Statement of Ranking Member Richard Burr

- Good morning, Mr. Chairman. I would like to welcome and thank Secretary McDonald and Acting Inspector General Griffin for being here. Today, the Committee is holding another hearing on the "State of VA Healthcare" specifically focusing on the final IG report, released last month, on the problems found at the Phoenix Healthcare System.

- Since our last hearing on the "State of VA Healthcare," Congress has moved forward on historic legislation that will improve access to healthcare to veterans across the nation and it was signed into law in August. This legislation is the first step in providing veterans with the ability to choose where they receive care, if VA is unable to provide care within a timely manner or if they live more than 40 miles from a VA facility.

- While this is an essential first step in addressing the systemic issues facing the Department of Veterans Affairs, there is still much more work to be done. The work of this Committee has just begun. As we move forward, it will be critical for this Committee to conduct aggressive oversight to ensure that veterans are able to receive the healthcare they need, when they need it.

- This IG report is instructive because it demonstrates critical breakdowns in the system that allowed systemic issues to take deep root not only in Phoenix, but throughout the entire VA system. I would like to highlight two specific issues that were identified in the final IG report on Phoenix.

- First, the IG report describes the care received by 45 veterans who faced either clinically significant delays in care or questionable care from the Phoenix facility. Additionally, the IG reviewed 77 suicides that occurred between January 2012 and May 2014 and found that nine veterans experienced a delay in care, one veteran experienced a clinically significant delay, and five veterans experienced other substandard quality of care. Many veterans experienced obstacles trying to establish needed care after hospitalizations or after being treated in the emergency room. The lack of follow-up, coordination, quality, and continuity of care many of these veterans experienced is troubling and unacceptable.

- Secondly, the most troubling issue described in the report was VA's awareness of the ongoing scheduling challenges that many facilities faced. Furthermore, VA had opportunities to address the systemic culture of inappropriate scheduling practices. However, VA did not act to address inappropriate scheduling practices or manipulation of wait time data. This lack of accountability was further ingrained by VA's decision to waive the fiscal year 2013 annual requirement for facility directors to certify compliance with VHA scheduling directives. Why would the requirement be waived, when VA knew there were questionable scheduling practices occurring within medical facilities?

- The magnitude of scheduling irregularities is demonstrated by the roughly 225 allegations at the Phoenix Healthcare System and the more than 445 similar allegations at VA facilities across the nation that the IG has received through numerous sources, including the IG Hotline, Members of Congress, employees, veterans, and their families.

Currently, the IG is actively investigating 93 sites related to the ongoing wait time manipulations.

- In the coming weeks, months, and years, VA will have to continue to take swift and firm action to dismantle the corrosive culture that has taken hold within VA and make sure it is not able to resurface. No matter what steps VA takes to address the challenges it faces delivering healthcare, VA will not be able to move forward if this corrosive culture is not effectively addressed. I have said this before, but I want to reiterate that the culture that has developed at VA and the lack of management and accountability is simply reprehensible.

- I commend the work that has been done over the last several months; however, there is much more work to be done to repair veterans' trust in the system. I look forward to working with the Secretary and this Committee on implementing the recently passed legislation and making any future significant reforms at the Department to help rebuild its reputation and improve the care that is provided by VA.

- I thank the Chair, and I yield back.