. Chairman, transformation is a marathon, not a sprint. It takes several years to turn any organization around, and VA is no exception. While I am proud of the transformation VA has undergone in response to being placed on the High-Risk List, and the progress we have made, I am also acutely aware we have much more work to do to meet all five of GAO's criteria for removal. I am grateful for the subject matter expert advice and consultation provided by Dr. Debra Draper and the GAO medical team; it has proved invaluable in helping VA achieve the progress we've made since 2015. We look forward to working with Congress and GAO to better serve our Veterans. Thank you for the opportunity to testify before the Committee. I look forward to your questions.

Senator TILLIS. Thank you, Dr. Clancy.

Are any of the other witnesses present intending to offer an opening statement? Here to answer questions?

[No audible response.]

Senator TILLIS. OK. Thank you.

Mr. Missal, I want to start with you. I want to get into some of your specific observations, and, Dr. Draper, this may relate to your lanes as well.

When we do these evaluations, do we do it purely from the perspective of the regulatory, statutory construct as it exists today? Is there ever a focus on the possible root cause of some of the problems that need to be addressed being exacerbated by current rules or regulations, or do you accept that as the norm?

Mr. MISSAL. No, we do not accept that as the norm. When we go into a project and we publish a report, I would like the reports to answer at least four questions. One, why we are doing this—and that may get to your question: is it a regulatory issue; is there something to put it in perspective? Two, what happened? Again, we should be accurate and fair as to what happened. Third, why something happened, and that really gets to the root cause of the problem. If a report is going to be a learning experience, helping VA improve, we really have to be pretty descriptive on why something happened. Then, fourth, who was responsible, so that if somebody did not perform as expected, that they could be held accountable.

Senator TILLIS. Thank you for that.

Dr. Clancy, I think you know that the Ranking Member and I worked together for the last couple of years, with Secretary McDonald, to take a look at the transformation effort, the breakthrough priorities, and getting updated on activities and actions there. I think that there is some progress to be made.

One question that I have, with the transition now of Dr. Shulkin to the role of Secretary, are any of those priorities changing? Are there any efforts being made to try to accelerate? Are we still on the same path, and can you give us some update on where either those breakthrough policies or specific remediation measures in reaction to the Inspector General's report are actually—are we making progress? In other words, where are we making traction?

Dr. CLANCY. We have made a great deal of traction to the transformation known as MyVA, in terms of the fact that all of our facilities achieved same-day access. These are the major medical centers for urgent problems and primary care and mental health at the end of calendar year 2016.

Senator TILLIS. How are we measuring that? I mean, how are we measuring things so that I can go back and get a review of the 100 or so recommendations, I think a quarter of which are 3 years old.

You referred in your opening comment to lean process. I like that, because I have done lean process design in the private sector. All those efforts are driven by metrics—current State metrics, future metrics, any of the metrics you are making positive progress along the way.

Are there specific things that you can speak to or submit for the Committee's purposes to look at quantitative, measurable changes that are in place, addressing the problems that are in the report?

Dr. CLANCY. We have a great deal of information on quantifiable improvements in access, both in terms of wait times and veterans' experience. There are reports of how often can they get care when they needed it right away, and so forth, and also plans in terms of future audits, because right at the end of calendar year 2016 is when we achieved that addition of same-day access.

Many of the priorities in the MyVA transformation are continuing. I expect, as Dr. Shulkin's team comes together, that some may just simply move to become organizational efforts and not at that very high priority level, because they are underway. You would expect that in any transformation. I would imagine that has been part of your background prior to joining the U.S. Senate as well, but certainly we would be happy to take that for the record for a more complete picture.

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

Senator TILLIS. Thank you. Mr. Missal, I also appreciate the work that was done, looking specifically at VISN 6. That is a little bit closer to home, since that covers my geography. But, has there been any work done, in terms of even rethinking—in my estimation, a lot of the problems that exist with VA as a whole is how we are organized and the duplicative technology processes that we see out there, inconsistent experiences from VISN to VISN, and actually even within a VISN.

Are there other things that we can do to really put the pressure on, and prioritizing in the right order? One of the concerns that I have with the number of recommendations for improvement, it is a target-rich environment for change. That is the good news. The bad news is if you are shooting at every target at the same time you are not going to hit any one of them.

What is your view of the remedial measures that have gone into place, and whether or not the department is organizing properly to address the problems, and ultimately, over some period of time, get off the High-Risk List?

Mr. MISSAL. We have looked at access to care in a number of different ways. Before the VISN 6 report, we had been looking at it facility by facility and it was hard to really get a sense of whether there are any themes, or is there a wider-spread problem other than at a particular facility. We obviously found significant problems at VISN 6. We are looking at another VISN, again, just to compare to see if it is a leadership issue at the VISN. Is it higher? Is it lower than that?

We try to make recommendations that are meaningful, that hopefully you do not see the same mistake happen again. We are going to continue to do that, and we are also going to be looking at the whole governance structure as well, because I agree, that could be an issue that could help a lot by addressing it.

Senator TILLIS. It just speaks to some of the impediments that are a part of the root cause of the problem.

Ranking Member Tester.

Senator TESTER. Thank you, Mr. Chairman. Mr. Missal, I appreciate your work at Fort Harrison. Since you have been confirmed I think you have done some very good work and I want to thank you for that.

Dr. Clancy, I spoke with Secretary Shulkin about this already and I need to make it clear. The findings in the report, as I said in my opening statement, unacceptable. Debra, as you may remember, the GAO issued a report in September 2014 on consult management. You made six recommendations that are all still open, per your website. In one, the VHA promised to complete the first round

of VAMC consult audits by September 2016. Debra, was that completed?

Ms. DRAPER. They have started the audit process. They provided us documentation in August, but we felt like the information provided was not complete. They did not provide all the documentation that we needed to assess the recommendations for closure, so we sent it back to them. Just recently they provided additional documentation; we are currently looking at what they provided so that we can assess whether the recommendation should be closed.

But, in the information they provided to us, 75 percent of the VAMCs had done at least one audit—one consult. So, there is work to be done.

Senator TESTER. Was Fort Harrison included in any of those results?

Ms. DRAPER. They did not provide us detail. It was 75 percent of the VA medical centers. I think this is being done, spearheaded, through Dr. Clancy's office. She may be able to tell you that.

Senator TESTER. Go ahead, Dr. Clancy.

Dr. CLANCY. Sure. I spoke with leadership from the facility and the network yesterday, and they have made substantial progress, about which I would be happy to provide specific details. What I heard that was more important was: in addition to the fact that they have already contacted three of the four veterans—the fourth they are having some difficulty reaching but will continue——

Senator TESTER. Right.

Dr. CLANCY [continuing]. And had disclosed to them and their families what had happened, that they have not only made progress but are looking upstream now at how did we get here. Right? How might we use electronic consults to specialists, noting a shortage of some specialists across the State, in Montana, not just in VA.

Senator TESTER. Yes, there are.

Dr. CLANCY. And also looking at, are there ways that we might be training primary care clinicians? Are they referring to specialists too often, right, that they might be able to get extra expertise——

Senator TESTER. Got it.

Dr. CLANCY [continuing]. If you have got a scarce resource.

I do not hear that very often. You are aware that the entire leadership team has turned over there.

Senator TESTER. I am.

Dr. CLANCY. It was a very different tone then when I have spoken to leadership at that facility before. We will certainly keep you updated, as I know it is very high on Dr. Shulkin's screen.

Senator TESTER. That is good, and I do think we have upgraded the leadership team in a big, big way—you guys have, I should say, at Fort Harrison.

Another VHA started calls to share best practices with respect to consults. Dr. Clancy, was Fort Harrison—did they participate in those calls too?

Dr. CLANCY. I would have to double-check to be concrete about that, and I will take it for the record. Thanks.

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

Senator TESTER. OK. All right.

Mike, your report on Fort Harrison indicated that steps had been taken to improve consult timeliness. Are you confident that these steps are sufficient?

Mr. MISSAL. You know, we have got recommendations. They have an opportunity to prove to us that the steps that they have agreed to take will be implemented. We look at all recommendations very closely, and if we believe additional work needs to be done we will do so.

Senator TESTER. OK. All right. OK, that is fine.

The High-Risk Report describes deficiencies in the action plan VHA submitted to address the high-risk status. Debra, can you articulate the impact these deficiencies are having on patient care within the VA?

Ms. DRAPER. Yes. Well, basically, our high-risk work is a culmination of our work since 2010, so it reflects work in areas like access, which includes wait time and scheduling, the Choice Program, quality. So, in some of our work we have found that delays in care have put patients at risk, or veterans at risk for bad outcomes. I mean, I think there is sufficient evidence to suggest that when care is delayed or care is not received at all, for certain conditions, that the conditions worsen and then it becomes much more complex and costly to then treat that particular condition.

I can give you a couple of examples in our mental health access report that we did in 2016. We found that for some veterans, when their mental health care was delayed, they decompensated and then their conditions became urgent and they then required urgent care, which sometimes resulted in hospitalization. We had other cases; for example, in the reprocessing of reusable medical equipment, if not cleaned properly or sterilized, it exposed many veterans to infectious diseases such as hepatitis.

We have numerous examples, from the five areas that we have identified as the areas of concern in our high risk report, that are the underlying underpinnings that really, if not addressed sufficiently, raise the risk of harm for veterans.

Senator TESTER. Thank you, Mr. Chairman.

Senator TILLIS. Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman. Mr. Missal, I would just like to start by asking a question about the hospital in Aurora, CO. It originally was set up with $600 and $700 million, as an estimate. Last time we checked, the estimated overrun was $1 billion. That has been more than a year ago. In your most recent review, is it still about $1 billion overrun or have we increased it since then?

Mr. MISSAL. We have not done any additional work. There is going to be an additional cost once the facility is done to essentially move into the facility, so that amount has to be on top of the building costs as well.

Senator ROUNDS. So, how much, in addition to the $1 billion overrun, are you estimating at this time, or are you anticipating, and how will they come up with the resources to pick up that cost?

Mr. MISSAL. I think it is going to be another—it was in our report, and my recollection it was somewhere around another $315 million, but these are not construction funds.

Senator ROUNDS. Did you look at—on another matter, have you looked at the Choice Program and the operation of the Choice Program?

Mr. MISSAL. Yes. We have done a number of reports on Choice.

Senator ROUNDS. When you did the review of Choice, did you look at the cost analysis of the administrative costs of Choice versus non-Choice activity?

Mr. MISSAL. We did not examine it that closely. We looked at, certainly, the administrative burdens of Choice and whether or not it operated as a barrier for veterans, but we did not actually look at the cost of each.

Senator ROUNDS. It seemed that—and the reason why I bring it up, it seems as though there may be a duplication of activity there, and I did not know whether or not you had found that or had addressed it at all. My understanding is that there is a third party which had been hired to actually do the administration of the Choice to begin with, in terms of the appointments, and then also for the billings on behalf of the physicians, and that same third party is the same organization that—like in our part of the country it is HealthNet, but HealthNet handles not only VA Choice but they also do TRICARE as well.

They seem to work very well within TRICARE but when it comes to working with the VA, my understanding is that they have a substantially higher cost, not because HealthNet charges more but because they are required to work through additional layers. In fact, every single time a veteran goes to a facility or to a physician or to a provider, it is a review and a reauthorization as opposed to a continuation of an existing approval method. Is that correct?

Mr. MISSAL. I believe that is correct. When we looked at Choice, we first looked at the implementation of Choice, which took it from the beginning of the program until September 30, 2015. We found a lot of administrative burdens and that the administration by VA caused significant delays.

We then looked at it again, as part of our VISN 6 report, which went to the end of the calendar year, meaning December 31, 2015. Again, we saw some changes. It got a little better but there are still burdens.

Senator ROUNDS. Just to continue along that same line, my understanding, also, is that although they are perfectly capable of making the review, delivering the requested payments through providers and so forth—we have had delays of up to 9 months for providers—it seems as though HealthNet is not the case where the problem is at. It actually goes into the VA and the VA then farms it back out for a second review, to be put back into their system, thus increasing the cost on a per claim basis by perhaps a tenfold factor. Were you able to look at that at all?

Mr. MISSAL. We understand that they have changed the payments, where now they are doing bulk payments with the two third-party administrators, HealthNet and TriWest. So, they are constantly making changes to try to facilitate the payments.

Senator ROUNDS. Do you know if they are still duplicating the efforts that those two third parties are expected to do?

Mr. MISSAL. I do not know precisely. I know they constantly are looking at it. We have not—we are taking a hard look now at it, but we——

Senator ROUNDS. Could I ask that in your next review you look to see, because it appears to me that Choice, one way or another, is going to continue on, and that we are going to continue to use third parties somewhere along the line. If that is the case, it seems inappropriate to have a duplication of efforts within the VA, simply to get things paid. Number 1, it seems to be a cost that we do not need, and second of all, it most certainly delays the payment to providers, which there is some reason why providers are not getting paid in a timely fashion.

Mr. MISSAL. Right. We have an audit ongoing on the payments. We can add that in.

Senator ROUNDS. OK. Thank you, sir. Thank you, Mr. Chairman.

Senator TILLIS. Senator Murray.

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

Senator MURRAY. Mr. Chairman, thank you very much. Thank you to all of our panelists for being here today.

Let me just say, veterans have really benefited from expanded access to affordable health insurance and the expanded Medicaid, in particular, under ACA. That progress is really in jeopardy as the American Health Care Act would effectively end the Medicaid expansion and eliminate the coverage that is helping so many of our veterans. This is more important now than ever, as the VA continues to struggle with wait times, and as we work to reform the way veterans receive care both in and outside the VA.

Dr. Clancy, I wanted to ask you, what would happen to the workload on VA and veterans' access to care if Congress repeals the Affordable Care Act?

Dr. CLANCY. We will be looking at that very closely, Senator. What I can tell you is that we did a policy analysis that compared States that had expanded Medicaid under the ACA, compared with those that had not, and saw that that increased demand for our services, somewhere between 6 and 18 percent—the broad range just refers to type of services. I believe 18 percent is outpatient care and 6 is inpatient. So, we would expect to see increased demand for our services for those veterans who had benefited——

Senator MURRAY. So, what you are saying is that States that expanded Medicaid, that it is now at threat of being taken away, those families would—how many people would that be that would increase the demand at the VA?

Dr. CLANCY. I would actually have to track it back to get you some good numbers, but could do that. This was an analysis done by some policy researchers working with academic colleagues, because I was wondering about the differential impact.

Senator MURRAY. Mm-hmm. Can you get us any studies you have done on the effects of the ACA on veterans' care or on the VA workload, for the record?

Dr. CLANCY. Mm-hmm.

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

Senator MURRAY. Because I think that would be really important to know.

OK. Dr. Clancy, I did note that at the end of your testimony you state that the VA will address the GAO recommendations in conjunction with implementing the Secretary's 10-point plan and implementing the President's priorities.

I have been watching, because I believe that actions speak louder than words, the President's actions, and I have seen him, at the VA, leave almost every senior position in the department without a permanent official in place. He is refusing to personally meet with major veterans' organizations. He has implemented a hiring freeze that prevents VBA from hiring the staff needed to process veterans' claims. We know he has raised money, allegedly, for veterans' charities and then avoided giving to those groups until questioned. Those actions I am deeply concerned about.

I did listen to him at the Joint Session of Congress a few weeks back, when he said his budget, which is not out yet, would somehow increase funding for veterans.

So, I wanted to ask you, is fixing the VA simply a matter of more money to the VA, regardless of any policy or leadership?

Dr. CLANCY. I think that we need both the necessary resources, the right strategy, and the right leadership. To that end, I think your confirmation of Secretary Shulkin was a really terrific move, because as he said to you at the time of his hearing, he would not have a learning curve. I did not realize just how much he meant that, but, you know, he has been able to move very, very swiftly, in my experience in transitions, which I think is going to be good for veterans.

I think you also heard him say "not on my watch," in terms of privatizing, and I have full confidence that he will let you know if we need more resources to get the job done right.

Senator MURRAY. I just think that that really matters.

Dr. CLANCY. Yes.

Senator MURRAY. Obviously, we all love to say we are getting more money. We would love to see that, but we need leadership too, from the top on this——

Dr. CLANCY. Yes.

Senator MURRAY [continuing]. And I do not know what that is yet, and I am not talking about the Secretary.

Dr. CLANCY. Yeah.

Senator MURRAY. So, I am concerned and I just wanted to register that.

Dr. Draper, good to see you again. Thank you for all the work you and GAO put into making sure we provide the best care for our veterans.

Your testimony is very concerning, particularly the apparent lack of urgency in VA's steps to get off the High-Risk List. Not one of the five criteria in any of the areas of concern GAO identified has been fully met by the VA. Can you tell us how far along the VA should be now that it has been 2 years since it was first put on that High-Risk List?

Ms. DRAPER. Well, we are very concerned that 2 years later we are not much further ahead, or the VA is not much further ahead in addressing the issues. Let me just tell you a little bit about what we have done in the past couple of years to really express the need for urgency.

The Comptroller General met with the then Secretary McDonald three times in the past couple of years. First was to tell him they were being put on the High-Risk List, the second time was that they were not making progress, the third time was that they were not making progress and that he offered the availability or access to subject matter experts within GAO that could help them with some of their initiatives, like contracting. We had a meeting in August between VA leadership and GAO subject matter experts, and unfortunately, to date, they really have not taken us up on accessing our subject matter experts that could really help point them, in terms of best practices. You know, we look across governments so we know what works well, what does not.

Senator MURRAY. So, which agencies would you point them to, to tell them to look at?

Ms. DRAPER. Well, it would really depend on what the issue was, but we had pointed the high risk—the group—Dr. Clancy's group to the Department of Homeland Security, which we feel has done a nice job addressing the high-risk concerns. I think they have a copy of their action plan and contact information related to that particular area.

As I think Dr. Clancy said, the Comptroller General and Secretary Shulkin did meet on March 3, to talk about the lack of progress and concerns, and what they needed to do. The most immediate thing to do was to have a viable action plan that really provides a roadmap and lays out what they need to do and how they are going to do it.

Senator MURRAY. OK. Thank you very much. Thank you, Mr. Chairman.

STATEMENT OF HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN [presiding]. Thank you all so much for being here, and I apologize for being late. I had to give a little talk, and we had votes, and it was during the period when the votes took up. You all know how these things are. We do appreciate all of your hard work, and for coming over and talking to us about these things that are so very important.

One of the areas that I really am concerned about, I think all of us are concerned about, is the management of information technology, which has been something that lots of people have been working on. I have been here since 2001, on the VA Committee in the House and now in the Senate, and this is just something that has been difficult.

We talked about before, that, you know, there are proprietary ways of doing this. I was pleased that recently, I believe Dr. Shulkin said that we were going to be looking at commercial applications. Is that correct?

Dr. CLANCY. [No audible response.]

Senator BOOZMAN. Dr. Clancy, in your testimony you mentioned that the VA will take steps this year to address patient scheduling and electronic health record systems. Again, Secretary Shulkin has mentioned the VA was pursuing VSE as a scheduling solution, as well as MASS, another scheduling tool. It was my understanding that a go or no-go has been reached regarding VSE. Can you talk to us a little bit about that?

Dr. CLANCY. I am going to hand this to my partner, Dr. Lee, who knows all of the details much more than I do. Thanks.

Senator BOOZMAN. Very good. I have partners just like that.

Dr. LEE. Thank you, Senator, for the question. We are currently moving ahead to implement a commercial scheduling solution called MASS, the Medical Appointment Scheduling System. We are currently piloting it right now at our site in Boise.

I had the opportunity to see a demo of MASS a few weeks ago, and I was really impressed. It is state-of-the-art, it is so far advanced from where we are right now, and it will build in all kinds of functionality for our patients that we do not have right now, including rules and the ability to see what services individual patients qualify for, inside the system.

Because it is so far advanced, it will take some time to fully implement across the entire system, on the order of probably several years, and because our current system is so primitive—as you know it is from the '80s and it is a DOS-based system with—just very difficult to use. In fact, I saw our schedulers—I spent a day at a site watching some of our primary care clinic schedulers use our system, and it is cumbersome.

We needed an interim solution that we could quickly roll out in the meantime, and that is the VistA Scheduling Enhancement, VSE. A few weeks—last month, actually, we did approve the national rollout of VSE as an interim scheduling solution, and we are planning to have that be implemented throughout the system through the summer.

Senator BOOZMAN. Very good. That is a great step in the right direction. That is encouraging.

Dr. Clancy, you also, in your testimony, you highlighted the progress of the Joint Legacy Viewer. I believe that that is available now to clinicians throughout the system, you know, which is a good thing. Can you talk a little bit about how many people are—how many clinicians are actually using it, and our progress in that regard, or Dr. Lee?

Dr. LEE. Currently we have over 200,000 authorized users for the Joint Legacy Viewer. This allows interoperability between VA and DOD health records. We are exchanging daily, on a daily basis, over 1.5 million data elements between VA and DOD.

Just to speak about this from my own personal experience, I am an ER doctor and I see patients at the DCVA in the ER there, on the weekends. I have used Joint Legacy Viewer myself to find records from DOD when I am seeing patients there. You can also see records from the community. So, as more of our care is provided in the community, we need to have that interoperability with our community partners. You can also see the records from the community, as long as they are participating in our health information exchange.

Senator BOOZMAN. Along with that, can you talk a little bit about the enterprise Health Management Platform and how that is going to become a major cog?

Dr. LEE. Yes, enterprise Health Management Platform, or eHMP, allows us to have even better interoperability by adding search, and also writes that functionality. JLV, the Joint Legacy Viewer, currently is in read-only state. The eHMP, brings all of the information together in one place. I have also used this myself. It allows providers on the same care team to communicate with each other. It can allow for clinical decision support to be added to the system, where you have many more tools in one place. This platform is really critical for us, as the clinical users and providers, to take care of our patients.

Senator BOOZMAN. Very good. Well, we look forward to hearing the progress, you know, as these things go forward. And it certainly seems like a big step in the right direction.

Dr. CLANCY. We could, if you were interested, I think arrange a demonstration locally, for you or your staff.

Senator BOOZMAN. Yeah, that would be great. Sure. Very much. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. Real quick, the incidences with servicemembers being sexually harassed on Facebook and other websites, it is critically important that we pay attention to what the heck is going on there, both from a DOD perspective and a VA perspective. The DOD, I believe, will bring the offenders to justice.

Dr. Clancy, as you know, the VA has the authority to provide counseling services at med centers to active duty servicemembers who have experienced military sexual trauma, which would seem to include this type of abuse and harassment. Is the VA taking any actions to make sure these servicemembers can seek help from the VA?

Dr. LEE. I can say, Senator, that it is our policy to—currently, to provide care for any servicemember or veteran who has experienced military sexual trauma——

Senator TESTER. OK.

Dr. LEE [continuing]. No matter where they enter our system.

Senator TESTER. OK. All right. Well, I would hope that you would take the necessary steps to let people know that if they have—we will call them challenges—that we are there, you are there. OK?

I notice there are three docs on this panel. Are we all medical doctors?

Ms. PARKER. I am not.

Senator TESTER. OK. So are there four docs? I did not see her. Do we have four docs on the panel?

Ms. PARKER. I am a Ph.D.

Senator TESTER. Oh. OK. All right. Sounds good. The others are medical doctors. OK.

One of the reasons—and correct me if I am wrong—that the VA was put on the High-Risk List is because of improper sterilization of equipment. Is that correct? [No audible response.]

To me, as not a doctor, but as a patient, it is pretty fundamental to good health care, and it seems to me it is something that kind

of takes me aback, to be quite frank with you. I mean, if I was looking at a hospital that had these kinds of problems, I would not step foot in the door.

So, the question is, does this still exist? I am talking about improper sterilization.

Dr. CLANCY. We have made enormous improvements in sterile processing, while recognizing, at the same time, that it is an area that needs careful attention at all times. Part of the reason it needs careful attention is that what they are sterilizing changes a lot. Scopes, for example, for gastrointestinal procedures, keep changing and becoming more sophisticated; each time those change the instructions that go with it do too, and so forth.

Quite recently, the people in sterile processing actually pointed out a problem, which we had to bring back to a device manufacturer, and they were very, very appreciative. This had to do with probes used for ultrasounds in sensitive areas, for men and women. Because of what someone in sterile processing had picked up, and noticed as part of their cleaning, they were worried about a concern of increased contamination. They flagged that right up through their supervisory chain, and we ultimately got a call from the CEO of the company, saying thank you. They have since changed their instructions for customers in this country and around the world.

So, we have made dramatic improvements. When you talked about seeing it when you walked in, you would not. It is an area where——

Senator TESTER. You are exactly right on that.

Dr. CLANCY. Yeah.

Senator TESTER. I mean, you would not see it, but if you read about it?

Dr. CLANCY. Yes. No, I would be very, very worried. It is absolutely vital. It is not an area where we need innovation; we need constant attention to detail. But, we also need for those folks to be able to share their concerns, and I was quite thrilled that recently they did that.

Senator TESTER. No, that is good. It is very foundational to good health care. I mean, you just cannot have one without the other.

I am just going to close it out with this. Oftentimes, it does not matter what business you are in; you want to do what you have been doing because it is just moving right along and you have got other things to think about.

Mike Missal, we spent a long time getting you confirmed as IG, which is bad on us, by the way. You should have been confirmed a long time ago. But, now that you are in there, I would hope that the VA treats you with the highest respect and integrity, because I believe you are a man of those qualities.

It is the same thing with the GAO. Gene Dodaro, your boss, Ms. Draper, is a fine, fine man, and has incredible respect within the Senate. I would just say that when they come forward with the recommendations, even if you do not like them, then tell this Committee that you think they are wrong. Then, we can bring him in and talk to him some more, and if you think they are right, fix it. OK?

That is it.

Dr. CLANCY. That is fair.

Senator TESTER. That is the best preaching job I have got for today. Thank you for being here.

Senator BOOZMAN. We appreciate your preaching job for today, and we appreciate all of you for being here. Again, I know you are busy but it is so, so very important that we understand what is going on. So, thank you for being here.

The record will be open for the next 5 days. With that we adjourn.

[Whereupon, at 3:32 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO DEBRA A. DRAPER, PH.D., DIRECTOR, HEALTH CARE TEAM, GOVERNMENT ACCOUNTABILITY OFFICE

FORT HARRISON REPORT

Question 1. In one open recommendation from the September 2014 GAO report on consults, VHA promised to complete a first round of VAMC consult audits by September 2016. Was Fort Harrison included and what were the results?

Response. While VHA has begun conducting its audits of consult management activities, it has not yet finalized a report summarizing the findings. Since the audits include all VAMCs, Fort Harrison should be included, but we have not yet received a copy of the audit results, which are expected to be finalized at the end of April 2017.

When VHA updated its national directive on consult processes and procedures in August 2016, it required VAMCs to engage in twice yearly audits of consult management activities and to report audit data to their Veterans Integrated Service Networks (VISN).[1] Specifically, compliance and business integrity officers at each VAMC are responsible for reviewing a statistically valid random sample of closed consults (i.e., consults that have been completed, discontinued, or canceled).

Compliance and business integrity officers from each VISN are responsible for validating the data VAMCs report to VHA's Office of Compliance and Business Integrity. Officials from VHA's Office of Compliance and Business Integrity are responsible for examining audit results to determine systemic causes and circumstances related to delays in consults and the accuracy of consult documentation. They also are responsible for identifying systemic trends, educational opportunities, and recommending consult process improvements as necessary.

In December 2016, VHA officials confirmed that VHA's Office of Compliance and Business Integrity had completed data collection for its initial audit of VAMC consult management activities in September 2016, and at that time, they expected to finalize a baseline report detailing the results of the audit in January 2017. VHA officials also told us in December 2016 that they began the data collection for the second national consult audit cycle in November 2016 and that they planned to finalize a second national consult audit report in February 2017. We received an update on the status of the consult audits in April 2017. When we requested copies of the initial consult audit reports, VHA officials told us that the analysis was not yet complete. They now estimate that their first national consult audit report—which will summarize the results of data collected during the first two audits—will be finalized at the end of April 2017. They agreed to provide us a copy of the report when it is ready. We will continue to meet with VHA officials to discuss how they are using the results of nationwide consult audits to inform their oversight of consult processes and procedures across VHA, as well as to obtain documentation of these efforts.

IMPLEMENTING RECOMMENDATIONS

Question 2. As of the date of the hearing, how many open recommendations does VA have?

Question 3. What progress is being made by VA in addressing these recommendations, and do you believe that they have been cooperative in this process?

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[1] See VHA Directive 1232(1), Consult Processes and Procedures (Aug. 24, 2016, as amended on Sept. 23, 2016).

Question 4. When VA and GAO agree on root problems but disagree on the path to address those problems, how is that resolved?

Response. We are providing a combined response to questions 2, 3, and 4, as all three relate to VA's progress in implementing GAO recommendations related to veterans' health care.

As of the date of the hearing (March 15, 2017), there were 113 GAO recommendations related to veterans' health care that VA had not yet implemented. See the following table for additional information about the status of the 255 recommendations related to veterans' health care that were included in products we issued between January 1, 2010 and March 15, 2017.

Status of GAO Recommendations Related to Department of Veterans Affairs (VA) Health Care from January 1, 2010 through March 15, 2017

Status of recommendations	Number of GAO recommendations, Jan. 1, 2010 through March 15, 2017
Open because VA has not yet implemented them	[a] 113
Closed because VA implemented them	128
Closed without VA implementing them [b]	14
Total	255

Source: GAO.

[a] Of these 113 recommendations, 32 have been open for 3 or more years.

[b] We close recommendations without agencies having implemented them primarily if the recommendation is no longer valid because circumstances have changed.

Since February 2015, when we designated VA health care as a high-risk area, VA has increased its focus on implementing our recommendations. At the time we added this issue to our High-Risk List in 2015, VA had only implemented about 22 percent of our recommendations related to VA health care. The rate at which VA has implemented our recommendations has increased steadily since then, and at the time of our February 2017 High Risk Update, VA had implemented about 50 percent of our recommendations related to VA health care.

Since 2015, GAO staff have been routinely meeting about every 4 to 6 weeks with staff from VHA's Management Review Service (MRS) to discuss the status of open GAO recommendations, and these meetings have been cooperative and productive. MRS staff have prioritized for closure GAO recommendations that have been open for 3 or more years, and they are working to identify and support the actions VHA program offices need to take to implement those recommendations. MRS staff have also facilitated meetings between GAO teams and VHA subject matter experts. The meetings help clarify actions VHA is taking, and allow for discussions of documentation VHA should provide to GAO to support closing a recommendation as implemented, as well as any ideas VA may have for addressing the intent of the recommendation even if it does not exactly match our recommendation wording.

In general, VA concurs with recommendations we have made, and it has been rare for VA officials and GAO staff to disagree about how our recommendations related to VA health care should be addressed. Sometimes, we need VA to provide us additional evidence showing that actions have actually been taken to address our recommendations (rather than just planned). In a few instances, the actions VA took were too late to meet the intent of our recommendation.

INFORMATION TECHNOLOGY

Question 5. The GAO report lays out a number of outdated IT systems operating at VA right now. What do you think is the most critical IT system for Secretary Shulkin to address immediately from the perspective of risk to veterans?

Response. The use of IT is crucial to helping VA effectively serve the Nation's veterans. Each year, the department spends more than $4 billion on IT and operates approximately 240 information systems. Many of VA's unmet IT needs have a direct relationship to the quality and safety of veterans' health care. However, GAO has not done work to prioritize VA's IT needs and therefore has no basis to identify which unmet IT needs are the most critical to address.

As we have reported for many years, VA has had difficulty managing its information systems, raising questions about the effectiveness of its operations and its ability to deliver intended outcomes needed to help advance the department's mission. We have published a number of reports about VA's need to address aging information technology (IT) systems, including those related to delivering health care services to veterans. For example, in addition to the VA IT systems we discussed in the

High Risk report, we also recently reported that VA is still using two of the Federal Government's oldest legacy IT systems—both of which have been in use for more than 50 years.[2]

VA's Office of Information and Technology (OI&T) has the important responsibility of providing IT services across VA and managing the department's IT assets and resources. VA has taken some steps to mitigate IT management weaknesses we have identified in past reports, such as transitioning oversight and accountability for IT projects to a new project management process.

In addition to considering whether an IT improvement could help mitigate risks to patient safety or quality of care, there are other key factors for OI&T to take into account. According to Federal IT investment best practices we have identified, OI&T should assess VA's IT needs in light of criteria such as investment size, project longevity, technical difficulty, project risk, business impact, customer needs, cost-benefit analysis, organizational impact, and expected improvement.[3] As new VA leaders transition into roles at OI&T, sustained management attention and organizational commitment will be essential to ensuring VA's progress in the area of IT management.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO DEBRA A. DRAPER, PH.D., DIRECTOR, HEALTH CARE TEAM, GOVERNMENT ACCOUNTABILITY OFFICE

MENTAL HEALTH CARE

Question 6. Dr. Draper, the GAO highlights mental health care as one area where inconsistent application of policies has created access issues for veterans. Secretary Shulkin recently indicated the VA would be offering urgent mental health care for former servicemembers with less than honorable discharges: is the VA even equipped to expand into providing such services? Do you have a general sense of whether or not this will further exacerbate the problem of access for veterans to mental health services?

Response. VA estimates that there are currently about 500,000 former servicemembers with other-than-honorable (OTH) discharges, and according to DOD data, approximately 117,000 of these servicemembers separated from active duty between fiscal years 2001 and 2014.[4] However, it is difficult to determine whether offering urgent mental health services to individuals with OTH discharges will negatively affect veterans' access to VA mental health care because of continued limitations of VA's appointment wait-time data. Without complete, reliable data on the extent to which veterans who are already receiving VA care are waiting for mental health care appointments, VHA lacks assurance that it has sufficient capacity to expand services to individuals with OTH discharges—even if it only offers urgent mental health care to these individuals.

For example, VHA has yet to implement our December 2012 recommendation to improve the reliability of its wait time measures either by clarifying its scheduling policy to better define the desired date (which at the time, was the name for the starting date that was used to calculate wait times), or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error.[5] In July 2016, VA published a revised VHA outpatient scheduling directive, which provided new instructions for scheduling appointments. However, the new instructions, which form the basis for measuring wait times, are still prone to scheduler interpretation, making training vital to consistent and accurate implementation of the policy. As of November 2016, VHA reported that the majority of staff responsible

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[2] One of these systems is the Personnel and Accounting Integrated Data system, which automates time and attendance for employees, timekeepers, payroll and supervisors. The other is the Benefits Delivery Network, which tracks claims filed by veterans for benefits, eligibility, and dates of death. See GAO, *Information Technology: Federal Agencies Need to Address Aging Legacy Systems*, GAO–16–468 (Washington, DC: May 25, 2016).

[3] See GAO, *Information Technology Investment Management: A Framework for Assessing and Improving Process Maturity*, GAO–04–394G (Washington, DC: Mar 1, 2004).

[4] These 117,000 servicemembers with OTH discharges separated from the Army, Navy, Marine Corps, or Air Force between fiscal years 2001 and 2014 (fiscal year 2014 data is as of June 2014). This data was accessed from HTTP://WWW.DOD.MIL/PUBS/FOI/READING_ROOM/STATISTICAL_DATA/14-F-0775_FY2001-2014_ACTIVE_ENLISTED_SEPARATIONS.XLSX on January 29, 2016. This figure does not include servicemembers who separated from the National Guard or Reserve.

[5] See GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO–13–130 (Washington, DC: Dec 21, 2012).

for scheduling appointments had been trained on the new directive and that separate training on a new scheduling system enhancement was scheduled to begin in February 2017. We cannot assess whether VHA scheduling staff are accurately implementing the new scheduling policy until all relevant staff are trained on the new system.

In addition, in October 2015, we reported that the way that VHA calculates veterans' wait times for full mental health evaluations (using veterans' preferred dates instead of the dates veterans initially request a referral to mental health care) may not reflect the overall amount of time a veteran waits for care.[6] Further, we found that VHA's mental health wait time data may not be comparable over time (due to definitional changes), or comparable between VAMCs, making it difficult for VHA to provide effective oversight of access to mental health care.

While there is uncertainty about the extent to which veterans are experiencing wait times for mental health care, VA has engaged in recent hiring initiatives to improve access to health care services. For example, the Veterans Access, Choice, and Accountability Act of 2014 appropriated $5 billion to expand VA's capacity to deliver care to veterans by hiring additional clinicians and improving the physical infrastructure of VA's medical facilities.[7] In addition, in our October 2015 report on VA's mental health access, we reported that VA was able to hire about 5,300 new clinical and non-clinical mental health staff as a result of a two-part hiring initiative from June 2012 through December 2013. While about 1,600 of these hires were for newly created mental health positions, about 2,300 filled existing vacancies (or vacancies that opened during the hiring initiative).[8] Officials at the five VAMCs we visited as part of this review reported local improvements in access to mental health services as a result of the additional hiring, such as the ability to offer mental health services in new locations.

VA exempted certain positions, including mental health providers, from the January 2017 hiring freeze on executive branch employees in order to meet the department's public safety responsibilities. This exemption allowed VA to continue to recruit mental health providers, although officials at VAMCs we visited for our October 2015 report told us they faced several challenges in hiring and placing mental health providers. These challenges included: (1) pay disparity with the private sector; (2) competition among VAMCs for staff; (3) the lengthy VHA hiring process; (4) a nationwide shortage of mental health professionals; (5) a lack of space to provide care; and (6) a lack of non-clinical support staff to relieve providers' administrative burden and increase providers' clinical availability. Officials at four of the five VAMCs we reviewed also stated that they were still unable to meet overall demand for mental health care despite VHA's recent hiring initiative.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO DEBRA A. DRAPER, PH.D., DIRECTOR, HEALTH CARE TEAM, GOVERNMENT ACCOUNTABILITY OFFICE

OVERSIGHT AND ACCOUNTABILITY

Question 7. Dr. Draper, in your testimony you raise concerns regarding self-reported data from facilities and whether that data could be independently corroborated. What steps would GAO recommend VA take to ensure that the data collected and report to VACO can be independently corroborated? There are concerns that the data reported through SPOT and other systems do not properly reflect the day-to-day safety, quality, and access concerns that have been raised by GAO over the years.

Response. There are several actions VA can take to independently corroborate self-reported data, including on-site inspections, pulling samples of patient records for independent review, ensuring that Veterans Integrated Service Networks (VISN) review reports generated by VA medical centers, and assigning responsibility to appropriate levels in the organization to verify data. When we added VA health care to the High Risk List in 2015, we noted that reliance on self-reported data contributed to weaknesses in VA's ability to hold its health care facilities accountable and ensure that identified problems are resolved in a timely and appropriate manner. We reiterated that concern in our 2017 high-risk report. Ensuring that self-reported

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[6] See GAO, *VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, GAO–16–24 (Washington, DC: October 28, 2015).

[7] Pub. L. No. 113–146, § 801, 128 Stat. 1754 (2014).

[8] The remaining staff hired as part of this initiative were either non-clinical support staff or peer specialists (veterans with mental health conditions who are in recovery and have been trained to help others with mental health conditions).

data are reliable can inform oversight decisions and help VA ensure that its corrective actions are addressing the root causes of the problem, which is part of our criteria for removal from the High-Risk List.

We have several open recommendations for actions VHA can take to address our concern about reliance on self-reported data from VAMCs. Addressing these open recommendations can not only serve to correct the specific deficiency identified, but also help address the underlying problem of inadequate oversight and accountability.

Descriptions of selected findings and open recommendations from recent GAO reports are provided in the table below.

Summaries of Findings and Open Recommendations (as of April 7, 2017) from Selected GAO reports Addressing Concerns with Reliance on Self-Reported Data at the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA)

Report	Finding Summary	Open Recommendation
GAO-17-242, VA Health Care: Actions Needed to Ensure Medical Facility Controlled Substance Inspection Programs Meet Agency Requirements	We found that two of the four selected Veterans Integrated Service Networks (VISN) in our review did not review their facilities' quarterly trend reports of controlled substance inspections, as required by VHA. Such reports identify inspection program trends such as missed inspections and areas for improvement. We found that one network that had reviewed the trend reports failed to follow up with a facility to ensure it had submitted missed trend reports.	To help VHA achieve its objective of reducing the risk of diversion through effective implementation and oversight of the controlled substance inspection program, the Secretary of Veterans Affairs should direct the Under Secretary for Health to ensure that networks review their facilities' quarterly trend reports and ensure facilities take corrective actions when nonadherence is identified.
GAO-17-52, VA Health Care: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans	We found VHA's lack of reliable data meant that it could not ensure medical center compliance with requirements related to the environment of care for women veterans. These requirements include standards for privacy at check-in and interview areas, location of exam rooms, and the presence of privacy curtains in exam and inpatient rooms. We found that only 3 of the 155 instances of noncompliance we observed during on-site inspections of waiting, procedure, and examination areas at six VA medical centers were reported to VA central office. Because VA uses these data to track facility compliance, their accuracy is vital for effective oversight.	To improve care for women veterans, the Secretary of Veterans Affairs should direct the Under Secretary for Health to strengthen the environment of care inspections process and VHA's oversight of this process by expanding the list of requirements that facility staff inspect for compliance to align with VHA's women's health handbook, ensuring that all patient care areas of the medical facility are inspected as required, clarifying the roles and responsibilities of VA medical facility staff responsible for identifying and addressing compliance, and establishing a process to verify that noncompliance information reported by facilities to VHA Central Office is accurate and complete.

Summaries of Findings and Open Recommendations (as of April 7, 2017) from Selected GAO reports Addressing Concerns with Reliance on Self-Reported Data at the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA)—Continued

Report	Finding Summary	Open Recommendation
GAO-14-808, VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care	We found that VHA's limited oversight of consults impedes its ability to ensure VA medical centers provide timely access to specialty care. For example, as part of its consult initiative, VHA required VAMCs to review a backlog of thousands of unresolved consults—those open more than 90 days—and if warranted to close them. However, VHA did not require VAMCs to document their rationales for closing them. As a result, questions remain about whether VAMCs appropriately closed these consults and if VHA's consult data accurately reflect whether veterans received the care needed in a timely manner, if at all.	To improve VHA's ability to effectively oversee the consult process, and help ensure VAMCs are providing veterans with timely access to outpatient specialty care, the Secretary of Veterans Affairs should direct the Interim Under Secretary for Health to enhance oversight of VAMCs by routinely conducting independent assessments of how VAMCs are managing the consult process, including whether they are appropriately resolving consults. This oversight could be accomplished, for example, by VISN officials periodically conducting reviews of a random sample of consults as we did in the review we conducted.

Source: GAO.

VHA has also taken some actions to implement recommendations that will help address the concern about the reliability of self-reported data. For example:

• In 2015, as part of our review of VA's primary care oversight, we found inaccuracies in VA's data on primary care panel sizes, which are used to help medical centers manage their workload and ensure that veterans receive timely and efficient care.[9] We found that while VA's primary care panel management policy required facilities to ensure the reliability of their panel size data, it did not assign responsibility for verifying data reliability to regional- or national-level officials or require them to use the data for monitoring purposes. As a result, VA could not be assured that local panel size data were reliable, or whether its medical centers had met VA's goals for efficient, timely, and quality care. We recommended that VA incorporate an oversight process in its primary care panel management policy that assigned responsibility, as appropriate, to regional networks and central office for verifying and monitoring panel sizes. In October 2016, VA reported that it had completed nationwide deployment of new software for managing panel sizes, called Primary Care Management Module (PCMM) Web, which is designed to enable better management and monitoring of primary care panel sizes. In addition, in September 2015 and December 2016, VA required all facilities to validate their data on primary care panel sizes, as well as the number of support staff and exam rooms. In February 2017, all but one VA facilities certified that they had validated their data (the remaining facility was still in the process of completing data validation efforts), and we closed this recommendation as implemented.

• In our July 2015 report examining VHA's root cause analysis (RCA) program for adverse events, officials from VHA's National Center for Patient Safety (NCPS) told us that VAMCs sometimes chose alternative processes, such as those based on Lean methods, to address adverse events when an RCA was not required.[10] NCPS officials told us they supported VAMCs' use of these alternative processes when appropriate, but acknowledged loss of information as the results of these processes were not required to be entered into WebSPOT (VHA's centralized RCA reporting system), or otherwise shared with NCPS. However, VHA was unaware how many VAMCs used these alternative processes. We recommended that VHA determine the extent to which VAMCs are using alternative processes to address the root causes of adverse events when an RCA is not required, and collect information from VAMCs on the number and results of those alternative processes. In September 2015, NCPS developed and fielded a survey to all medical centers to assess

[9] See GAO, *VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care*, GAO–16–83 (Washington, DC: Oct. 8, 2015).

[10] See GAO, *VA Health Care: Actions Needed to Assess Decrease in Root Cause Analyses of Adverse Events*, GAO–15–643 (Washington, DC: Jul. 29, 2015).

what degree they were utilizing alternative processes to address root causes of adverse events when a root cause analysis is not required. NCPS was able to obtain data from 86 percent of medical centers that demonstrated the types of alternative processes used and how medical centers were using them. As a result, we closed this recommendation as implemented.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO MICHAEL J. MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

FORT HARRISON REPORT

Question 1. The recent report on Ft. Harrison indicated that steps have been taken to improve consult timeliness. Are you confident those steps are sufficient and do you believe they will appropriately address factors that contribute to delays in care for veterans?

Response. In comments to our draft report (which are included in the final report), leadership described ongoing steps to address factors within the system's control that contributed to consult delays. We will monitor system leadership's actions on these issues, which include hiring additional staff to administratively process consults and reducing the number of unnecessary consults. We anticipate that completion of those steps will have a positive impact on timeliness of care for some Montana veterans. However, consult delays for many veterans will likely persist because of other factors outside the system's control, including the adequacy of the provider network for the Veteran's Choice Program. We highlighted our concerns about network adequacy in another report, Review of VHA's Implementation of the Veterans Choice Program (January 30, 2017), and made recommendations to the Under Secretary for Health that will help to address nationwide issues that hinder consult timeliness.

HIGH RISK LIST

Question 2. Have you met with Dr. Shulkin in his capacity as Secretary? And have you received assurances of a high level of engagement on these issues?

Response. Yes, I have met with Dr. Shulkin several times since he was confirmed. We have a regularly scheduled monthly meeting. I have also called him and requested a meeting when I felt that an issue needed to be addressed. Also the OIG meets monthly with leaders in the Veterans Health Administration.

IMPLEMENTING RECOMMENDATIONS

Question 3. As of the day of the hearing, how many open recommendations does VA have that are over 60 days old?

Response. As of March 15, 2017, there were 120 reports and 366 recommendations that had been open for greater than 60 days.

Question 4. What progress is being made by VA in addressing these recommendations, and do you believe that they have been cooperative in this process?

Response. Overall, VA is receptive to OIG recommendations and provides action plans to correct the identified issues. At times, however, VA may underestimate the time it takes for corrective actions to be implemented and demonstrate a sustainable improvement.

Question 5. When VA and OIG agree on root problems but disagree on the path to address those problems how is that resolved?

Response. If VA management concurs with a finding but non-concurs with a recommendation, VA should provide an alternative course for corrective action that VA believes is responsive to satisfying the intent of the OIG recommendation. If the issuing OIG office agrees with management's proposal, follow-up will be on the agreed-to corrective action. If VA continues to non-concur with an OIG recommendation and does not propose corrective action, the Assistant Inspector General of the appropriate OIG Directorate will discuss the matter with the Inspector General and the Deputy Inspector General for an OIG decision on whether to submit the unresolved issues to the Deputy Secretary for final resolution or to publish the final report without the concurrence of VA on the findings and recommendations or without an implementation plan acceptable to OIG.

In most instances, whenever VA and OIG disagree on an action plan to implement a recommendation that VA has concurred with, both sides will have productive discussions to address the issues.

INFORMATION TECHNOLOGY

Question 6. The GAO report lays out a number of outdated IT systems operating at VA right now. What do you think is the most critical IT system for Secretary Shulkin to address immediately from the perspective of risk to veterans?

Response. We believe the following are some of most critical IT systems that Secretary Shulkin should address that have a direct impact on veterans:

- Veterans Health Information Systems and Technology Architecture (VistA)
- VA's Outpatient Appointment Scheduling System—The OIG is currently conducting an audit of the VistA Scheduling Enhancement (VSE) which is considered the near-term solution for updating VA's archaic scheduling system
- Veterans Benefits Management System (VBMS)—VBMS is the replacement for the Veterans Benefits Administration's (VBA) legacy systems, Benefits Delivery Network (BDN) and Veterans Service Network (VETSNET). BDN still has some functionality related to processing entitlements for three of the five business lines (Compensation and Pension, Education, and Vocational Rehabilitation and Employment). Until there is confidence that VBMS can process payments, VA will have to maintain these legacy systems which is a costly both in time, staff, and funding.
- Financial Management System (FMS)—While FMS is not involved in direct patient care, it supports payments to vendors that provide the goods and services the Veterans Health Administration needs to operate, as well as keeps track of the status of VA's budgetary resources.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO MICHAEL J. MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

APPOINTMENT CANCELLATIONS

Introduction: Mr. Missal, in your testimony you refer to OIG's (June 2016) report that claimed supervisors at a VA facility in Houston instructed staff to cancel appointments for veterans who were offered appointments at alternative locations but declined. Even though staff canceled these appointments, they were instructed to record them as canceled by the veterans themselves.

Question 7. Do you have reason to believe that these kinds of situations could have occurred in VA facilities in Hawaii or in other states?

Response. We conducted investigations at over 100 VA facilities regarding the manipulation of wait time data. We discovered that the over-riding issue was the lack of training and understanding of VA's policy regarding scheduling. We did review allegations received by the OIG Hotline concerning Matasunga VA Medical Center (VAMC) in Honolulu, Hawaii. The allegations were different from the scheme uncovered at the Houston VAMC. Our Honolulu review did not develop any information that management instructed staff to disregard patient desired dates when inputting appointments.

Question 8. Can you discuss the recommendations that OIG made to address these situations? How can we ensure that veterans, especially veterans in rural communities who may have difficulty traveling to a nearby VA facility, do not have their appointments canceled?

Response. We recommended the Veterans Integrated Service Network 16 Director provide scheduling staff training; improve scheduling audit procedures for use of dates and appropriateness of the cancellation type used; and take actions when the audits identify deficiencies.

VA facilities should follow VHA's Directive 1231, Outpatient Clinic Practice Management, November 15, 2016, which states that staff should determine which patients can be seen by another provider, and contact patients that need to be rescheduled as soon as possible prior to their scheduled appointment in order to avoid them arriving at the facility without the ability to be seen.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO JOHN D. DAIGH, JR., M.D., CPA, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 9. Over the course of the Inspector General's reports, what are the most pressing issues you have uncovered concerning opioid prescribing in the VA? How is the VA addressing the concerns IG investigations have discovered?

Response. The most pressing issue that VA providers must address is the creation of an appropriate treatment plan for veterans who are prescribed narcotic medications. One group of patients has a history of chronic pain, co-morbid mental health issues, and a long history of narcotic use. The other group of patients are relatively naive to narcotic medications, and yet present with an acute pain syndrome, that if not properly managed, may lead to a life of chronic narcotic use/dependence.

VA has produced a number of directives and undertaken a number of efforts to improve VA providers' ability to effectively treat these veterans' symptoms to include the creation and dissemination of: a Clinical Practice Guideline Management of Opioid Therapy for Chronic pain, an Opioid Safety Initiative, an Opioid Safety Initiative Tool Kit, a Pain Management Opioid Safety Education Guide, and a Pain Management Opioid Safety Quick Reference Guide.

The OIG recommended that VA improve the supervision of providers to ensure that the best insights of the most experienced VA providers can influence the care of each veteran. In addition, the OIG encouraged VA to partner with non-VA entities to improve clinical research trials in these populations with the hope of improving the guidance providers can offer over time. In discussions with VA leaders and providers, they appear dedicated to addressing these issues by improving the capabilities of VA providers and increasing reliance upon community resources.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO MICHAEL J. MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

WHISTLEBLOWERS

Mr. Missal, thank you for the work that your office has done investigating allegations of misconduct and mismanagement at the Cincinnati VAMC. I look forward to reading the report, which should be forthcoming. VA employees, acting as whistleblowers, raised concerns and demanded change for our veterans. There are still concerns however that VA employees who reach out through appropriate channels to raise concerns are retaliated against. We've seen this over and over throughout the system.

Question 10. What steps does OIG take to protect those interviewed so that they don't face reprisal?

Response. The OIG takes all possible steps to protect the identity of complainants. Often complainants have made similar complaints to management, so it is possible for management to identify them. However, we do not provide the identity of complainants, confidential sources, or self-identified whistleblowers to VA. We advise complainants to contact the Office of Special Counsel (OSC) regarding protection under the Whistleblower Act. OSC is a separate Federal agency with authority to review allegations of prohibited personnel practices, including reprisal for whistleblowing. The VA OIG is certified by OSC as having met the statutory obligations to inform the employees about the rights and remedies under the Civil Service Reform Act, the Whistleblower Protection Act, and the Whistleblower Protection Enhancement Act.

OVERSIGHT AND ACCOUNTABILITY

Question 11. Mr. Missal, has OIG received requests to review the self-reporting processes at VAMCs?

Response. The OIG has completed numerous evaluations of the accuracy of VA-reported data. For example, in our recent report, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, we described our evaluation of the accuracy of wait time data within the Veterans Integrated Service Network (VISN) 6 medical facilities and through Choice. We raised concerns that VA-reported wait time data understated the actual amount of time veterans waited for health care services. To address our concerns, we made 10 recommendations, four to the Under Secretary for Health and six to the VISN 6 Director. Last year, we reviewed whether information contained in a letter from VISN 23 to Congressman Walz accurately reported information on primary care staffing at the St. Cloud VA Health Care System. In our report, *Healthcare Inspection—Reported Primary Care Staffing at St. Cloud VA Health Care System*, we indicated that data reported were inaccurate and that VISN and facility leadership acknowledged that no data validation steps were taken prior to submitting information to the Congressman. We made one recommendation to the VISN Director to address the inaccuracies we identified.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS

FORT HARRISON REPORT

Question 1. GAO issued a consult audit in 2014 with 6 recommendations that are still open. In one open recommendation from this report, VHA promised to complete a first round of VAMC consult audits by September 2016. Was this completed, and what were Ft. Harrison's results?

Response. All facilities, including Ft. Harrison, were included in the two national consult audits (completed in September 2016 and January 2017) conducted by the Office of Compliance and Business Integrity (CBI). CBI is finalizing the results of these audits. The findings will be published once the results are compiled.

Question 2. In another recommendation from the same report, VHA indicated calls to share best practice with respect to consults were forthcoming. If these happened, did Ft. Harrison participate? What actions are continuing in VHA to share practices on consult management?

Response. To promote nationwide communication, VHA established a system-wide process for identifying and sharing best practices. Facility level consult steering committees were created and participated in weekly national consult performance improvement calls. VHA began holding national calls with these Veterans Integrated Service Network (VISN) and facility consult points of contact (POC) on November 14, 2014. Each week, more than 400 attendees participate in these calls, which include training on consult policies and processes, review of consult performance data, and presentations on best practices. The calls also provide a forum for discussion and answering questions, which are published for reference in a Frequently Asked Questions (FAQ) document. In addition, VHA has created a Consult Cube with many different Pyramid views enabling easy access to consult data and developed a SharePoint page, which serves as a repository for all consult policy documents, training materials, FAQs, and contact information for VISN and facility consult experts and steering members.

VISN and facility staffs from all sites, including Ft. Harrison, are invited to these calls. There has been significant leadership and staff turnover at Ft. Harrison since calls started. When questioned again in March, 2017, leadership was unsure if anyone was attending the calls. This issue is currently in the process of being corrected.

Question 3. Overall, given the continued concern with consults, what is VA doing to improve the consult process and ensure no additional veterans are harmed by delays in care?

Response. VHA has taken many actions such as those listed below to improve consult processes and ensure timeliness of care:

- VHA finalized Directive 1232 "Consult Processes and Procedures" in September 2016. VHA also distributed the Standard Operating Procedure (SOP). These policy documents clarify procedures for completing consults and provide guidance for tracking and monitoring consults throughout the organization and provide the basis for consult oversight.
- A Consult Management Trigger report was developed to measure VISN and facility consult performance. The Consult Trigger Tool automatically sends notifications to leadership at facilities not meeting requirements to assist in consult oversight and management.
- VHA provided extensive national, VISN, and facility consult training:
  - October and November 2014, national training was provided to facility level staff via webinars and to 975 employees via VA eHealth University (VeHU) training. This training was also made available in the Talent Management System (TMS).
  - March, April, October, and November 2015, training with VISN and facility leadership and staff of all VISNs was provided.
  - Weekly consult best practice/training calls began in November 2014. Over 400 consult POCs attended training calls.
  - National consult training module #24762 was deployed in TMS. As of August 2015, 97 percent of Licensed Independent Practitioners (LIP) assigned the TMS training completed it. An additional 12,740 staff who were not assigned the consult training module in TMS also completed the training. Residents/trainees were provided separate consult training by October 1, 2015.
  - Approximately 60,000 schedulers and 600 VISN and facility consult POCs and Group Practice Managers (GPM) completed training on the Consult Directive. Updated LIP consult training including training on the Consult Directive

will be available in TMS in April 2017. Residents/trainees will receive updated mandatory consult training in July 2017.

• VHA implemented the Consult Improvement Initiative (CII) from March thru June 2016 to provide assistance to selected facilities identified by the Consult Trigger tool as having issues in consult processes and timeliness of completion. All participating facilities demonstrated improvement by reducing consult process failures and reducing delays.

• CBI, in conjunction with the Office of Veteran's Access to Care (OVAC), developed and implemented an independent consult audit process. CBI reviewed all facilities reviewed in two national consult audits. CBI will release the results once finalized. During FY 2017 and until further notice, routine audits will be conducted by compliance staff at a minimum of twice annually for the use of VHA's standardized consultation process and to identify causes of delays of outpatient specialty care consults.

Question 4. Can VHA certify that every employee who is involved in the consult process has been trained on last year's new Directive 1232, Consult Processes and Procedures? What training has been provided, and what metrics will measure adherence to Directive 1231, Outpatient Clinic Practice Management?

Response. Consult Directive Training was developed for the roles of schedulers, VISN and facility consult POCs, GPMs, residents/trainees and LIPs. Training for schedulers, facility consult POCs and GPMs was delivered by live and recorded webinars and completion of training is tracked in TMS. Approximately 600 facility consult POCs, GPMs, and 60,000 schedulers completed the training. This group is considered complete.

Training content for LIPs has been updated and is in the process of being delivered and tracked in TMS. Residents/trainees will be required to take training on the Consult Directive as part of Mandatory Training in July 2017. Consult Directive training is also included in current Medical Support Assistant (MSA) and new MSA onboarding training and will be part of recently-updated scheduling training modules in TMS required for all new schedulers. Generally, as a result of the training, VHA expects to see outcome improvements in areas such as the time to schedule and complete clinical consults, the number of consults linked to appointments, and improvements in the associated consult process metrics.

HIGH RISK LIST

Question 5. Can you provide a timeline for when the root cause analysis for each deficient area in GAO's report will be complete? VA needs to have a well-established timeline.

Response. VA will submit the root cause analyses and VA corrective action plan to GAO in June 2017. The corrective action plan will include schedules and milestones for each initiative by which to gauge VA's progress in achieving the desired outcomes.

IMPLEMENTING RECOMMENDATIONS

Question 6. What progress is VA making in addressing the hundreds of open recommendations?

Response. During the past 2 years, VHA closed 91 GAO recommendations. GAO added 75 new recommendations during that same timeframe. As of March 2017, VHA is actively working on 81 open recommendations, of which GAO provided more than half during the past 12 months. VHA has completed actions on 20 recommendations and awaits GAO's decision regarding closure.

Question 7. When VA and GAO or OIG agree on root problems but disagree on the path to address those problems how is that resolved?

Response. In the event, GAO or the VA Office of Inspector General (OIG) are seeking a different resolution than the actions VHA has taken, VHA engages the OIG or GAO team in discussions regarding the details of actions taken and provides evidence of the effectiveness of those actions. Upon learning more detail, the OIG or GAO may find that the actions have been effective and close the recommendation, on occasion they request additional data collection over time to assess for lasting effectiveness, or they specify what additional actions would be needed to satisfy the intent of the recommendation.

Question 8. Does VA have any Department-level tracking of the administration's open and oldest recommendations? If so, please provide the name of the accountable office. What actions is Dr. Shulkin taking to focus attention on these issues, or is this not a priority?

Response. VA's Office of Congressional and Legislative Affairs maintains a list of open GAO recommendations. Dr. Shulkin appreciates GAO's work to improve services to our Veterans and takes GAO's recommendations to the Department very seriously. The Department's Administrations and Staff Offices that have open recommendations are in the process of implementing action plans outlined in the responses to GAO draft and final reports.

STAFFING MODEL

Question 9. Three OIG reports have been issued on staffing shortages, and all have recommended VA create a staffing model that considers demand and complexity and matches that to budget requests and allocations. Why has this not yet been completed?

Response. As reported in the VHA concurrence to the OIG Recommendation (Report No. 16–00351–453, 9/28/2017), VHA is pursuing multiple courses of action. These include the following:

(1) Completion of the draft Specialty Care Clinical Staffing Model. As noted, in the OIG report, this is a project to research, develop and ultimately implement a cross-disciplinary staffing model. In January 2015, the Under Secretary for Health chartered a working group for a staffing model across all 25 Specialty Care disciplines, at all VA medical centers, both inpatient and ambulatory. The objective of this team is to develop a model that correlates Veteran population and utilization with productivity and capacity, and then to cost. From there, the model can be used to assist in both individual staffing determination and for overall "make/buy" decision on expanding or contracting clinics and other medical facilities.

The draft model is complete and is undergoing review by several VHA senior leaders and by VA's OIG. The final draft will incorporate feedback from each of these offices, which will then lead to field validation and development of policy for implementation.

(2) Evaluation and enhancement of other VHA clinical staffing models continues across multiple fields, including the Primary Care Patient Aligned Care Team (PACT) model, Nurse Professionals, and Medical Support Assistant staffing. Each of these efforts is making significant progress in their respective arenas and is also being connected with similar enhancements to hiring and onboarding practices. Feedback will be solicited from field clinics to validate the ongoing work.

The ongoing clinical staffing work at the James A. Lovell Federal Health Care Center (FHCC) in Chicago, Illinois is another staffing modeling activity, focused on leveraging best practices and common strategies in a joint clinical environment. Since September 2016, a team of Department of Defense (DOD) and VHA professionals have regularly convened to review alignment of VHA and DOD staffing models in such practice areas as Primary Care and Nursing. VHA is currently exploring mechanisms to import staffing data from DOD, and incorporate the information into VHA's productivity tools—regarded by both DOD and VHA as a potential asset for productivity and integration. As the joint VHA-DOD staffing strategy matures, VHA will examine the applicability of DOD staffing techniques in VHA-specific environments.

INFORMATION TECHNOLOGY

Question 10. The GAO report lays out a number of outdated IT systems operating at VA right now. How does Dr. Shulkin intend to prioritize funding amongst the various systems that need to be upgraded or replaced, and what role will OIT play in those decisions?

Response. The VA does have a large number of legacy systems and have embarked on a strategy to prioritize the divestiture of legacy systems. In FY 2017 we will retire the Bi-directional Health Information Exchange (BHIE) and have started a project to divest our legacy Financial Management System (FMS) and other ancillary financial systems. We also have projects currently underway with our business partners in VBA, NCA and BVA to retire the Benefits Delivery Network (BDN), Burial Operations and Support System (BOSS), and Veterans Appeals Control and Logistics System (VACOLS), respectively. The Secretary will also announce the VA's path forward on Electronic Health Record modernization by July 2017. Divestiture of legacy systems and the modernization of the VA's IT infrastructure is one of our highest priorities and we are aligning resources around these projects to reflect that commitment. The process and decisionmaking has involved close cooperation between the CIO and senior VA leadership by reviewing and discussing the IT and operational risks associated with each system.

Question 11. I understand that VA had a goal of having 50 percent of the active IT projects on budget and on schedule by the end of 2016. Did VA meet that goal? What is the new goal moving forward?

Response. VA has met the on-time rate of 50 percent of projects being on budget for the end of 2016. VA has exceeded the on-time rate of 50 percent of projects being on schedule for the end of 2016. At this time, the goal is 50 percent for 2017.

Question 12. VA appears poised to make an announcement in early Summer 2017 regarding its intent to procure a commercial electronic health record as a replacement for VistA. Please describe how VA has been consulting with the Department of Defense (DOD) during DOD's ongoing EHR transition and what lessons VA has learned from that implementation. Please describe the experience VHA and VHA patients who are receiving care at Fairchild Air Force Base or any other facility deploying the Cerner Millenium EHR have had to date.

Response. VA continues to consult and work closely with DOD to learn lessons from its acquisition and ongoing implementation of the Military Healthcare System (MHS) GENESIS efforts.

VA continues to consult and working closely with DOD to gather information on the acquisition of MHS GENESIS. VA has received and reviewed the business and clinical workflow models which were developed as part of the MHS GENESIS scope of work. DOD has pledged to provide additional information to VA as it becomes available through the DOD/VA Interagency Program Office, in consultation with the functional and program offices in the Defense Health Agency and Program Executive Office, Defense Healthcare Management System.

VA has worked with DOD to obtain information on the acquisition of MHS GENESIS, such as market research information, certain contract clauses related to compliance with national health data standards and basic contract structure, and request for proposal statements of work. VA has also worked with DOD to receive business and clinical workflow models developed as part of DOD's scope of work on the Department of Defense Healthcare Management System Modernization (DHMSM) effort. VA will receive additional information from DOD through the DOD/VA Interagency Program Office (IPO) as information becomes available in consultation with the functional and program offices in the Defense Health Agency and Program Executive Office, Defense Healthcare Management Systems.

As an example of VA and DOD's coordination, on October 26, 2016, VA held an Electronic Health Record (EHR) Roundtable with the objective to discuss EHR transformation best practices and lessons learned with public and private sector health care industry leaders to inform the way forward for VHA. This meeting included participation from external partners including the Office of the National Coordinator and Colonel/Dr. Aronson who has been the Chief Medical Information Officer for the DHMSM. Key lessons learned included: 1) need for highly resource intensive change management strategies; 2) best practices for addressing legacy systems, including re-training of staff; and 3) strategies, such as phased roll-outs, to mitigate impacts to patient access.

Meetings and coordination between VA and DOD to ensure interoperability and lessons learned are and will be ongoing throughout the DHMSM/MHS GENESIS program.

Finally, VA officials were pleased to attend the ribbon cutting ceremony and lessons learned sessions at the Fairchild Air Force Base (AFB) in February 2017. An example of the lessons learned was the central role organizational change management plays in any large deployment of this kind. We do not have any information on VHA patients receiving care at Fairchild AFB or another facility where MHS GENESIS is deployed, but we will continue to monitor.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 13. During last week's hearing, Dr. Lee responded to a question on how the Department of Veterans Affairs (VA) provides care to survivors of military sexual trauma (MST) by saying that VA's policy is to provide care to Servicemembers, former Servicemembers with an other than honorable (OTH) discharge for MST care regardless of how they enter the VA system. Previous communications with both VA and Department of Defense staff have indicated that these services are only being provided to active duty Servicemembers, including members of the National Guard and Reserves, and those with an OTH discharge at Vets Centers but not at VA medical centers (VAMC) or Community-Based Outpatient Clinics (CBOC). Could you please clarify whether such services are available at VAMCs and CBOCs and if

there are any locations in which MST services are not available for active duty Servicemembers and former Servicemembers with an OTH discharge?

Response. VA has been offering a full range of health care services to Active Duty Servicemembers (ADSM) under sharing agreement authority for many years; this care has been available at both VA medical centers (VAMC) and community-based outpatient clinics (CBOC) depending on the nature of specific sharing agreements. Services provided under this authority likely have included care for conditions related to military sexual trauma (MST), but because such care was provided under VA's sharing agreement authority, not its MST treatment authority (as specified in 38 United States code (U.S.C.) § 1720D), it has not historically been tracked as part of VA's national MST monitoring efforts. ADSMs typically must receive a referral from TRICARE or a military treatment facility to seek care at a VAMC or CBOC under the sharing agreement authority.

The amendments to 38 U.S.C. § 1720D in section 402 of the Veterans Access, Choice, and Accountability Act of 2014, which became effective on August 7, 2015, authorize VA to extend VA's MST-specific treatment authority to ADSMs without the need for a DOD referral. 38 U.S.C. § 1720D(a)(2). VA has implemented this discretionary authority to permit ADSMs to receive counseling to overcome psychological trauma resulting from MST at Vet Centers without a DOD referral. Vet Center records are confidential and maintained independent of DOD and VA medical records. Additionally, Vet Centers have staff with particular expertise in MST and are located in the community, apart from DOD installations. In addition to treatment available to ADSMs under VA/DOD sharing agreements, VA is collaborating with DOD to provide MST-related care and services to ADSMs at VAMCs and CBOCs without the need for a referral.

Eligibility criteria and services available for former Servicemembers with an Other Than Honorable (OTH) discharge are separate and distinct from the above description pertaining to ADSMs. In general, to qualify for VA health care, a former Servicemember must meet the definition of a "Veteran" as this term is defined in 38 U.S.C. § 101: "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." An OTH discharge is not necessarily a bar to receipt of VA services, and individuals with OTH discharges can potentially receive VA health care, including MST-related care, upon review of their discharge by the Veterans Benefits Administration (VBA). If VBA determines that the individual qualifies as a "Veteran," the individual may enroll in VA's health care system and be placed in the priority group for which he or she qualifies. Former Servicemembers with OTH discharges may receive VA emergency care pending these Veterans Benefits Administration reviews.

A former Servicemember with an OTH discharge who is subsequently determined (by VBA) to be a "Veteran," as described above, is eligible to receive counseling and treatment to overcome psychological trauma resulting from MST, as described in § 1720D.

If VBA determines that the character of discharge is a bar to receiving VA benefits, and thus that the individual does not qualify as a "Veteran," the individual is still eligible for VA health care needed to treat a service-incurred or service-aggravated disability (unless subject to one of the statutory bars to benefits set forth in 38 U.S.C. § 5303(a)). See Section 2 of Public Law 95–126 (Oct. 8, 1977). VA is reviewing whether such an individual who is determined pursuant to § 1720D to have psychological trauma resulting from MST would qualify for care for that trauma under section 2 of Public Law 95–126.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS

VA SCHEDULING SYSTEM

Question 14. Dr. Clancy, in the testimony of Mr. Missal, he indicates that VA's continued issues with their scheduling system stem from the VA's failure to identify their requirements for such a system. However, Secretary Shulkin has indicated that VA is giving up on the in-house solution for a scheduling system and will be buying one off the shelf-what measures will the VA be taking to ensure the produce will integrate with the electronic health records of the VA, the Choice program, and the DOD?

Response. In February 2017, VA announced it has decided to proceed with rolling out VistA Scheduling Enhancement (VSE) as a low-cost, temporary improvement to the current outdated scheduling system. VSE will be VA's interim scheduling solu-

tion to fulfill requirements for patient scheduling until a robust, commercial scheduling system can be implemented. VSE provides a more user-friendly interface that makes it easier to view available appointment times and reduces errors on entry. This functionality improves our ability to schedule Veterans efficiently and accurately.

VA will still pursue the Medical Appointment Scheduling System (MASS) scheduling pilot as part of a longer term, comprehensive strategy to modernize VA scheduling and meet all of VA's scheduling needs, like resource-based scheduling. VA's overall electronic health record modernization plan is set to be released this summer. VA will roll out VSE nationally over the next several months as safely and quickly as possible.

Question 15. Do you have a target date for complete interoperability between the VA and the DOD? The move by the VA to capitalize on using military treatment facilities will be a failure if you cannot make the systems work seamlessly.

Response. VA and DOD systems are interoperable today. In April 2016, VA and DOD were proud to certify to Congress that VA had met the National Defense Authorization Act for Fiscal Year 2014 interoperability standards. But meeting those standards was only one part of our ongoing work, not the end state. We continue to push our interoperability efforts every day to include interoperability with the private sector.

As of March 19, 2017, more than 236,000 VA health care and benefits professionals have access to real-time EHR information, which they can access from VA, DOD, and VA external partner facilities (including private sector) where a patient has received care. On a daily basis, approximately 1.5 million data elements are shared between DOD and VA. The tool that provides this capability is called the DOD/VA Joint Legacy Viewer (JLV). Since its implementation, JLV has allowed VA staff to view more than 2.5 million records. VA's Enterprise Health Management Program (eHMP) incorporates JLV's capabilities and provides even more robust capabilities, including team management and communications, task management, and clinical decision support. eHMP is built upon an event-driven architecture and includes the ability to search the comprehensive patient record for specific terms and conditions.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 16. Two of the high risk issues identified by GAO are ambiguous policies and inconsistent processes throughout the VA system. If a policy or procedure is developed at the VA Central Office level in Washington, DC, how is VA guaranteeing proper articulation of that new policy to VA employees at the local level?

Response. First, VHA has developed a system to ensure field review during development, so that policies produced by VA Central Office have already been thoroughly analyzed and commented on by the field before they are published. Under the new development process, each policy is placed into a portal where field offices at the local and VISN level can read and provide detailed comments on every aspect of the policy. Although this process is still relatively new, it has already yielded hundreds of comments and has led to major revisions of several developing policies.

Second, after VHA publishes a policy, the policy is communicated through a variety of means including an e-mail to all publication control officers nationwide and specific communications, which are developed by the responsible program office and tailored specifically for the primary users of the policy.

The new development process was piloted in 2016 and put in place in January 2017. We are continuing to assess how well it is working by focusing on existing policies that need to be updated and recertified, and we meet regularly to revise based on user experience. We also have long-term plans to develop pre- and post-publication assessments, metrics, feedback loops, and communication tools that will apply to all national policy.

Question 17. The Inspector General Audit of VA's Recruitment, Relocation and Retention (3R) Initiatives exposed a lack of oversight and accountability in the program that had expensive consequences. If certain individuals are taking advantage of this program, money is not reaching essential recruitment programs needed for rural VA hospitals and CBOCs, like those in West Virginia. What is the VA doing to adequately monitor the critical 3R incentive program?

Response. There are various monitoring and reporting requirements outlined in current VA policy regarding recruitment, relocation, and retention incentives. On an annual basis, each servicing human resources office is responsible for compiling a

certification report attesting to the strategic and prudent use of all incentives authorized during the prior calendar year. The report requires information from each incentive authorization, and the Network, Area, or Deputy Assistant Secretary level or higher must sign-off. These reports are submitted to the Deputy Assistant Secretary for Human Resources Management and form the basis for a Department-wide report to the Secretary.

In addition to the annual certification report, the VA Office of Human Resources Management (OHRM) Compensation and Classification Service extracts data from the human resources information system on a quarterly basis to identify any trends or anomalies in usage. As needed, the Compensation and Classification Service contacts servicing human resources offices to verify information and to obtain copies of authorizations or other relevant documents needed for the analysis.

Additionally, OHRM's Oversight and Effectiveness Service will continue to review a facility's incentive authorizations during onsite visits and reviews. This review includes verifying justifications and authorizations and ensuring incentives are approved in accordance with VA policies and Federal Government regulations.

There are also impending policy revisions that will strengthen monitoring requirements for Recruitment, Relocation, and Retention incentives. One of the proposed changes to the policy is the addition of a template for the mandatory annual review of all recruitment, relocation, and retention incentives. The Annual Certification on Usage of Recruitment, Relocation, and Retention Incentives template was developed to collect mandatory information on the usage of recruitment, relocation, and retention incentives. Section 5 of this proposed template requires a narrative description and information to the following: Description of any workforce or succession planning efforts used or proposed that have or will eliminate or reduce the use of recruitment, relocation, or retention incentives. In addition to the workforce or succession planning narrative, each report must provide certification.

Question 18. Given the historically long process of agency removal from the GAO's High-Risk List, how long do you anticipate it will take VA to make it off the list? What do you need from Congress to expedite this process?

Response. The average removal time from the High-Risk List is 9 years. VA will do everything possible to achieve success more rapidly than average and keep the Committee informed about our progress.

VA requests Congress work with VA on Choice eligibility criteria, pass VA accountability legislation and appeals modernization legislation.

Question 19. West Virginia has a population with a high number of veterans and a high number of individuals utilizing the Affordable Care Act. If the ACA is repealed, it is safe to assume there will be changes to coverage, deductibles, and out-of- pocket costs for many. How, if at all, do you foresee the repeal of the Affordable Care Act affecting VA Healthcare? For example, do you expect to see an uptick in enrollment?

Response. Changes in health insurance coverage, deductibles and out-of-pocket costs as a result of Affordable Care Act (ACA) reform depend largely upon how the ACA isrepealed and replaced. As such, we cannot speculate as to how ACA repeal and replace might impact VA health care. West

The chart below depicts the Veteran population in West Virginia including Veterans enrolled in VHA, Medicare and Medicaid, as reported in the 2015 American Community Survey.

	National Veterans			Non-VHA Veterans			VHA Veterans		
State	Estimated # of Veterans	Estimated # in Medicaid	Estimated # in Medicare	Estimated # of Veterans	Estimated # in Medicaid	Estimated # in Medicare	Estimated # of Veterans	Estimated # in Medicaid	Estimated # in Medicare
WV	133,132	15,337	75,374	76,696	9,286	37,176	56,436	6,051	38,198

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS

STERILIZATION

Question 20. Dr. Clancy, during your testimony you referenced steps VA took to correct safety and quality concerns as it relates to sterilization of medical equipment. This is an issue that many medical facilities face and was a focal point during last year's allegations of misconduct at the Cincinnati VAMC. Please provide me with an overview of the sterilization concerns that VA has review this past year and the steps taken to address each concern.

Response. The VA National Program Office for Sterile Processing (NPOSP) ensures the safety of Veterans by developing national policy and oversight of all sterile processing and high-level disinfection activities for critical and semi-critical Reusable Medical Equipment (RME).

During FY 2016, NPOSP conducted 81 site review inspections identifying the continued need for oversight and auditing of RME on an annual basis. NPOSP conducts facility site visits in collaboration with subject matter experts to review and advise on sterile processing activities and to provide special assistance when failures in sterile processing activities might pose potential risks to Veterans. For example, NPOSP diligently looks for errors in not only documentation but sterile processing activities that do not meet manufacturer's guidelines which could potentially pose a risk to Veterans. If NPOSP discovers errors, they will apply corrective actions dependent on the complexity of the error to ensure Veteran safety. In addition to conducting site visits, NPOSP also provides guidance and policies for facility and VISN-led inspections of sterile processing activities and assists with the analysis of data to identify trends. Using the trends and data from the facilities, NPOSP recommends corrective actions across the health care system.

NPOSP conducts training and continuing education programs to ensure competencies in the sterile processing workforce and develops national policy and guidance for sterile processing activities. Such direction and policy may include technical specifications, competency assessments, oversight of sterile processing functions at the facility level, and integration of sterile processing activities with other clinical services.

NPOSP collaborates with the VA National Center for Patient Safety (NCPS), Biomedical Engineering, Center for Engineering, Occupational Safety and Health (CEOSH), Food and Drug Administration (FDA) and multiple vendors/manufacturers to correct defects in design and reprocessing of RME issues. During this past fiscal year, NPOSP offered guidance and provided corrective action to ensure Veteran safety with the following instruments used in VA facilities:

- General Electric (GE) ultrasound Endocavity Transducer (IC5–9D)
  – The transducer could not be deemed bioburden free due to the design of the instrument. NPOSP worked with GE to redesign the transducer probe and update Instructions For Use (IFU).
- Olympus rigid cystoscope bridge
  – The bridge was identified to have defective adhesive material that deteriorated after the sterilization process. NPOSP is working with Olympus for corrective design options.
- 3M Attest Biological indicator
  – The testing indicator was not compatible with the sterilizer. NPOSP collaborated with the manufacturer to provide the correct guidelines for use that meet quality assurance indicators of VA.
- Arobella Quostic Wound Therapy System Model AR1000 ultrasound debridement
  – The design of the Arobella Quostic Wound Therapy System Model AR1000 hand piece did not allow for proper reprocessing. NPOSP provided guidance and discontinued using the old version of the ultrasound hand piece nationally in VA and now only purchases the up-to-date model from the manufacturer that could be effectively reprocessed.
- Conmed Hyfrecator
  – The Hyfrecator was noted to only have 100 uses validated for proper usage; however, the manufacturer representative failed to inform end users that the hand piece must be disposed of, tracked, and disposed of after 100 uses. NPOSP implemented a national quality assurance program to ensure proper tracking and disposal of the Hyfrecator. NPOSP also worked with the manufacturer to create a sheath with correct guidelines for use to ensure the sheath covered the Hyfrecator which protects patients from biohazard material.

- Parks Medical Doppler Probe
  – The manufacturer only allows for the Doppler probe to be used on intact, external skin only. NPOSP identified the Doppler was being used intraoperatively with a sterile sheath that had not been approved by the vendor. NPOSP implemented a national quality assurance program to ensure proper usage of the Doppler and education and training was provided for the end-user. VA no longer uses the Doppler perioperative setting.
- Custom Ultrasonics Automatic Endoscope Reprocessor (AER)
  – The AER had not been validated for multiple high-level disinfection solutions but was sold for the use of multiple high-level disinfection solutions without any FDA validation. NPOSP worked with FDA and Custom Ultrasonics to pull and replace all AERs that did not meet FDA clearance.

SAME DAY ACCESS

Question 21. Dr. Clancy, in GAO's testimony Dr. Draper raises concerns regarding access to same day care throughout VHA for veterans in need of mental health and primary care. These findings are based on GAO reports from 2015 and 2016. VHA says that there are same day appointments for mental health and primary care in all facilities. Please provide me with a snapshot from one day of all the VAMCs and CBOCs in Ohio that illustrate same day availability for veterans.

What metrics are used to measure same day availability for veterans and is there any way for a facility to report inaccurate data regarding availability?

Response. Asking our Veteran patients to tell us about their experience is the most important way to find out if a facility is meeting same day service expectations. In VHA, one way this is done is through the standardized survey called Consumer Assess of Health Care Providers and Systems (CHAPS), a standardized tool used in the health care industry. One of the CHAPS questions is, "In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?"

Since survey results report past performance, lag, and are available less frequently, VHA is also using objective, process measures believed to provide a daily snapshot of system performance in achieving same day services for Veterans. One process measure is the number of face-to-face appointments completed the same day they are scheduled. VA recognizes not all appointments represented by this measure meet the definition of "same day services;" however, many of them are a result of same day requests from patients. This measure is readily available to VA staff and actionable. The definition of same day services includes not only requests from traditional face to face visits but also responses to requests made by phone, secure messaging email, and responses from appropriate support services such as Pharmacy, Social Work, Nursing, etc. For this reason, VHA continues to work to identify ways in which to measure these individual types of same day services and develop more useful collective process and outcome measures.

As of December 31, 2016, same day services in mental health and primary care were made available at all medical centers across VHA. This included those in Ohio, i.e., Chillicothe, Cincinnati, Cleveland, Columbus and Dayton. Facilities have continued to work to expand same day services to their CBOCs. In Ohio, a snapshot of same day services availability as reported by facility leadership as of March 31, 2017, is listed below.

		Primary Care	Mental Health
(3V10) (538)	Chillicothe VAMC	Yes	Yes
(3V10) (538GA)	Athens	Yes	Yes
(3V10) (538GB)	Portsmouth	Yes	Yes
(3V10) (538GC)	Marietta	Yes	Yes
(3V10) (538GD)	Lancaster	Yes	Yes
(3V10) (538GE)	Cambridge	Yes	Yes
(3V10) (538GF)	Wilmington	Yes	Yes
(3V10) (539)	Cincinnati VAMC	Yes	Yes
(3V10) (539A4)	Cincinnati VAMC-Fort Thomas	No	No
(3V10) (539GA)	Bellevue	Yes	Yes
(3V10) (539GB)	Clermont County	Yes	Yes
(3V10) (539GC)	Dearborn	Yes	Yes
(3V10) (539GD)	Florence	Yes	Yes
(3V10) (539GE)	Hamilton	Yes	Yes
(3V10) (539GF)	Georgetown	Yes	Yes
(3V10) (539QB)	Highland Avenue	No	No

		Primary Care	Mental Health
(3V10) (541)	Louis Stokes Cleveland VAMC	Yes	Yes
(3V10) (541BY)	Canton	Yes	Yes
(3V10) (541BZ)	Youngstown	Yes	Yes
(3V10) (541GB)	Lorain	Yes	Yes
(3V10) (541GC)	Sandusky	Yes	Yes
(3V10) (541GD)	David F Winder VA CBOC	Yes	Yes
(3V10) (541GE)	McCafferty	Yes	Yes
(3V10) (541GF)	Painesville	Yes	Yes
(3V10) (541GG)	Akron	Yes	Yes
(3V10) (541GN)	State Street	Yes	Yes
(3V10) (552)	Dayton VAMC	Yes	Yes
(3V10) (552GA)	Middletown	Yes	Yes
(3V10) (552GB)	Lima	Yes	Yes
(3V10) (552GC)	Richmond	Yes	Yes
(3V10) (552GD)	Springfield	Yes	Yes