Senator Burr's opening statement for Senate Committee on Veterans' Affairs'

"The State of VA Health Care" Hearing

May 15, 2014

Good morning, Mr. Chairman. I would like to welcome all of today's witnesses and thank you for being here. The issue before the Committee today is the state of the VA healthcare system. We have a sacred obligation to ensure those who have fought for this nation receive the highest quality of services from the Department of Veterans' Affairs.

In fiscal year 2013, for established patients, VA reported that 93 percent of specialty and primary care appointments and 95 percent of mental health appointments were made within 14 days of the patient's or provider's desired date. At first glance, these numbers appear to demonstrate that veterans are receiving the care they want and when they want it. However, we know this is not the case. I think, if VA had asked hard questions regarding these statistics, we would not be here today discussing recent allegations surrounding many VA facilities.

More specifically, we are here to discuss when senior leadership in the Department became aware that local VA employees were manipulating wait times to show that veterans do not wait at all for care. It seems that every day there are new allegations regarding inappropriate scheduling practices ranging from "zeroing out" patient wait times, to scheduling patients in clinics that do not even exist, and even to booking multiple patients for a single appointment.

The recent allegations were not only reported by the media, but in some cases have even been substantiated by the GAO, IG, and the Office of the Medical Inspector. Here are a few examples:

- The GAO released a report on the reliability of reported outpatient medical appointment wait times and scheduling oversight in December 2012 and has testified multiple times on this issue.

- Several IG reports have been issued regarding delays in care and scheduling irregularities, including reports on Temple, TX, in January 2012, and up to the most recent and egregious report in September 2013 at the Columbia VA medical center.

- Two publicly released Office of the Medical Inspector reports related to whistleblowers' allegations at the Jackson VA medical center and the Fort Collins Community Based Outpatient Clinic.

Even more troubling is that, with the numerous GAO, IG, and Office of the Medical Inspector reports that have been released, VA senior leadership, including the Secretary, should have been aware that VA was facing a national scheduling crisis. VA's leadership has either failed to connect the dots or failed to address this ongoing crisis, which has resulted in patient harm and even death.

The question we must answer today is, even with all of the information available to the Secretary, starting over a year and a half ago, and specific instances of patient harm and death directly related to delays in care, why were the national audits and statements of concern from VA only made this month?

I thank the chair, and I yield back.