Statement of Senator Bernard Sanders, Chairman
Senate Committee on Veterans' Affairs
Hearing: The State of VA Health Care
September 9, 2014

Good morning and welcome to what I think will be a very productive hearing.

Today we will discuss some of the very serious issues facing the Department of Veterans Affairs on the heels of the Inspector General's findings related to long wait times and poor patient care at the Phoenix VA.

The IG's report provides troubling details about a hospital that failed to meet our nation's obligation to provide timely, high-quality health care to veterans. What happened in Phoenix is inexcusable and must never happen again in any VA facility.

I was especially disappointed to learn the extent to which Phoenix VA executives and senior clinical staff knew about inappropriate scheduling practices.

In a telling exchange, when asked by a physician in Hawaii to share best practices about how the Phoenix VA had been able to reduce its new patient wait time from 238 days down to 7, the chief of primary care, emailed one of his fellow colleagues in Phoenix and stated, "Wonderful. Not sure how to answer this. Can I just say smoke and mirrors?"

The people who lied or manipulated data at Phoenix and elsewhere must be held accountable. The endemic nature of this problem as identified by the IG's report cannot be tolerated.

The report detailed numerous cases of poor patient care. In fact, several of those cases raised serious concerns about two of Phoenix's specialty care clinics. Reviews of patient files found problems with continuity of mental health care, delays in assignment to a dedicate psychiatrist or mental health nurse practitioner and limited access to psychotherapy. Additionally, the IG also discovered the Urology Service struggled to provide timely care. In fact, the IG has launched a separate investigation into this service. A report regarding the findings will be released in due course.

While the results of the IG's report paints a troublesome picture, the IG was 'unable to conclusively assert' that patients died because of long waiting lines as news media reports had widely speculated.

I also understand as a result of the attention focused on Phoenix, the IG has opened additional investigations at 93 sites of care as a result of receiving approximately 445 allegations regarding manipulated wait times at other VA facilities. I will continue to monitor the results of these investigations and use this information to inform the Committee's oversight efforts in the future.

ACCESS

I, like most Americans, have major concerns about the inability of veterans in various locations across this country to access care in a reasonable period of time. According to recent audit data from VA:

- **More than 26,000 veterans are on lists waiting to be scheduled for medical appointments, 3,000 of them have been waiting more than 120 days to receive an appointment – that's 120 days of waiting and they still don't have an appointment; and**

- **More than 632,000 veterans have an appointment scheduled that is more than 30 days from the date that the appointment was initially requested or from the date that was desired by the patient. Of that amount, more than 382,000 veterans are waiting between 31 and 60 days for their appointments, more than 169,000 are waiting between 61 and 90 days for theirs, and more than 33,000 veterans are waiting more than 120 days. This doesn't account for how long new patients have been waiting on lists, so a new patient who waits for an appointment that is scheduled more than 30 days from when he or she asked for it may have also waited 120 days, just to receive that appointment.**

While this data indicates VA has been able to decrease the number of veterans on wait lists since implementing its Accelerating Access to Care Initiative, it must do much more to improve veterans' access to care. We have a moral obligation to provide veterans with the timely access to the health care they need.

Conference Committee

As details surrounding events in Phoenix and elsewhere unfolded, it became increasingly apparent legislative action was required. Many voices offered suggestions and paths forward.

Just over a month ago, Congress accomplished something significant and something that does not happen very often in Congress. The House and Senate voted in an overwhelming and bi-partisan manner to pass, and President Obama signed into law, the Veterans Access, Choice and Accountability Act of 2014.

This important law begins to address the immediate crisis of veterans gaining access to VA health care. It provides the Secretary with critical tools as well as the resources necessary to immediately and effectively begin to address the challenges facing VA.

This law addresses the very serious problems of accountability and expands VA's ability to provide non-Department care. As a result:

- **Enrolled or newly discharged combat veterans who are unable to secure an appointment within 30 days or reside more than 40 miles from their nearest VA medical facility will now be able to seek care from non-Department providers including Federally-qualified health centers, Department of Defense facilities and the Indian Health Service.**

- **The Secretary now has the authority to immediately remove incompetent senior executives based on poor job performance or misconduct.**

We have heard from Veterans Service Organizations time and time again that VA's physical infrastructure plays a significant role in its ability to provide timely and high quality care to veterans in a safe environment. This law authorizes VA to enter into 27 major medical facility leases in 18 states and Puerto Rico. In many instances, these leases will improve access to care closer to home, and will increase the availability of specialty care services in these locations.

In addition to addressing these immediate needs, this law does something very important. It begins the process of rebuilding VA by providing the Department with 5 billion dollars to strengthen its internal capacity through the hiring of doctors, nurses, and other clinical staff and the funding of emergency leases and other infrastructure projects that would directly improve veterans' access to care.

While the provisions in this law will not solve all of the problems facing VA, I am hopeful it will begin to address some of the critical need issues.

Moving forward we must remember the costs of war does not end when the last shots are fired and the last missiles are launched. The cost of war continues until the last veteran receives the care and benefits that he or she has earned on the battlefield. I remain committed to working with VA and its other stakeholders to ensure that happens.

Closing

With that, I look forward to hearing from the Inspector General about the important recommendations his organization has outlined in regards to Phoenix and I am eager to hear from Secretary McDonald how VA plans to address the critical issues highlighted in this report.