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THE STATE OF VA HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

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C O N T E N T S

JULY 16, 2014

SENATORS

WITNESSES

APPENDIX

THE STATE OF VA HEALTH CARE

WEDNESDAY, JULY 16, 2014

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

The Committee met, pursuant to notice, at 10:02 a.m., in room SD–G50, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders, Murray, Tester, Begich, Blumenthal, Hirono, Burr, Isakson, Johanns, Moran, Boozman, and Heller.

OPENING STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Chairman SANDERS. Let us get to work. Good morning, and welcome to everyone to what I think will be a very important and productive hearing. We welcome Mr. Sloan Gibson, the Acting Secretary of the Department of Veterans Affairs, who will be discussing with us what he has been doing in what I perceive to be a very active 6 weeks on the job. We also look forward to hearing from him as to what he perceives are the problems facing the VA.

I want to mention to the Members of the Committee that next week, on the 22nd, we will be holding a confirmation hearing for Bob McDonald, the President's nominee for Secretary of VA.

Last week despite a very partisan environment here in Congress, 93 Senators put their differences aside to vote in favor of a significant piece of legislation which we hope will address many of the immediate problems facing the VA. It is an issue that Senator McCain and I and all of us in this room worked very hard on, and I want to thank everybody for their support. It is my hope that the conference we are having with the House will be completed by the time we leave here for the August break.

It is clear to all of us that the VA faces many, many challenges, and they are well documented. It is well known that we have many, many, many veterans in this country who are unable to access VA care in a timely manner. We have significant problems in terms of accountability. All of us find it totally unacceptable that people have manipulated data in terms of waiting times; people have treated whistleblowers in a contemptuous way; people have lied. That is unacceptable. We want to hear from Mr. Gibson in terms of what he is doing to address those many problems.

The issue that I want to focus on is that while we are determined to do everything that we can to make the VA—which is a huge institution, providing 6.5 million veterans a year with health care—efficient and accountable, there is another issue that we have got

to address that is also part of our responsibility. That is, what are the legitimate needs, what are the real needs facing the 22 million veterans in this country, and how as a Congress are we responding to those needs?

So, first, the VA has got to be accountable. It has got to be efficient. We have got to address many of the internal problems that we have all heard in the last several months.

Second, we have also got to ascertain what the problems facing the veterans community and their families are and do everything we can to make sure that the VA is on the kind of position that it needs to be to address those problems. Let me just mention some of them.

Of the 2 million men and women who served our country, put their lives on the line in Afghanistan and Iraq, studies suggest that 20 to 30 percent have come home with PTSD or TBI. Simply stated, that means those wars have created some 500,000 mentally wounded American veterans, and as a result, very serious problems regarding suicide—and this Committee will be dealing with that issue in connection with PTSD—substance abuse, inability to hold onto a job, divorce, emotional problems for the kids. When you are dealing with PTSD, it is not just the veteran. It is the wife, it is the kids.

Since fiscal year 2006, the number of veterans receiving specialized mental health treatment has risen from just over 927,000 veterans to more than 1.4 million in fiscal year 2013. This means that in fiscal year 2013 over a quarter of those receiving care at VA were being treated for mental health conditions.

In other words, VA currently provides 49,315 outpatient mental health appointments a day. A day. Forty-nine thousand mental health outpatient appointments a day. Imagine the scope of that. And imagine the challenge.

If we had an endless supply of money, if we had an adequate number of psychologists and psychiatrists in this country—which we do not have—this would be a very daunting tast. And yet we are where we are. That is the cost of war.

Ensuring timely access to high-quality mental health care is critical for our veterans and for their loved ones, and the stakes are high. As I have said, we are all aware—and I know Johnny Isakson, among others, has taken a hard look at suicide—it is a tragedy beyond words, not easily dealt with, but it is one that we have got to address.

Like most Americans, we are all concerned about these horrendous waiting periods, and I know that Mr. Gibson is going to be talking about that in his testimony. Let me just go through the numbers to understand the scope of the issue that we are dealing with.

More than 46,000 veterans are on lists waiting to be scheduled for medical appointments. More than 8,000 of them have waited for more than 120 days. Now, we can have an argument about whether 14 days was an appropriate number. I think it was not and that it was overly ambitious. We do not have the resources to deal with it. But I do not think there is much argument that when you have more than 8,000 veterans waiting over 120 days to receive an appointment date. That is unacceptable.

More than 600,000 veterans have an appointment that is more than 30 days from the date that the appointment was initially requested or from the date that was desired. That is not acceptable. The numbers are staggering, and that is an issue obviously that we are addressing right now, and we will hear from Mr. Gibson as to how he is going to go forward with that.

I think the goal of every Member of this Committee—and I would hope and expect every Member of Congress and of the American people—is that the veterans of this country, people who have suffered so much, deserve quality health care and they deserve it in a timely manner. What I look forward to hearing from Mr. Gibson is some straight, honest talk about the needs of the VA in achieving that goal.

If we are talking about a staggering number of veterans coming home with PTSD or TBI, how many mental health workers do you need? And how are you going to get them? Because that is tough. We do not have enough doctors in this country. How many primary care physicians does VA need? How many specialists does VA need?

If the goal is to provide quality, timely health care in a cost-effective manner, we need some answers from the VA, and I hope we will begin to get some of them today from Mr. Gibson.

Needless to say, the other issues that I know that Members of the Committee are going to be asking are: what actions the Department has taken to reprimand employees who have lied or manipulated data? That is something that nobody on this Committee tolerates. What has the Department done to ensure that such manipulation no longer occurs? What has the Department done to improve other areas of concern identified by the Inspector General, the GAO, and other auditing organizations?

So with that, let me give the microphone over to the Ranking Member, Senator Burr.

[The prepared statement of Chairman Sanders follows:]

PREPARED STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Good morning and welcome to what I think will be a very important and productive hearing. We look forward to hearing from Mr. Sloan Gibson, Acting Secretary of the Department of Veterans Affairs, who will discuss with us what he has been doing in the last six weeks since he assumed that position, and what he sees as the major challenges facing VA in the future.

First, I would like to take a brief moment to discuss the status of the Conference Committee.

CONFERENCE COMMITTEE

Last month, despite a very partisan environment here in Congress, 93 Senators put their differences aside to vote in favor of a significant piece of legislation, which Senator McCain and I worked very hard to craft, to address the very serious problems currently facing VA.

I am confident that my colleagues on the Conference Committee will also put their differences aside and come together to provide much needed access to health care for veterans in a timely manner, and give the Secretary the ability to hold dishonest or incompetent senior officials accountable and the resources needed to increase capacity at VA medical facilities around the country.

I am pleased that, in reality, there are more similarities than differences between the House and Senate bills. We have been making significant progress in the last month and I believe that we can reach an agreement very soon. Millions of veterans

are counting on us to do so. We can't afford to make them wait any longer for the care and services they have earned and deserve.

With that said, I would like to discuss, what I believe, are the biggest issues facing VA health care.

VA HEALTH CARE

VA's challenges are well-documented. As any organization would, it faces significant challenges in providing timely and high-quality health care to millions of veterans all across this country. That's why it's important we have some context as we begin today's discussion. VA is the largest integrated health care system in America.

- VA operates over 1,700 points of care, which include 150 hospitals, 820 CBOCS, and 300 Vet Centers.
- In fiscal year 2013, VA provided 89.7 million outpatient visits.
- VA conducts approximately 236,000 health care appointments per day.

Overall, according to veterans that I talk to in Vermont and around the country, according to the national veterans' organizations that represent millions of veterans, and according to a number of independent studies, VA does a good job at providing quality health care to veterans—once they get into the system. In fact, they have been doing some cutting edge work in a number of areas—including tele-health and CAM.

But the simple reality is that the problems they face are staggering.

MENTAL HEALTH

Of the over 2 million men and women who served in Afghanistan and Iraq, studies suggest that 20 to 30 percent have come home with PTSD or TBI. Simply stated, that means the wars have created some five hundred thousand mentally wounded American veterans and, as a result, very serious problems regarding suicide, substance abuse, inability to hold on to a job, divorce and emotional problems for children and family members.

Since FY 2006, the number of veterans receiving specialized mental health treatment has risen from just over 927,000 veterans to more than 1.4 million in FY 2013. This means that in FY 2013, just over a quarter of those receiving care at VA were being treated for mental health conditions.

In other words, VA currently provides 49,315 outpatient mental health appointments a day. During the last four years (FYs 2009–2013), VA outpatient mental health visits have increased from 14 million a year to more than 18 million.

VA has noted on numerous occasions that it anticipates its need to provide mental health services will continue to grow for the next decade as current military operations come to an end.

Ensuring timely access to high-quality mental health care is critical for our veterans and their loved ones. The stakes are high. Statistics show that on average 22 veterans a day commit suicide—that's more than 8,000 veteran deaths a year. Even one veteran suicide is too many. 8,000 suicides are absolutely unacceptable.

While many individuals with mental illnesses do not commit suicide, it is clear the consequences of failing to properly address and treat mental illness are serve.

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 a recent VA audit:

- 46,236 veterans are on lists waiting to be scheduled for medical appointments, 8,126 of them have waited over 120 days to receive an appointment—that's 120 days before they are told when they are going to be seen; and
- More than 636,000 veterans have an appointment that 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, nearly 360,000 veterans are waiting between 31 and 60 days, nearly 180,000 are waiting between 61 and 90 days, and more than 40,000 veterans are waiting more than 120 days for their appointments. 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.

This is unacceptable. VA must do much more to improve access to the VA Health Care System. We have a moral obligation to provide veterans with the timely access to the health care they need.

A lot of attention has been given to the provision in the bill that allows veterans to access outside care. That provision in important because it will immediately bolster VA's capacity to address veterans' health care needs.

However, the simple truth of the matter is that the VA needs more doctors, more nurses, more mental health providers and, in certain parts of the country, more space for a growing patient population. VA's ability to provide timely care both now and in the future must be strengthened by building capacity within the system. This is done by ensuring VA has the resources, including physical space and the health care providers and support staff necessary to provide such care.

I think I speak for everyone on this Committee when I say we need more details on your current initiatives to address access issues, such as:

- How has the Department's Accelerated Access to Care Initiative improved the care and services VA provides veterans and how long does the Department intend to carry out expanded care options under this initiative, such as evening and weekend appointments;
- When does the Department estimate it will roll out its updated scheduling system; and
- Has VA completed all the recommendations in the IG's interim report on Phoenix.

In order to address the issue of long wait times, the Department and Congress must work together. It is important that you keep us abreast of your initiatives and maintain close communication with the Members of this Committee.

ACCOUNTABILITY

Further, it is beyond words that some employees have lied or manipulated data. These issues must be dealt with immediately. The Department must take swift action to hold those who may have manipulated data or failed to carry out their duties accountable for their actions.

Today I would like to hear:

- What actions the Department has taken to reprimand employees who have lied and manipulated data;
- What has the Department done to ensure such manipulation no longer occurs; and
- What the Department has done to improve other areas of concern identified by the IG, GAO, OSC, and other auditing organizations?

I believe it is important for the Department to create an accountable, safe, and, transparent culture for its employees. Only then would we be able to prevent these egregious actions.

WHISTLEBLOWERS

Finally, I have been deeply troubled by the recent Office of Special Counsel reports that detail deliberate retaliation against the brave VA employees who seek to improve the care and services veterans receive by exposing deep flaws within VA's system.

I will not accept honest whistleblowers—who want to improve the system—being silenced or having their concerns ignored. VA must have zero tolerance for the actions outlined by the Office of Special Counsel in recent weeks.

During today's hearing, I would like to hear what the Department has done to prevent such retaliation from occurring.

CLOSING

With that, I look forward to hearing Acting Secretary Gibson's plans to address the critical issues I have highlighted.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman; and Acting Secretary Gibson, welcome.

Since our last hearing, there have been several developments related to the scheduling irregularities across the VA and its negative impact on patient care. The VA has begun to take the necessary steps to address the systemic problems and the corrosive culture that have been identified and substantiated by several

independent sources. However, these changes will not happen overnight, and this Committee must provide the critical oversight to ensure those changes occur and are effective.

Even with the steps VA has taken to improve access for many veterans, there will continue to be reports and allegations regarding VA health care facilities and workers. These reports will not only highlight critical areas of needed reform, but identify the magnitude and the breadth of the systemic issues facing the VA. The ongoing internal evaluation by VA as well as investigations currently being conducted by the Office of Special Counsel and the VA's Office of Inspector General are essential to eliminate employees and rebuild not only veterans' trust but also the trust of stakeholders.

To undertake the needed reforms within VA, the role of the Office of Special Counsel and the Inspector General are even more crucial now than ever before. Both offices have been essential in identifying systemic issues facing the VA. I would like to highlight a few critical reports that have been released since the last hearing.

At the time of the May 15th hearing, there were several stakeholders who did not want to rush to judgment until the allegations surrounding Phoenix had been substantiated. Since that hearing the IG released an interim report regarding the allegations of scheduling irregularities and a secret wait list at the Phoenix VA health care system. Not only did the IG substantiate scheduling irregularities and a secret wait list at Phoenix, but the IG identified roughly 1,700 veterans who were waiting for appointments and were not included on an appropriate electronic waiting list.

The IG found that scheduling irregularities are a systemic issue across VA's health care system and that this was not an isolated event. Additionally, the IG has received numerous allegations regarding, "mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility." These allegations speak to the corrosive culture that has taken deep root throughout the entire Department.

Within a 3-week period, the Office of Special Counsel released a statement on VA whistleblower reprisals and sent a letter to the President regarding VA's lack of responsiveness to OSC requests. In this letter, the Office of Special Counsel described the Office of Medical Inspector's, or OMI's, consistent use of, "harmless errors." This is their defense, where the Department acknowledges the problem but claims patients were not—their cases were unaffected.

The letter details ten cases of egregious patient care provided by VA facilities in which the OMI substantiates errors in patient care but dismisses potential patient harm. In one case, two veterans were admitted to an inpatient mental health ward at the Brockton VA facility and did not receive comprehensive evaluations for more than 7 years after being admitted to the facility.

Another case in the letter describes how a pulmonologist copied previous provider notes in more than 1,200 patient medical records instead of recording current readings for these patients.

I want to be crystal clear. The culture that has developed at VA and the lack of management and accountability is simply reprehensible, and it will no longer be tolerated.

Secretary Gibson, you have taken several actionable steps in the last month and a half, and I commend the work that you have done. However, what has happened over the course of years is a horrendous blemish on the VA's reputation, and much more work will be needed to repair that damage.

As VA continues to move forward in improving veterans' access to care and changing the culture that has taken deep root within the Department, this Committee has a lot of work to do. The Committee needs to take an active, vigorous oversight role to ensure that the problems that have been identified over the last several months—and, I might say, over the next several months as a host of IG reports come out—are effectively and appropriately addressed and they are not allowed to happen again.

Again, Secretary Gibson, thank you for being here. Mr. Chairman, I thank you and I yield.

[The prepared statement of Senator Burr follows:]

PREPARED STATEMENT OF HON. RICHARD BURR, RANKING MEMBER

Good morning, Mr. Chairman. I would like to welcome and thank Acting Secretary Gibson for being here. Today, the Committee is holding a second hearing on the state of VA healthcare.

Since our last hearing, there have been several developments related to the scheduling irregularities across the Veterans Health Administration and its negative impact on patient care. VA has begun to take the necessary steps to address the systemic problems and the "corrosive culture" that has been identified and substantiated by several independent sources. However, these changes will not happen overnight and this Committee must provide the critical oversight to ensure these changes occur and are effective.

Even with the steps VA has taken to improve access for many veterans, there will continue to be reports and allegations regarding VA healthcare. These reports will not only to highlight critical areas of needed reform, but identify the magnitude and breadth of the systemic issues facing VA. The ongoing internal evaluation by VA, as well as investigations currently being conducted by the Office of Special Counsel and VA's Office of Inspector General, are essential to rebuilding not only veterans' trust, but also the trust of stakeholders and employees.

To undertake the needed reforms within VA, the role of the Office of Special Counsel and the IG are even more crucial now than ever before. Both offices have been essential in identifying systemic issues facing VA; I would like to highlight a few critical reports that have been released since the last hearing.

At the time of the May 15th hearing, there were several stakeholders who did not want to rush to judgment until the allegations surrounding Phoenix had been substantiated. Since that hearing, the IG released an interim report regarding the allegations of scheduling irregularities and a secret wait list at the Phoenix VA Healthcare System.

Not only did the IG substantiate scheduling irregularities and a secret wait list at Phoenix, but the IG identified roughly 1,700 veterans that were waiting for appointments and were not included on appropriate electronic wait lists. The IG found that scheduling irregularities are a systemic issue across VA's healthcare system and this was not an isolated event.

Additionally, the IG has received numerous allegations regarding (quote) "mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior- level managers at this facility." These allegations speak to the corrosive culture that has taken deep roots throughout the entire Department.

Within a 3 week period, the Office of Special Counsel released a statement on VA whistleblower reprisals and sent a letter to the President regarding VA's lack of responsiveness to OSC requests. In this letter, the OSC describes the Office of Medical Inspector's consistent use of (quote) "a 'harmless error' defense, where the Department acknowledges problems but claims patient care is unaffected."

The letter details ten cases of egregious patient care provided by VA facilities in which the OMI substantiates error in patient care but dismisses potential patient harm. In one case, two veterans who were admitted to an inpatient mental health ward at the Brockton VA facility didn't receive comprehensive evaluations for more

than seven years after being admitted to the facility. Another case in the letter describes how a pulmonologist copied previous provider notes in more than 1,200 patient medical records instead of recording current readings for these patients.

I want to be crystal clear; the culture that has developed at VA and the lack of management and accountability is simply reprehensible. And it will no longer be tolerated. Secretary Gibson, you have taken several actionable steps in the last month and a half. I commend the work you have done; however, what has happened over the course of years is a horrendous blemish on VA's reputation. And much more work will be needed to repair the damage.

As VA continues to move forward in improving veterans' access to care and changing the culture that has taken deep roots within the Department, this Committee has a lot of work to do. The Committee needs to take an active, vigorous oversight role to ensure the problems that have been identified over the last several months are effectively and appropriately addressed, and they aren't allowed to happen again.

I thank the Chair, and I yield back.

Chairman SANDERS. Thank you, Senator Burr.

Senator Murray?

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

Senator MURRAY. Mr. Chairman, thank you so much for holding this hearing. As we all know, this is really a critical time for the Department. The VA is still struggling with major systemic problems. There are many vacancies in key leadership positions, and most importantly, veterans are still waiting too long for care.

Secretary Gibson, as we talked about yesterday, I really appreciate your stepping up during this crisis. The Department needs strong leadership right now because the VA is facing serious challenges. Rob Nabors' review identified several of these issues which we have also been discussing here for some amount of time. A corrosive culture has developed in the Department, one that is unworthy of VA's many dedicated and talented medical providers who only want to help veterans. Management failures and lack of communication is a problem at all levels of the VHA, and VA needs more providers, more space, and modern IT systems.

As we continue to work in the conference committee to craft a final bill, I hope an agreement will be reached so we can send it to the President and start making the changes needed at VA so veterans get into care, we create transparency, and hold people accountable.

The compromise bill will be an important first step. As more reviews are done and more problems found, we will need to take additional steps.

And while we continue working on these problems, we cannot lose sight of many other pressing issues. Too many veterans still die by suicide each day. Sexual assault survivors still need help. The VA has to continue to make progress toward the commendable and even more challenging goals of eliminating veterans' homelessness and reducing the claims backlog.

On a positive note, Secretary Gibson, I really appreciate your help in finally getting the money to build the Walla Walla State Veterans Home. We have been working on this, as you know, for a very long time, and now hundreds of veterans in that area will be able to access the long-term care that they need.

As I have said repeatedly here in this room, when the Nation goes to war, it also commits to taking care of the veterans when

they return home. Their needs are a cost of war, and we will provide for them no matter what. We know many veterans will need VA care for several decades to come. Others will come to the VA for the first time many years after their service has ended. So today I am hoping to hear about solutions to these systemic problems and smart ways to strengthen the VA for the long term, because the VA does need to be there for our veterans, ready to help right away every time.

Thank you, Mr. Chairman, and I yield to Senator Isakson.

STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you, Senator Murray.

Secretary Gibson, thank you very much for accepting this interim responsibility. You are a brave and courageous man. And while I am encouraged by some of the serious steps you have taken, I am still not satisfied. We have tremendous problems as indicated by the letter from Special Counsel Lerner to the President of the United States, from which I want to quote one paragraph, "I remain concerned about the Department's willingness to acknowledge and address the impact of these problems"—meaning the whistleblowers' problems—"may have had on the health and safety of veterans. In particular, the VA Office of Medical Inspector has consistently used the term 'harmless error' as a defense where the Department acknowledges the problem but claims patients have been unaffected. This approach has prevented VA from acknowledging the severity of systematic problems and from taking necessary steps to provide quality care to veterans."

The letter goes on to delineate specific cases where veterans' health suffered because of the agency looking the other way.

I have become personally convinced that this begins and ends with the failure of senior leadership in VA for years to overlook or to look over the manipulation of numbers, to make things look better than they really were, to hope that Congress would not come look. I think Congress is partially to blame for not coming and looking enough.

You know, I learned when I was raising my children that if parents come every now and then, open the bedroom door and look inside, you have a better behaved kid than if you never look inside. I think some of the departments of the VA are exactly the same; and the pervasive culture of cooking the books for personal benefit, such as pay raises, is absolutely inexcusable.

Last, I hope in your remarks, which I am looking forward to, you will address how the memo that was written by Mr. Schoenhard on August 26, 2010, that delineated specifically many of the problems we are now discovering—this was 4 years ago. I don't know how a memo to senior VISN leaders across the network and to senior management could have gone totally without follow-up by anybody in the VA. The problems that we are now trying to fix lasted 4 more years within the VA because there was a culture of just looking the other way when there was a criticism or accountability in place.

So, while I appreciate very much your willingness to come forward as a citizen and take on this interim responsibility, and I ap-

preciate the steps that you have made, I am not satisfied yet that the VA's culture is any different than it has been. We are going to have to see to it that the culture of the VA changes and we have accountability from top to bottom, but in particular, in the senior leadership and management of the Veterans Administration and Veterans Health Care.

I will now yield to——

Senator MURRAY [presiding]. I will just say that a vote has been called, so a number of Senators are going to be leaving. We will go to Senators Tester, Moran, Hirono, and Johanns, and by then the Chairman will return.

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

Senator TESTER. All right. Thank you, Senator Murray, and I want to thank Senators Sanders and Burr, even though they are not here, for their work on this Committee.

Access to health care for our veterans did not pop up overnight. This is a topic that many of us have been working on for years. Solutions must be based on good information. You cannot make good decisions without good information. And hopefully the conversation today will be straightforward and frank so we can get down to some solutions.

It is going to require tough decisions. It is going to require some creativity. It will require focus and engagement from folks on the ground and in Washington that lasts well beyond the media span. Veterans deserve better than to have folks jump on the latest crisis or two and then you never hear about it again. They want answers. They want solutions. They want the benefits that they have earned, not press releases.

I am approached by veterans every time I go home, whether it is in the grocery store or at the service station. They are direct, they are straightforward, and they give me the best view of what is happening on the ground with the VA. In fact, this Friday I am going to be holding another roundtable, this time in the capital city of Helena, MT, to hear from veterans about the VA and the services that they are getting and the difficulties they are having, along with the successes.

Since our last hearing on VA health care, the VA conducted a nationwide audit. They found that the biggest obstacle to timely medical care at the VA is the lack of service providers. It is a lack of service providers. I am looking forward to hearing from the VA on this audit and the follow-up actions moving forward.

Since our last meeting, the White House has also completed a review on issues impacting access to care. This review echoed what we have already heard, that the VA provides high-quality health care once the veterans get in the door. The review also learned that the VA's scheduling technology is outdated—I believe 30 years old. It is secondary to the need for additional resources such as doctors, nurses, and other health care professionals, physical space, and appropriately-trained administrative support personnel.

Since our last hearing, the Senate also passed a comprehensive bipartisan bill that would address some major issues impacting access to timely medical care at the VA. It passed by an over-

whelming 93 votes. We seldom get 93 votes for anything in the U.S. Senate.

Right now we are conferencing that bill. We are in the fourth week. There is not much to show for it. Those questions would be good to get answered today, too, because I think some members of the conference committee are balking at the cost. Look, we just shipped 800 folks off to Iraq. I did not hear one person talk about cost.

Back in 2003, when we invaded Iraq, I was not here, but I certainly never heard anybody talk about the cost and making sure that there were offsets for that cost.

Look, these folks went to war. They performed incredibly well. Some of them came back missing arms and legs. Some of them came back with mental health conditions that they did not have when they left or health problems they did not have when they left.

It is very frustrating from my perspective coming from a State where we are about 22 doctors short to hear folks on the conference committee a few weeks back say, "What we need to do is we need to schedule more patients for the doctors. That will solve the problem." That will not solve the problem. We need more health care professionals on the ground.

And, Sloan, I hope to hear from you today on those issues about what those deficiencies are, because I think it is critically important that we get our arms around that as a Committee so that we can move forward, so that we can provide the kind of accountability that needs to happen within the VA to make sure that ultimately the veterans get the care they deserve.

I will tell you something right now. I am very concerned that this conference committee will end up taking a step backward for veterans' health care in this country. That cannot happen. Veterans deserve better. They have earned the health care. We need to make sure we step up to the plate, give VA the resources they need, and then hold them accountable for the job that they do. Veterans deserve our best. They have demonstrated their best in the field. We need to demonstrate our best as policymakers and you folks as leaders of the VA.

With that, I would yield the floor to my friend, Senator Moran.

STATEMENT OF HON. JERRY MORAN,
U.S. SENATOR FROM KANSAS

Senator MORAN. Thank you very much.

Mr. Secretary, thank you for joining us. Thank you very much for having a conversation with me by phone several weeks ago. I appreciate that outreach. It has been one of the experiences that I have had in recent years with the VA that leaves me feeling that I have no ability to convey the concerns of Kansas veterans. We have the ability to convey that information to the Department, but receive virtually no response time and time again. So, I appreciate the fact that you took the time to have a telephone conversation with me.

I am going to present to you today, or shortly, a letter that I have compiled addressed to you. I heard the testimony from the House Veterans' Affairs Committee last week in which some of the topic was about whistleblowers and the apology that the Depart-

ment made. What I have discovered as a result of what has transpired over the last several months is that many Kansans, veterans in particular, but also many employees of the Department of Veterans Affairs, are presenting me now with stories of problems within the VA, and they are reluctant, in fact, disinclined, to present that information as a whistleblower in a formal way because of fear of retribution and concern about their future and their employment.

So, Mr. Secretary, we will be providing you an outline of things that we still consider significant challenges and problems in my homestate of Kansas.

I indicated several months ago that I had been a member of the Veterans Committee since I came to Congress, 14 years in the House, 4 years in the Senate, and there have always been challenges at the VA. There are always challenges in health care. What seems to me to be different today, Mr. Secretary, and it has occurred over time, is the recognition that the VA, in a sense, was just shrugging its shoulders, no real attention to problems, and what that resulted in, then, were veterans telling me that they no longer had faith in the Department of Veterans Affairs to provide the services that they are entitled to as military men and women of our country.

So, I thought a change in leadership at the Department of Veterans Affairs was required. It is now taking place. I look forward to meeting Mr. McDonald this afternoon in my office. But, what I know is that only changing the Secretary, only changing the top leadership is insufficient to solve the problems that exist.

So, I look forward to working with you during your time at the Department of Veterans Affairs to see that the results are things that we all can be proud of and that the commitments that we have made to our veterans are kept.

Most of my conversations with Secretaries of Veterans Affairs—I think there have been nine of them in my time—have dealt with rural issues, and I want to explore that with you today in your testimony. First, I am very anxious to hear about the steps that you are taking to change the nature—so it does not matter whether you are an urban, suburban, or rural veteran—that the Veterans Affairs Department is something different than it has been over the last several years. Then I will be happy to get to the issues that we face in a rural State like ours.

Mr. Secretary, as we know, change is necessary. I want to do everything I can to make certain that the Department of Veterans Affairs has the tools necessary. It has been my commitment since I came to Congress, but I need the commitment from the Department of Veterans Affairs that those resources that they are provided, the tools they are given, are going to be used in a cost effective, compassionate, and caring way, and that there is an attitude at the Department of Veterans Affairs that there is no higher calling than to take care of the men and women who served our country.

Thank you, sir.

Chairman SANDERS [presiding]. Thank you, Senator Moran.

Senator Hirono.

STATEMENT OF HON. MAZIE HIRONO,
U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Acting Secretary Gibson, for being here, and thank you, Chairman Sanders and Ranking Member Burr, for our continuing focus on the issues and challenges facing the VA.

When the issues relating to wait times first arose over a month ago, the situation was described as an emergency. There was a sense of urgency. And, I want this Committee and this Congress to continue to be motivated by the sense of urgency and to continue to recognize that this emergency needs to be addressed, because there is every potential for other issues to come to the fore and for Congress to be distracted, important as these other issues may be. We owe it to the veterans to stay the course.

I share the sentiments of the Chairman and many of the Members' statements this morning that we need to hear from you your short-term solutions for addressing the issues at hand and over the long term to address the systemic problems and challenges facing VA.

I, like so many of my colleagues, have been visiting with the veterans in my State, frankly, long before the particular crisis arose. And, of course, they have shared with me their concerns about the lack of doctors, the changeover of doctors, and those are some of the practical considerations that they have raised with me.

So, most of us—I think all of us—have had the opportunity to talk with veterans in our communities one-on-one and we have a commitment to make sure that we continue to stay the course. That, to me, is the most important thing that this Committee can do, and I thank the Chairman for not allowing us to move on to other matters that may be pressing, but what could be more pressing than to make sure that our veterans receive the care that they need and deserve.

Thank you, Mr. Chairman.

Chairman SANDERS. Other members will be filtering back, but I would like to hear from the Acting Secretary now. Customarily, we give 5 minutes, but you will have more time. This is a serious discussion and we want you to have the time you need to make your case and we want the Members here to have the time they need to ask you their questions.

All right. Senator Burr suggests that we should wait a few minutes to make sure that other Members get back here, so let us take a very quick recess. [Recess.]

Let us reconvene, and Senator Johanns, I think we are ready for you and your opening statement.

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Thank you, Chairman Sanders and Ranking Member Burr, for convening another very important hearing to address issues at the VA. It is critical that we continue to have these oversight hearings to do everything we can to hold VA's feet to the fire and make sure that accountability is there.

We know some things now that we did not know at the last hearing. We know for a fact that VA's wait list manipulation and access

to care issues is, in fact, systemic. Report after report has confirmed this. In fact, 77 facilities are currently under investigation by the VA Inspector General. That is an astounding number. And, I believe the scheduling problems are the tip of the iceberg. Now we have allegations of whistleblower retaliation and improper payment of claims. The cancer does not seem to stop, but it must be stopped.

While I appreciate your efforts, Secretary Gibson—I think you have done some things and they are recognized and acknowledged—but I think we would all acknowledge there is so much more to be done.

There has to be accountability for wrongdoing or these issues will continue and the Senate will have more hearings, not only next week or the week after, but in 5, 10, 20 years from now.

There is a serious lack of leadership from the top. The White House needs to have a more visible role in addressing the crisis. We, collectively, have the ability to fix this agency. We just have to find the will and the common ground to do it. All of us have to be a part of the solution.

In May, during our last committee hearing, I encouraged the expanded use of non-VA care to get urgent treatment to those veterans that were languishing on both secret and official waiting lists. The bill recently passed by the Senate gives greater flexibility and treatment options for veterans faced with long wait times or lengthy travel. The "choice card" injects much-needed competition, in my opinion, into the process, and it demands of the VA that they get their act together.

The accountability and transparency pieces of the legislation are not only important, they are critical. The notion that employment should be tied to performance might seem elementary to most people, but this has not been happening at the VA. There have been several instances in which senior VA executives who were involved in mismanagement or negligence were not reprimanded, but instead received bonuses and positive performance reviews. Shameful.

And, while Senior Executive Service employees can be disciplined and fired under current law, it is a very long and very drawn-out process. Again, that does not work.

The Secretary needs the authority this bill provides to cut through bureaucratic red tape and, most importantly, to hold individuals responsible. We have to root out the culture of corruption that is contributing to nearly all of VA's most pressing issues.

It is a huge challenge, but we can and must get the VA back on track and focused on their core mission of providing quality health care to our veterans. They deserve nothing less.

Thank you, Mr. Chairman. I yield back.

Chairman SANDERS. Thank you, Senator Johanns.

Now, I want to take this opportunity to welcome Mr. Sloan Gibson, Acting Secretary of the VA. Thank you very much for joining us to give us an update on the state of health care at the Department of Veterans Affairs. We look forward to hearing your testimony.

Secretary Gibson is accompanied by Mr. Philip Matkovsky, the Assistant Deputy Under Secretary for Health for Administrative Operations.

Your prepared remarks will be submitted for the record.

Secretary Gibson, please begin.

STATEMENT OF SLOAN GIBSON, ACTING SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PHILIP MATKOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATIVE OPERATIONS, VETERANS HEALTH ADMINISTRATION

Mr. GIBSON. Mr. Chairman, forgive me if I dispense with the traditional niceties and get straight to business. As has been recounted this morning, we have serious problems. Here is how I see the issues.

First and foremost, veterans are waiting too long for care.

Second, scheduling improprieties were widespread, including deliberate acts to falsify scheduling data.

Third, an environment exists where many staff members are afraid to raise concerns or offer suggestions for fear of retaliation.

Fourth, in an attempt to manage performance, a vast number of metrics have become the focal point for staff instead of focusing on the veterans we are here to serve.

Fifth, VA has failed to hold people accountable for wrongdoing and negligence.

And, last, we lack sufficient clinicians, direct patient support staff, space, information technology resources, and purchased care funding to meet the current demand for timely, high-quality health care. Furthermore, we do not have the refined capacity to accurately quantify our staffing requirements because, historically, we have not built our resource requirements from the bottom up. We have instead managed to a budget number.

As a consequence of all these failures, the trust that is the foundation of all we do, the trust of the veterans we serve and the trust of the American people and their elected representatives, has eroded. We will have to earn that trust back through deliberate and decisive action and by creating an open, transparent approach for dealing with our stakeholders to better serve veterans.

To begin restoring trust, we focused on six key priorities. Get veterans off wait lists and into clinics. Fix systemic scheduling problems. Address cultural issues. Hold people accountable where willful misconduct or management negligence are documented. Establish regular and ongoing disclosures of information. And, finally, quantify the resources needed to consistently deliver timely, high-quality health care.

Here is what we are doing now. VHA has reached out to over 160,000 veterans to get them off wait lists and into clinics and made over 543,000 referrals for veterans to receive care in the private sector, 91,000 more than in the comparable period a year ago. This is in the last 2-month period. And, I would point out here that for each of those referrals, on average, they result in seven visits to a clinician.

VHA facilities are adding more clinic hours, aggressively recruiting to fill physician vacancies, deploying mobile medical units,

using temporary staffing resources, and expanding the use of private sector care. We are moving rapidly to augment and improve our existing scheduling system while simultaneously pursuing the purchase of a commercial off-the-shelf, state-of-the-art scheduling system.

I have directed medical center and VISN directors to conduct monthly inspections in person of their clinics to assess the state of scheduling practices and to identify any related obstacles to timely care for veterans. To date, over 1,100 of these visits have been conducted.

We are putting in place a comprehensive external audit of scheduling practices across the entire VHA system. We are building a more robust continuous system for measuring patient satisfaction, which I believe will be central to our measurement processes in the future.

I have personally visited ten VA medical centers in the last 6 weeks to hear directly from the field on the actions being taken to get veterans off wait lists and into clinics. I leave later today for Albuquerque and El Paso.

The inappropriate 14-day access measure has been removed from all individual employee performance plans to eliminate any motive for inappropriate scheduling practices. In the course of completing this task, over 13,000 performance plans were amended.

Where willful misconduct or management negligence is documented, appropriate personnel actions will be taken. This also applies to whistleblower retaliation. I am sure we will talk about that further.

I have frozen VHA central office and VISN office headquarters hiring as a first step to ensure that we are all working to support those delivering care directly to veterans.

VHA has dispatched teams to provide direct assistance to facilities requiring the most improvement, including a large team on the ground right now in Phoenix.

All VHA Senior Executive Performance Awards for fiscal year 2014 have been suspended.

VHA is expanding our use of private sector health care to improve access.

I sent a message to all 341,000 VA employees and have reiterated during every single visit to VA facilities that whistleblowers will be protected. We will not tolerate retaliation against whistleblowers.

I have conducted over a dozen meetings and calls with senior representatives of VSOs and other stakeholder groups to solicit their ideas for improving access and restoring trust.

I have named Dr. Carolyn Clancy Interim Under Secretary for Health. She will spearhead our immediate efforts to accelerate veterans' access to care and restore the trust of veterans.

Dr. Jonathan Perlin, a former Under Secretary for Health at VA, currently on leave of absence from his duties as Chief Medical Officer and President of Clinical Services for Hospital Corporation of America, has begun his 2-month assignment at VA as Senior Advisor to the Secretary. Dr. Perlin's expertise, judgment, and professional advice will help bridge the gap until VA has a confirmed Under Secretary for Health.

Dr. Gerald Cox has agreed to serve as Interim Director of the Office of Medical Inspector, a Navy Medical Officer for more than 30 years and the former Assistant Inspector General of the Navy for Medical Matters. Dr. Cox will provide new leadership and a fresh perspective to help restructure OMI and ensure a strong internal audit function.

As we complete reviews, fact finding, and other investigations, we are beginning to initiate personnel actions to hold those accountable who committed wrongdoing or were negligent in discharging their management responsibilities. To support this critical work, Ms. Leigh Bradley has begun a 4-month assignment as Special Counsel to the Secretary. Ms. Bradley is a former General Counsel at VA and most recently a senior member of the General Counsel team at the Department of Defense, where she had direct responsibility for the ethics portfolio for DOD.

Before I conclude, let me briefly address the need for additional resources.

I believe that the greatest risk to veterans over the immediate-to-long-term future is that additional resources are provided only to support increased purchased care in the community and not to materially remedy the historic shortfall in internal VA capacity. Such an outcome would leave VA even more poorly positioned to meet future demand.

We have been working closely with the Office of Management and Budget for several weeks to develop the request for funding. While the amounts under consideration are large in the context of VA's size, scope, and existing budget, they represent moderate percentage increases in annual expenditures. Furthermore, a substantial portion of the funds required are non-recurring investments in space and information technology that would not be reflected in long-term run rates.

Resources required to meet current demand, covering the remainder of fiscal year 2014 through fiscal year 2017, total $17.6 billion. These funds address only the current shortfalls in clinical staff, space, information technology, and purchased care necessary to provide timely, high-quality care.

In closing, we understand the seriousness of the problems we face. We own them. We are taking decisive action to begin to resolve them. The President, Congress, veterans, VSOs, the American people, and VA staff all understand the need for change. We must, all of us, seize this opportunity. We can turn these challenges into the greatest opportunity for improvement in the history of this Department. I believe that in as little as 2 years, the conversation can change, that VA can be the trusted provider of choice for health care and for benefits.

If we are successful, who wins? The growing number of veterans that turn to VA for health care each year. The 700,000 veterans who are currently diagnosed with post-traumatic Stress Disorder. The million Iraq and Afghanistan veterans that have turned to VA for health care since 2002. And, the average veteran who turns to VA for health care who is older, sicker, and poorer than average patients in the private sector. These are the veterans who will win when VA becomes the trusted provider of care and benefits.

That is what and where we want to be in the shortest time possible. Our ability to get there depends on our will to seize the opportunity, to challenge the status quo, and to drive positive change.

I appreciate the hard work and dedication of VA employees, the vast majority of whom I continue to believe care deeply about the mission, want to do the right thing, and work hard every day to take care of veterans. As well, I appreciate our partners from the veterans service organizations, our community stakeholders, and dedicated VA volunteers.

Last, I deeply respect the important role that Congress and the Members of this Committee play in serving veterans, and I am grateful to you for your long-term support. I am prepared to take your questions.

[The prepared statement of Mr. Gibson follows:]

PREPARED STATEMENT OF HON. SLOAN D. GIBSON, ACTING SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Senate Committee on Veterans' Affairs, thank you for the opportunity to discuss with you the Department of Veterans Affairs (VA) health care system. We at VA are committed to consistently providing the high quality care our Veterans have earned and deserve in order to improve their health and well-being. We owe that to each and every Veteran that is under our care.

As the Chairman noted in May 2014, the Veterans Health Administration (VHA) operates the largest integrated health care delivery system in the United States. VHA has over 1,700 sites of care, including 150 medical centers, 820 community-based outpatient clinics, 300 Vet Centers, 135 community living centers, 104 domiciliary rehabilitation treatment programs, and 70 mobile Vet Centers. VHA conducts approximately 236,000 health care appointments every day and approximately 85 million appointments each year. Over 300,000 VHA leaders and health care employees—many who also are Veterans—strive to provide exceptional care to nearly 6.5 million Veterans and other beneficiaries annually.

The Chairman also noted in May 2014 that there are things that VA does very well, and there are areas that need improvement. My testimony today will provide some updates on a number of actions that the Department has taken since the last hearing in May 2014.

We know that unacceptable, systemic problems and cultural issues within our health care system prevented some Veterans from receiving timely care. That breach of trust—which involved inaccurate reporting of patient wait times for appointments—is irresponsible, indefensible, and unacceptable to the Department. We apologize to our Veterans, their families and loved ones, Members of Congress, Veterans Service Organizations (VSO), and to the American people. We can and must solve these problems as we work to earn back the trust of Veterans.

NATIONWIDE DATA ON ACCESS TO VETERANS HEALTH CARE

At VA, our most important mission is to provide the high quality health care and benefits Veterans have earned and deserve—when and where they need it. In mid-April, VA began a nationwide Access Audit to assess the integrity of our scheduling practices, the adequacy of training, compliance with policy, and proper use of systems. As a result of the audit, we now know that in many communities across the country Veterans wait too long to receive care.

As of July 8, 2014, VHA has reached out to over 160,000 Veterans to get them off wait lists and into clinics sooner. Also, between May 15 and June 30, 2014, we have made over 430,000 referrals for Veterans to receive their care in the private sector. VA made roughly 351,000 referrals during this same time period last year in 2013, an increase of roughly 79,000. As we continue to address systemic challenges in accessing care, we are providing regular data updates[1] to enhance transparency and provide the immediate information to Veterans and the public on improvements to Veterans' access to care. We are fully committed to fixing the problems we face in order to serve Veterans better. We know that we must not only re-

[1] http://www.va.gov/health/access-audit.asp

store the public's trust in VA, but more importantly, we also must restore the trust of our Veterans who depend on us for care.

Following the release of results from VA's nationwide Access Audit, along with facility level patient access data, I personally visited VA medical centers in Fayetteville, NC; Gainesville, FL; Baltimore, MD; Washington, DC; Columbia, SC; Philadelphia, PA; Augusta, GA; and Jackson, MS, to gain a clearer understanding of the extent of the problems that we face.

The following actions have been taken in response to the nationwide Access Audit findings and data:

- Removing 14-Day Scheduling Goal
  VA has eliminated the unrealistic 14-day access measure from all employees' performance plans. This action will eliminate incentives to engage in inappropriate scheduling practices or behaviors. As of July 3, over 87,000 performance plans have been reviewed and over 13,000 performance plans have been amended, including over 3,500 front line schedulers.
- Mandated Site Inspections
  Medical Center Directors and VISN Directors are responsible for ensuring Veterans receive timely, high quality healthcare. As of June 17, every Medical Center Director has been conducting in person visits to every clinic. Site inspections include observing daily scheduling processes and interacting with scheduling staff to ensure all policies are being followed. In addition to monthly reviews of VHA facilities nationwide, VISN Directors will also conduct similar visits to at least one medical center within their area of responsibility every 30 days, completing visits to all medical centers in their network every 90 days. This action ensures leadership knowingly accepts accountability for the integrity of scheduling practices. As of July 9, 683 site inspections have been completed.
- Establishing New Patient Satisfaction Measurement Program
  VHA immediately began developing a new patient satisfaction measurement program to provide real-time, robust, site specific information on patient satisfaction, including satisfaction measurements of those Veterans attempting to access VA health care for the first time. This program will include input from VSOs, outside health care organizations, and other entities.
- Holding Senior Leaders Accountable
  Where audits identify concerns within a medical center clinic, VA will trigger administrative procedures to ascertain the appropriate follow-on personnel actions for specific individuals. We will hold people accountable where misconduct is found.
- Ordering an Immediate VHA Central Office and Veterans Integrated Service Network (VISN) Office Hiring Freeze
  VA has redirected its focus and resources to staffing at the facility level to increase personnel who can directly serve Veterans.
- Increasing Transparency by Posting Access and Patient Wait Time Data Twice-Monthly
  VHA is now posting regular updates to the access data released at the middle and end of each month at VA.gov. The first one of these was on June 9, 2014. These twice-monthly data updates will enhance transparency and provide the immediate information to Veterans and the public on Veterans access to VA health care.
- Initiating an Independent, External Audit of Scheduling Practices
  I directed that an independent, external audit of system-wide VHA scheduling practices be performed. We are working with an outside private entity to conduct the audit and anticipate initiating these audits early next fiscal year.
- Utilizing High Performing Facilities to Help Those That Need Improvement
  VHA will formalize a process in which high performing facilities provide direct assistance and share best practices with facilities that require improvement on particular medical center quality and efficiency performance measures.
- Suspending Performance Awards
  VA has suspended all VHA senior executive performance awards for fiscal year 2014.
- Enhancing Non-VA Care
  VHA is employing guidelines for using private sector care to improve access to health care for Veterans who are or who may experience excessive wait times for primary, specialty and mental health care. VHA is now operationally monitoring the effectiveness of our sites use of non-VA care to ensure Veterans are receiving their timely care.
- Quickly Bringing in Veterans for Care

VHA facilities are improving access to health care for Veterans by: adding more clinic hours to evenings and weekends, recruiting to fill physician vacancies, deploying mobile medical units, using temporary staffing resources and expanding the use of private sector care.

SCHEDULING SYSTEM UPDATES

VA recognizes that its medical appointment scheduling system is antiquated and we are replacing it through an acquisition process. VA hosted pre-solicitation "Industry Day" meetings with technology vendors on June 18 of this year to discuss the Department's upcoming scheduling system acquisition. This Industry Day presented an important opportunity for VA to communicate directly with potential vendors on all aspects of the upcoming scheduling system acquisition. The Industry Day served as a face-to-face platform for exchanging information about business needs, industry best practices, and challenges specific to VA's scheduling system. We recognize the need to develop lasting, long-term reforms, including a complete overhaul to replace the outdated technology for our scheduling system. Bringing an innovative scheduling product into our world-class electronic health record system is a crucial part of providing the scheduling staff in our facilities with the necessary tools to succeed.

VA's scheduling technical requirements are complex and require clear, well-articulated communication to ensure comprehensive understanding by industry and potential vendors. VA conducted a live scheduling system architecture question-and-answer session to ensure potential solutions seamlessly interface with VA's Veterans Health Information Systems and Technology Architecture electronic health record. The information shared during the Industry Day will provide VA with a better understanding of what needs to be included in the upcoming scheduling system solicitation, with the ultimate goals of receiving solid proposals and reducing time to field new technologies.

WHISTLEBLOWER PROTECTIONS

At VA, we depend on the service of VA employees and leaders who place the interests of Veterans above and beyond self-interest, and who live by VA's core values of Integrity, Commitment, Advocacy, Respect, and Excellence. On June 13, 2014, I sent a message to all VA employees regarding the importance of whistleblower protection and met with employees at VA medical centers across the country to reemphasize that message. I reminded all 341,000 of our employees in messages and during site visits to VA facilities around the country that we must protect whistleblowers and create workplace environments that enable full employee participation. Intimidation or retaliation—not just against whistleblowers, but against any employee who raises a hand to identify a problem, make a suggestion, or report what may be a violation in law, policy, or our core values—is absolutely unacceptable.

Following the recent release of the Office of Special Counsel's (OSC) recommendations to President Obama, I directed an immediate review of the Office of the Medical Inspector's (OMI) operation, process, and structure. After I was briefed on this review, I determined a clear need to revise the policies, procedures, and personnel structure by which OMI operates, and I directed a restructuring of the organization. As long-term restructuring moves forward, I have appointed an interim Director of OMI from outside the current office to assist with transition, and VA has suspended OMI's hotline and is currently referring all hotline calls to Office of Inspector General (OIG). On July 2, 2014, I met with Carolyn Lerner, Special Counsel of the United States Office of Special Counsel. VA has begun the process of completing the OSC 2302(c) Certification Program and is focused on ensuring protection from retaliation for employees who identify or report problems. Special Counsel Lerner and I identified ways to streamline the organizations' work together to ensure whistleblower protection during the course of an OSC investigation.

SUMMARY

VA has also recently initiated the process of selecting the next Under Secretary for Health of VHA—one of the most important jobs in government today. VHA's new leader will be a change agent and deliver necessary reforms to provide our Veterans timely access to the world-class health care that they have earned through their service and sacrifice.

These are just a few of VA's actions to improve Veteran's access to high quality health care. There is always more work to do, and VA is focused on continuous improvement to the care we provide to our Nation's Veterans. I appreciate the hard work and dedication of VA employees, our partners from VSOs—important advocates for Veterans and their families—our community stakeholders, and our dedicated VA volunteers. Just two weeks ago, I met with the leadership of 26 Military

and Veterans Service Organizations (MSOs and VSOs) to reaffirm VA's commitment to work together to address the unacceptable, systemic problems in accessing VA health care. During this meeting, I updated the organizations' representatives on VA's work to restore Veterans' trust in the system and on VA's progress in reaching out to get Veterans into clinics and off of waiting lists. I appreciate MSOs and VSOs for being VA's valuable partners in serving Veterans and continuing to improve the Department, and I solicited their ideas on how VA can improve Veterans' access to care and services.

I also respect the important role Congress and the dedicated Members of this Committee play in serving our Veterans. I look forward to continuing our work with Congress to ensure Veterans have timely access to the quality health care they have earned.

Again, thank you for the opportunity to appear before you today and for your unwavering support of those who have served this great Nation in uniform.

Chairman SANDERS. Well, Mr. Acting Secretary, thank you very much for not dealing with niceties, for dealing with realities.

As I understand it, we are talking, in a broad sense, about two very serious problem areas. Number 1, I trust that every Member of this Committee understands that we have an immediate crisis, that we have hundreds of thousands of veterans on wait lists, that those folks must get the medical care they need in a timely manner. I am pleased to see, Mr. Acting Secretary, that you have moved aggressively in that area.

But, if I understand you correctly, the second point you made is that while it is important we put out the current fire, unless we effectively deal with the long-term capacity issues facing the VA, we are going to be back here year after year with similar types of problems.

You mentioned the number, and I want you to get into some detail. What are we talking about?

Let us just start off with personnel. How many doctors, how many nurses, how many other types of medical personnel do you need to achieve that goal? Be as specific as you possibly can—and, how much is that going to cost?

Mr. GIBSON. Mr. Chairman, of the $17.6 billion, approximately $10 billion is allocated for a combination of purchased care and hiring additional clinical staff. The blend of that will change over time as we ramp up that capacity, as we are successful in hiring people, yes——

Chairman SANDERS. Is it fair to say that to the degree that we strengthen the VA, we become less dependent on expensive contract care? Is that a fair statement?

Mr. GIBSON. It is absolutely a fair statement, Mr. Chairman.

Chairman SANDERS. OK. Please continue. I interrupted you.

Mr. GIBSON. So, over the 3-plus-year period of time that $10 billion gets allocated—a portion to purchased care, probably more on the front end than on the back end as we are successful in hiring.

As I mentioned in my opening statement, you know, our ability to develop highly-refined bottom-up estimates of specific physician and clinician requirements is pretty limited. Our best estimates at this time is that this would—that closing this gap would require hiring approximately 10,000 additional clinical staff. Those are divided among primary care, specialty care, and mental health care. And, of the 10,000, roughly 1,500 of those are actually physicians. Others are nurses and nurse practitioners and other direct patient support staff.

Chairman SANDERS. You talked about space.

Mr. GIBSON. Yes, sir.

Chairman SANDERS. I trust that you are not talking about building some Las Vegas-type expensive buildings. What is the relationship between space and the emergency that we currently have in terms of waiting periods?

Mr. GIBSON. I will tell you, Mr. Chairman, in every medical center I visited except one, and that is in Augusta, the number 1 constraint that they are operating under right now is space. Fayetteville, NC, for example, is growing their patient population at a 7-percent annual rate. And, when it takes us 5 or more years to get a building out of the ground, it does not take long to fall behind.

So, where we are today as a Department is we are behind in terms of the space required today to serve patients, that there are $6 billion included in the $17.6 billion total that is designed for infrastructure.

Chairman SANDERS. And, can you tell us what are those projects? Do you have them?

Mr. GIBSON. There are—I am going to ask Philip to go into some of the details—there are eight major projects there. There are 77 lease projects for outpatient clinics that would add about two million square feet and roughly four million appointment slots. And then there are both minor construction and non-recurring maintenance that would add several million—roughly four million, in round numbers—additional outpatient visit slots there.

Chairman SANDERS. We have heard time and time again that the dysfunctionality in terms of appointments for the VA has something to do with a significantly outdated scheduling system. Can you say a word on that?

Mr. GIBSON. There are actually four parallel tracks underway right now dealing with the scheduling system. There are 11 existing defects in the system that are being patched as we speak.

There are four different interfaces that are in the process of being developed to make it easier for schedulers to access and to actually provide the opportunity for veterans to be able to directly access their schedule.

On the 11th of July, we let a contract for major enhancements to the existing scheduling system that will remedy many of the most egregious problems that we have right now that make it hard to deal with.

Then, parallel with all of that, as I mentioned in my statement, we are pursuing the acquisition of a commercial off-the-shelf, state-of-the-art system. That is probably 2 years down the road in terms of actually having that functionality in place, which is why we are pursuing these other tracks in parallel.

Chairman SANDERS. All right. Let me conclude. I have gone over my time. If we do not have the resources at the VA to address issues like hundreds of thousands of folks coming home with PTSD and TBI, space issues, what happens in years to come?

Mr. GIBSON. The wait times just get longer. We do not—meet any acceptable standard of timely and consistent quality health care. It is—you know, I have committed to the President, I have committed to veterans, I have committed to the staff at VA, I will

not hold back asking for resources because we have not been managing to requirements as a Department.

This would never happen in the private sector. You would never stand for it. You would fail as a business if you did this. It makes no sense and I will not—I am not holding back now and will not hold back in the future.

But, I have also told these folks that have worked on these numbers, I do not want a penny in there that we cannot justify, not one cent.

Chairman SANDERS. OK. I have gone over my time.

Senator Burr.

Senator BURR. Mr. Chairman, thank you.

Secretary Gibson, again, I commend you. You have made all of us go back and sort of ask about numbers because it was not that long ago that we wrote off $127 million for that new software program to do scheduling, and I think that was the second time.

And the $14 billion-plus that we have got currently in the construction and maintenance account, that means that projects are on a 7, 8, 10-year timeline.

So, it is good to see, one, that VA has a sense of urgency; two, that OMB is recognizing the realities of what the needs are.

I have got a set of questions for you, but I intend to send those to you and ask you to respond to them.

I would ask unanimous consent that all Members have an opportunity to do that, Mr. Chairman.

Chairman SANDERS. Without objection.

Senator BURR. Sloan, I want to focus for just a few moments on data integrity specifically at VBA.

I want to give you some examples of testimony provided by the Office of the Inspector General and the General Accounting Office in a House hearing on Monday night.

The Inspector General made these statements; all quotations:

> "We have concerns that VBA's performance goals are not realistic and comprised by data integrity issues."
>
> "We are receiving numbers of serious allegations regarding mail mismanagement, manipulation of dates of claims and other data integrity issues in the Baltimore, Philadelphia, Los Angeles, Oakland, and Houston VA Regional Offices, and today, we received an additional allegation regarding the Little Rock VA Regional Office. We are concerned at how quickly the number of regional offices with allegations is growing."
>
> "VBA removed all provisional rated claims from its pending inventory. VBA's process misrepresented the actual workload of pending claims and its progress toward eliminating the overall claims backlog."
>
> "An Office of Inspector General team sent to Philadelphia Regional Office on June 19, 2014, determined that there were significant opportunities for regional offices to manipulate and input incorrect dates of claims in the electronic record. Incorrect application of date of claim comprises data integrity related to timeliness of claims processing."

Then there is this exchange that took place between Congressman Bilirakis and the Assistant IG, Linda Halliday.

Mr. Bilirakis said, "You remarked in your opening statement that VBA has self-reported a decrease in the national backlog by more than 50 percent since March 2013. Do you trust those numbers?"

Ms. Halliday's response was, "At this point, I would say no; I cannot trust those numbers. I think we have a lot of work ahead of us to address the allegations we have just received. They all seem to focus on data integrity, and they need to be looked at very carefully. So, I do not want to say I trust them."

Near the end of the hearing, Congressman O'Rourke asked Ms. Halliday, "One of the things you said in your opening comment that struck me was that some of the success may be comprised by data integrity issues. [Is there] anything that Secretary Hickey has said tonight that alleviates those concerns that you raised in your opening statement?"

Ms. Halliday simply responded, "No."

Also, on the issue of whether VBA's quality metrics are reliable, the General Accounting Office provided this testimony:

> "In prior work, we have documented shortcomings in VA's quality assurance activities; and more recently, concerns have been raised about the lack of transparency related to the changes in the Agency's national accuracy rate for disability claims."
>
> "In several basic areas, they are not following general statistical procedures. That looseness in their methodology translates to numbers that are not accurate and are not very helpful in terms of looking at trends over time, in terms of performance accuracy rates and/or comparing offices in terms of relative performance. That is not good metrics."

Simply, the Inspector General's Office testified that they, "continued to identify a high rate of errors in regional offices' processing of claims decisions."

Now, Under Secretary Hickey was the one that testified for the VA. And, despite her testimony, which was refuted by the Inspector General, the GAO, VA put out a press release the very next day, entitled "VA Takes Action to Ensure Data Integrity of Disability Claims," in which the VA touts that it has reduced the backlog by 55 percent and has reduced the number of days it takes to process claims and has improved their accuracy rate to over 90 percent.

Now, listen; you have said that you have got to gain the trust of the Committee, of the veteran, of the country, and I think we agree with you.

Let me ask you, how smart was that press release? Did you sign off on that press release?

And how can numbers that were refuted by the people that are actually doing the investigations of VA facilities, how can they refute the numbers and the next day VA come out with the same numbers and tout them?

Mr. GIBSON. Senator, I think, as you have noted, trust is the foundation of everything that we do, and where there are questions

about data integrity I think we have got to bore into those very deeply.

There are a number of issues that have been raised there. I could sit and go through and pick at an item or two, but the fundamental issue remains that there are questions about whether or not we have got good data integrity there. And just as we are undertaking independent reviews in the VHA side, we will undertake those in the VBA side.

Senator BURR. But, Mr. Secretary, they have been underway, much of it initiated by Members of this Committee, with the Inspector General, with the General Accounting Office.

And you have acknowledged the shortcomings on the VHA side.

This is fresh. This is this week. And, still, that press release stresses that the VA will continue to post these performance data on its Web site.

How does publicizing suspect data increase the integrity and the trust that you——

Mr. GIBSON. Senator Burr, I would tell you I come into this organization from the private sector. I look at the transformation that has been wrought in VBA over the last 2 to 3 years, and I defy anybody to show me any major part of the Federal Government anywhere that has transformed that much in that period of time. I think it is amazing, looking at it from a private sector perspective, much less doing it in the context of a Federal Government agency.

There is room to improve there. I got it.

We have got to restore trust there. I got it.

They pulled the 100 percent provisional ratings out, and those did not get counted in the backlog. I got it.

My recollection, round numbers, is it was about 12,000. I may not have that exactly right.

The backlog is down 350,000 in round numbers.

So, I get it. We need to make sure that the data integrity is there, but I am not going to pull back from standing by that Department and the good work that has been done.

You know, we cannot have back and forth between IG. IG has findings, and we have got to embrace those findings.

Senator BURR. Well, I appreciate the Chairman's leniency here.

I am not sure you are embracing those findings, especially in comparison to how you have embraced the VHA findings.

It concerns me because these are veterans that are waiting for their determinations to be made. In some cases, as the IG and GAO have pointed out, it involves overpayments—overpayments that are due the American taxpayer, that are due back to the VA, to help fund other things.

It just strikes me—and I realize this was a VHA hearing—it strikes me that you could have testimony like we had on Monday night and yet turn around and put out a press release still stating the same numbers the next day when every one of the investigators found that those numbers could not be trusted.

So I will work with you. It is an area of great concern. It is as big, if not bigger, a problem than the VHA because the budget is the biggest budget at the VA.

I thank the Chair.

Chairman SANDERS. Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman.

Mr. Secretary, the VA has removed wait time criteria from the performance contracts of network and medical center directors. And I do understand the need to be wary of creating incentives for people to game the numbers, but we also have a serious accountability problem.

How will you still hold network and medical center directors accountable for wait times if it is not in their performance contract?

Mr. GIBSON. I think the first step that we have got to do is get integrity in the data, and so the idea behind pulling that out at this stage of the game was to eliminate any questionable motivation.

Senator MURRAY. Understood.

Mr. GIBSON. I think as we move forward what we are going to find is that average wait times are a very poor gauge for timeliness of care for a large integrated health system. You do not really find that out in the private sector.

That is one of the reasons we are boosting our patient satisfaction measurement activities because I think patient satisfaction is going to become central. Even at a 14-day standard, if the veteran needs to be seen today, we have failed that veteran.

Senator MURRAY. So you are looking for different ways to——

Mr. GIBSON. So I think we are going to be looking at different ways to evaluate timeliness of care. It will be a combination of patient satisfaction. It will be a combination of veterans that are waiting too long and seeing that number coming down steadily; and then, as we have the system capability to do things like you see over in the private sector, metrics like the third next available appointment, which gives you some gauge of the capacity of the system to be able to handle that veteran as they come in.

Today, at least, we are able to look at same-day appointments. Roughly, in the primary care area, we see about 100,000 veterans on a same-day basis every single month in primary care. That, to me, suggests that there is capacity that is being maintained to take care of that veteran who cannot wait 14 days or 21 days or 30 days.

Senator MURRAY. OK. Health care from the private sector does play a critical role in making sure that veterans get their care in a timely fashion, but there are some drawbacks to that care that VA has been trying to overcome, like not being able to get medical records returned to the Department and very little ability to see the quality of care that is provided.

If Congress were to expand the authority for non-VA health care, what steps would be necessary to address those kinds of problems?

Mr. GIBSON. I am going to ask Philip to jump in here in a moment.

One of the biggest challenges we have with purchased care in the community is maintaining continuity of care for the veteran. So, the ability to get information, medical information, medical record information, back and forth is a vital part of this—ensuring the quality of care.

I would tell you if the floodgates open it will present the Department with challenges.

But the fact remains, right now we are referring out roughly a quarter of a million referrals every month to purchased care. And, as I mentioned before, every one of those referrals, on average, will result in roughly seven appointments. That is an awful lot of activity.

Last year, 15 million visits to non-VA providers over the course of the year plus the 85 million outpatient clinic visits that we have is 100 million outpatient visits a year that we are managing.

So, it is already a very large number and a challenge for us, but it would be—if we open the floodgates, it would be an even bigger challenge.

Anything to add there, Philip?

Mr. MATKOVSKY. No, sir.

Senator Murray, the one thing I would add is purchasing care in the community does not absolve us of the requirement, the responsibility, to coordinate that care.

In addition to the assurance that we can both send and receive clinical data, there is just the hands-on coordination required to make sure that an appointment has occurred, that the veteran knows where to go——

Senator MURRAY. Right.

Mr. MATKOVSKY [continuing]. That their family is involved, all the rest of that.

If we just look at the cost of the care alone, we are missing a big responsibility.

Senator MURRAY. So when we look at how we do this and expand that, we have to look at all those issues as well and get them right, or we are just going to create a bigger problem for the future. OK.

Finally, VA has had a lot of difficulty hiring providers for a number of reasons, including pay that is lower than the private sector and, as you mentioned, a very long, cumbersome hiring process plus the challenge itself of hiring in shortage areas in health care anyway because we know there are national shortages, as well.

Now VA does a lot of training for doctors and nurses and works very closely with a lot of our universities.

What more can the VA do to help build the health care workforce that is necessary to meet the needs of the Department and our country?

Mr. GIBSON. That is a great question, ma'am.

I think one of the significant opportunities—and the Chairman and I have talked about this before—are opportunities where we can work collaboratively there, maybe tuition payment programs or tuition reimbursement programs, ways that we can encourage that.

We certainly rely very heavily on our academic affiliations as a source for new clinicians, and we are doing some things from a compensation standpoint as well, where we have got some flexibility to be able to meet local market——

Senator MURRAY. OK. I am very interested in that because I think that that is part of the reason for a backlog as well.

Mr. GIBSON. Yes, ma'am.

Senator MURRAY. I mean, there is a variety of reasons, but we cannot ignore that side of it. So I am interested in hearing more of that.

Mr. GIBSON. Yes, ma'am.

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

Chairman SANDERS. Thank you, Senator Murray.

Senator Isakson.

Senator ISAKSON. Following up on Senator Murray's question about referrals, in particular to the private sector, I wrote down this from your statement. You said you all had recently made 543,000 referrals for veterans for private care.

What percentage of those would you guess were mental health referrals?

Mr. MATKOVSKY. I am sorry. I could hasten a guess, but I would take that one for the record.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOHNNY ISAKSON TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. From May 15, 2014 to July 30, 2014, VHA made approximately 541,000 outpatient referrals. Based on the identified category of care, there were 8,454 referrals that were for mental health services.

Question 2. What is VA doing to ensure coordination of care for mental health patients?

Response. It is the responsibility of the Veteran's treating clinician(s) to lead coordination of care for a Veteran receiving mental health care in the community, in coordination with clinic administrative staff, Health Information Management Service, and the facility staff responsible for the business (clinical and administrative) processes related to Non-VA Medical Care Coordination (NVCC).

The NVCC model is a system of business processes that standardize front-end business processes and improve patient care coordination VA-wide.

In the NVCC model, the Veteran is notified of the approval of non-VA medical care and contacted to identify availability, preferences, and needs. Once this information has been obtained, the non-VA medical care provider is contacted to schedule an appointment for the Veteran. The appointment is then captured in VistA. The Veteran and non-VA medical care provider are sent the authorization and the appropriate release of information form, to ensure the medical records are received by VA.

After the appointment date, the Veteran is contacted to verify that the authorized non-VA medical care has been received. If the Veteran missed or did not attend their medical appointment, VA staff will work with the Veteran to reschedule the missed appointment. NVCC staff will then work with the non-VA medical care provider to obtain the required clinical documentation. The documentation will then be scanned into the appropriate system, and uploaded to the Veteran's electronic medical record. If additional review and follow-up action is required from the referring VA provider once the clinical documentation is received, an alert will be sent to notify the VA provider of the required action.

At the Atlanta VAMC, in particular, since 2013, VHA has greatly consolidated the number of contract providers it utilizes for mental health services, from 26 to 5, to ensure there is greater coordination of patient care.

Senator ISAKSON. The reason I ask that question is I got into the Atlanta VA starting in August of last year when we had two suicides and a drug overdose.

When we dug down, they were using a community-based provider for mental health. VA would see the patient, refer them to the community-based provider, with no follow-up between the referral and the appointment. And, in that period of time, when the person was determined to be at risk for themselves and their own life, in two cases they took their own life because they did not get timely services on the referral.

I think Mr. Matkovsky made an interesting observation about coordinated care.

As we expand private sector options in veterans' health care, which we may or may not do—I hope we do in terms of the legislation going forward—care coordination is going to be one of the se-

crets to making that work, not just in reducing wait times but increasing the quality of care to the veterans, particularly with the number, as Chairman Sanders said, the number of veterans seeking mental health care coming forward.

That is going to be an ongoing process. It is going to be one that is going to have to be coordinated and monitored.

My question is, did you ever see the William Schoenhard memorandum?

Mr. MATKOVSKY. Yes, Senator.

Senator ISAKSON. In May, when Secretary Shinseki and Dr. Petzel were here to testify, I asked them both the question, had they seen it?

Dr. Petzel said he had seen it and read it, and Secretary Shinseki said he had not.

I think both of them told the truth. I do not think Secretary Shinseki ever saw it, and I do not think he ever saw it because the senior leadership of the VA did not let him see it.

My experience of a lot of these problems lies at the highest levels of the veterans administration and veterans medical services that insulate the leadership of VA from the problems that they had. Why else would a memorandum written 4 years ago, describing what we are all discovering now in 2014, not have been acted on?

The last sentence of the third paragraph says, "These practices will not be tolerated." It does not say, "Look at this when you get a chance."

And it delineates each of the programs just like the testimony that the whistleblowers gave the other night in the House hearing.

You are an interim secretary. You are going to be handing off, presumably, to Mr. McDonald, who I understand is a well-qualified individual.

Mr. GIBSON. Yes.

Senator ISAKSON. What are you doing to put in place—the type of information transfers and conduits—that will see to it Mr. McDonald does not become a rookie victim as a distinguished general did, in terms of Secretary Shinseki?

Mr. GIBSON. I am not going to let him. I am not going to let my old friend become a rookie victim of anything.

More fundamentally——

Senator ISAKSON. Let me interrupt. I am not being trite when I ask this question.

Mr. GIBSON. No, no, I understand.

Senator ISAKSON. For 4 years the VA insulated its leader, in the case of Secretary Shinseki.

Mr. GIBSON. I would tell you from my own personal perspective I have learned to never have all my information filtered through a couple of people, and so from the first day that I got to VA I started reaching down in the organization to get additional information.

I think your sense is a very accurate one. I think, historically, VHA has operated a fairly insular organization—not fairly, a very insular organization; and I think part of what we have been doing is dismantling a lot of those barriers.

Since my first day as Acting Secretary, every single morning at 9 a.m. we have something called Access Standup. We have senior

leaders from across VHA as well as senior leaders from across the Department. We are up in our integrated operations center, and we are boring into data around access to care:

What is the status?

What are we doing?

How many contacts?

How many appointments?

What are the wait times?

What is the status on many of these different initiatives that I have alluded to in my opening statement?

It is just part of what we are putting in place.

I would have to say this young guy right here—I have said before, if I was half as smart as Philip, I would be darn smart—he has been doing an awful lot of the work to put in place the kind of management information that you are talking about so that we are not just relying on, by chance, that information filters up, that we have got dashboards in place that will help us identify where there is scheduling malpractice. That is in place right now, where there are productivity opportunities for us to wring more productivity out of a particular clinic, that we are able to identify those things, and then, in tandem, requiring medical center directors and VISN directors to get out in their clinics so that they take direct ownership for the consequences.

The first sentence in the memo that provided that direction was, "Medical center directors and VISN directors are directly accountable for the quality of care and the timeliness of care that is delivered by VA."

That was the first sentence, and it was in there because I wrote it.

That is part of ensuring that we have got that kind of accountability, and frankly, it is part of the culture change for the organization. VHA is not used to operating that way.

Senator ISAKSON. Well, my time is up, but with that endorsement of Philip, I have to ask this question; Philip, you are not leaving when Secretary Sloan leaves, are you?

Mr. GIBSON. I am not going anywhere either. I am going to stick around.

Senator ISAKSON. I am talking about in the leadership. Make sure he is at the right hand of Mr. McDonald.

Mr. MATKOVSKY. There are a lot of good people building a lot of good tools.

One of the things that we have a team working on right now is to take that memo and actually develop tools that allow us to mine data to look for those patterns, to give us a risk score at the timeliness data that we are looking at.

So, as we are looking at our timeliness data, Secretary Gibson has directed us to place an integrity score against it and rate it. Are there certain questions? And, if the questions persist, then have an audit come in, take a look at it, and manage it.

Senator ISAKSON. Thank you both very much.

Chairman SANDERS. Thank you, Senator Isakson.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

You are right; there are a lot of good people in the VA building tools and there are also a lot of them delivering some damn good health care on the ground. We need more of them, and we need to get rid of the bad apples that are in that bunch.

Mr. Sloan, you said that you have a concern about purchased care trumping VA capacity. I assume that is during this conference committee and other times, where we will put more emphasis on purchased care and not enough emphasis on VA capacity.

Have you been able to do any sort of cost analysis on providing care for veterans outside the VA? Is it more expensive, less expensive, about the same?

You can kick it over to Matkovsky if you would like.

Mr. MATKOVSKY. There are instances where we have taken what we would consider to be the mix of patients that we would be serving—veteran patients—and the types of services we would provide, and we compare them to a private sector model. Sometimes we do it for a community-based outpatient clinic, sometimes larger.

As a general rule, it tends to be more expensive.

And there are two different types of contract actions that we have used: capitated models and fee-for-service models. They both have their problems.

Senator TESTER. OK. I come from a State where, quite frankly, it is a frontier in a lot of areas. And the private care may or may not solve the problems, but it looks pretty attractive.

If it breaks the budget of the VA, though, and we do not get better health care in the private sector, which I think both of those are up for debate, it can be a problem. That is why I agree with your capacity issue with the VA.

In the meantime, I want to talk about an issue that Senator Moran worked on, and that is Project ARCH. I think it has worked well. It has not been perfect, but it has worked well.

Can I get any assurance from you that ARCH will not be prematurely shut down before it is reauthorized?

Mr. GIBSON. The discussion that Senator Moran and I had the other day was exactly to that issue.

My commitment is we will not, to the extent that I have got the authority—there is some question there—but we will not end a program that is providing access to veterans until we have the robust replacement in place so that there is no lapse in care for the veterans that are being served in Project ARCH.

That is my commitment to Senator Moran. It is my commitment to you and the veterans that we serve.

Senator TESTER. That is good. I mean, I think the Project ARCH definitely works, and it definitely allows you to have control of those medical records too as you move forward, which is a big concern when we start going to the private sector.

Could I ask you, what do you say to folks that say the VA's work shortages are a myth and that the real problem is the medical personnel are just not working hard enough or fast enough?

Mr. GIBSON. I will begin, then I will probably pass it over to Philip for a wrap-up.

I think when you look—I mentioned earlier in my opening remarks, older, sicker and poorer, when you look at the typical VA patient.

First, you start talking panel sizes or RVUs when you are looking at specialty care. You have to take into account the very different patient population that VA is dealing with. So the number of primary care patients that a clinician sees at VA is, in all likelihood, going to be different than what you see in the private sector.

Second, there are oftentimes factors that bear on their ability to see. For example, space, as we talked about that earlier.

I think the average in the private sector for primary care is two and a half treatment rooms for a primary care provider. And I do not think we have good data on what that looks like across VA, but I strongly suspect we do not have those resources.

In the case of specialty care, I would tell you one of the places we are significantly underleveraged—and it is addressed in these numbers in this request—is, on average, we have one support person for every specialty care provider at VA. That compares to a goal, or a target, of three and a half to one in primary care. We are underleveraging our specialty care providers, and as a result they are not seeing as many patients as they ought to be able to see.

So, we get these differences in comparison to the private sector.

I am convinced we are going to see some productivity enhancement, but it also means that we have got some investments to make to be able to deliver those.

Senator TESTER. Will that productivity enhancement meet the needs of the veterans that do not have access to the VA?

In other words, what I am saying is that I was told, for instance, VA-Montana has 22 slots short on docs and nurses are significantly higher than that. Productivity can probably take care of some of those docs—maybe, maybe not.

But, my point is that if we are short 22 docs, it just means harder work for the doctors there, it becomes an issue of are they going to be as happy with the VA. Nine out of ten say they are happy with the service now—the ones that get through the door.

Mr. GIBSON. Let me ask Philip to take just a moment and summarize the process that we have been going through across VA.

Senator TESTER. Yes, that is fine.

Mr. MATKOVSKY. When we did accelerated care, one of the things we pushed out was productivity data for specialty care. I may touch on panel size a little bit because I think there is some criticism there, but we sometimes miss the comparative patient populations when we do that.

We are looking at productivity. We are comparing productivity internally. Where we have highly-productive facilities, we are looking at how they got there. Part of that is smart use of support staff, but part of it is actually just monitoring RVUs and productivity in our appointments that we have available.

Some of that can be covered internally. Some of it will require additional resources. So when we pushed out accelerating care, we asked every facility to look at their productivity numbers as well as whether or not they could increase them; if they could not, to give us a requirement for some non-VA care resources. And we used that as the basis to accelerate care.

Senator TESTER. OK. Thank you very much.

Thank you, Mr. Chairman.

Chairman SANDERS. Senator Moran.

Senator MORAN. Chairman, thank you very much. Again, Secretary Gibson, thank you for your presence today.

Senator Burr and others, including you, have used the word "trust." I have never asked for a Cabinet Secretary's resignation. This is the first time I have ever done that in my time in Congress. And we were indicating at the time that there was a problem with the culture, systemic problems, lack of leadership. It was my sense that all that was true, or I would not have taken the steps that I took.

I was—I do not know—somewhat comforted in the position, but actually, you know, very concerned but what I heard Secretary Shinseki say on the day that he announced his departure, which was something to the point that he had been surrounded by people whose views he trusted that he should not have trusted. The reason that there was some assurance to me is it seems to me that we were right, there is a culture and a systemic problem if the Secretary cannot trust the people that he or she must deal with on a day-to-day basis to provide information.

I want my comments here today to be broad and not provincial just to Kansas. I appreciate the Senator from Montana raising this issue of ARCH, but I want to use that program as an example of why I, as a Member of Congress, have had difficulty trusting the Department of Veterans Affairs. I do not mean this in a personal way. I do not mean to suggest that I am personally offended by the circumstances that have developed over a period of time. What I mean is that my ability to assess what you are doing, to make decisions as a member of the Appropriations Committee, but most importantly, my ability to care for the veterans back home in Kansas is handicapped by the sense that I have had that the Department of Veterans Affairs does not trust us, does not share information with us, is not honest with us, and perhaps most importantly, has rarely responded to issues that we have raised.

Again, this is not a personal concern of mine; it is not like I am personally offended. But when a veteran in Kansas brings an issue to me and I raise it with the Secretary or anyone else at the Department of Veterans Affairs, I think we should be able to expect an honest, fair, and timely response, and it has not occurred. So, my ability to trust the Department of Veterans Affairs has been significantly handicapped.

An example of that is this ARCH program. I authored legislation that ultimately created a pilot program—it got narrowed down to be a pilot program—that says if you live long distances from a VA hospital outpatient facility, you can access that at home by the Veterans Department giving you the ability to do that paying for the service. That pilot program, five of them across the country in rural areas, was created in 2011. I kept continually asking questions of the VA: how is it going? Some pride of authorship, but mostly, is it working? How are veterans—are they liking it? Is it cost-effective? Does the technology work? And we got virtually no answers over a long period of time.

Finally, at the hearing with Secretary Shinseki—this program is about to end. Its 3-year pilot program is coming to a conclusion, although we are pleased to know that you have the authority to ex-

tend it. Secretary Shinseki in March of this year indicated to me that I would have an answer to my question by sunset. Those were his words, "by sunset." I never got an answer.

Then on March 20—and, incidentally, one of the things I have learned since then is that in the spring of 2012, a year after the pilot program gets started, the Wichita VA is interested in promoting this program to rural veterans, and they were instructed by folks in Washington, DC, that you cannot recruit veterans for ARCH and you cannot "market" ARCH.

My concern is that we have created a program that somebody at the Department of Veterans Affairs does not like, so they are out and about trying to make certain they prove is does not work. For somebody at the VA to tell folks in Kansas, "Do not market this, do not encourage veterans to participate," suggests that they wanted failure. So, I became more suspicious as I learned this.

On March 26 of this year, the national program director directed the five pilot programs to notify veterans the program was coming to a conclusion. At the same time—in fact, in April, a week or so later—senior staff at the VA assures my staff and Committee staff that we are continuing to assess the program. Subsequently, we have learned that already the memo has gone out telling those five pilot programs to notify veterans the program will no longer exist, but 10 days later or 2 weeks later, we are assured VA is continuing to assess. That again makes me suspicious about the inability to get the report promised by the Secretary of Veterans Affairs by sunset that I will know what is going on with ARCH.

Then, in June of this year we discovered that there was an email ready to be sent terminating the program. I and several other Senators, including some on this Committee, asked that not to be the case, and we are told just in time the "Send" button was never pushed.

So, there were a series of things that cause us to have great doubts about who is telling us what; what the truth is. And I guess in a more fundamental way, these programs authorized by Congress, can they be easily undermined by personnel at the Department of Veterans Affairs who apparently do not like the suggestions that we have made? This is not a suggestion; this is the law that we passed.

Finally then, our telephone conversation of June 27, I appreciate you reiterating what you just said to Senator Tester. So, that is the circumstance that I find myself in as someone who is a supporter of veterans and, therefore, a supporter of the Department of Veterans Affairs whose mission it is to take care of veterans across our country and our States.

Mr. GIBSON. Just a quick comment. I alluded in my opening remarks to openness and transparency. I think that is central to maintaining trust. And the position that we are in right now, reestablishing trust, this is one of the central cultural issues that we have to deal with as an organization. I would tell you that there is a—I used the word "insular" earlier to describe particularly VHA. As I find it coming into the Department, I think that is the case. As you know, what I have been doing over the last 6 weeks is pushing information out the door as fast and as hard as I can push it out. I prod behind the scenes for responses to Congress, and

we have got a lot of work to do in that regard. We have to earn the trust back.

Chairman SANDERS. Thank you.

Senator Hirono?

Senator HIRONO. Thank you.

We know there are capacity issues at the VA, and I would just like some clarification on some comments or statements that you made. Did you say that based on your assessment of the capacity issues that you would need 10,000 additional staff? I think you were talking about some $17.6 billion that——

Mr. GIBSON. That is correct.

Senator HIRONO [continuing]. You would be requesting.

Mr. GIBSON. That is correct, yes, ma'am. I know that sounds like a huge number. There are 300,000 people in VHA alone.

Senator HIRONO. So is that 10,000 additional staff—and I know you broke it down into how many doctors, et cetera, within the specialties, et cetera. So is that for the emergency situation we have now; or is this an assessment that reflects your long-term staffing needs?

Mr. GIBSON. There was a reference made in one of the opening statements earlier about the findings of the field audit, and the number 1 cause for scheduling difficulties was that there were not sufficient provider slots to be able to schedule patients into. So what we are talking about here, my comment earlier that we have not historically managed to requirements, we have managed to a budget number.

So, basically, we took a budget number, and we did what folks thought they could do. And the veterans wound up being the shock absorber in that process——

Senator HIRONO. So meanwhile, if you are looking at what your true needs are, then you are saying that you would need to hire——

Mr. GIBSON. Yes, ma'am.

Senator HIRONO [continued]. 10,000 additional staff.

Mr. GIBSON. Yes, ma'am.

Senator HIRONO. And that would, of course, depend on the appropriations that we provide.

Mr. GIBSON. Yes, ma'am.

Senator HIRONO. So, if you were to have the appropriations to hire 10,000 people, how long do you think it would take for 10,000 people to be hired? Because one of the things that I did hear about the hiring in VA is that it takes a long time to hire a doctor. So, I hope that in your review you are also looking at your hiring processes, because it should not take a long time, whatever that means. That is one question.

Then to hire 10,000, do you have any sense of how long this would take should you get the funding from us?

Mr. GIBSON. A couple of comments. One, at every single medical facility I visit, I hear from rank-and-file staff that it takes too long to hire. Staffing practices is one of our areas of concentration. My guess is there are some of those things that we are going to find it just a function of being in the Federal Government, and that is the regulation and statute that we have got to follow. But my guess is that we are going to find a large portion of that is self-inflicted,

and we have got to clear that stuff away so that we can hire more expeditiously.

Second, round numbers, I would say in VHA we probably hire 30,000 people every year anyway. So I know 10,000 sounds like a huge number. It is about 3 percent of staff, maybe a little bit less than that. But recognize that some of these are in places like primary care physicians and mental health providers, and we know and you all know that those are tough to find. So, it will take time for us to be able to hire them.

Quite frankly, the other problem we have, even if we could go out and hire them all tomorrow, we do not have a place to put them all. So in some instances, what we are going to have to do is deal with some space issues in tandem with this. We may be able to do—there are actually some provisions in here for what are called Emergency Leases. I actually authorize some of these when I go out to the field where somebody has found some clinic space that is local, that can be occupied quickly—10,000 square feet, something like that—they can go put three patient line care teams in there and take care of an additional——

Senator HIRONO. Excuse me. I do not want to interrupt you, but my time is running out.

Mr. GIBSON. Yes, ma'am.

Senator HIRONO. My concern is mainly that you are addressing the length of time it takes, and if you are hiring 30,000 people every year, there are probably some retention issues that you are also probably addressing.

Mr. GIBSON. It is 10-percent turnover, which, in fact, is relatively low if you look at health care organizations.

Senator HIRONO. That is good. You had mentioned in response to a question that when the IG has findings, to quote you, "we are embracing those findings." And since the problems and challenges at the VA have been longstanding, I wonder whether you have a process or someone in the VA who provides a response to the IG's findings. Should you be providing a report to Congress to respond to the IG's findings so that we also can provide the kind of oversight that Congress should provide as to what is happening at VA?

Mr. GIBSON. There are responses to those, and unless I am mistaken, I believe that those responses are shared. Is that correct, Philip?

Mr. MATKOVSKY. Yes.

Mr. GIBSON. So, there are responses. What I would tell you is that I do not believe that those have always gotten visibility and attention. Some of the examples surrounding the Office of the Medical Inspector and some of those reports, quite frankly, I do not think those were getting the attention that they deserved. So, as we look at overhauling certain of our processes, part of what we have got to do is make sure that the issues that need to be elevated all the way to the Office of the Secretary are, in fact, being elevated.

Senator HIRONO. Yes.

Mr. GIBSON. And that is where somebody says, "We have taken care of this issue," that we know what has been done and we have confirmed that.

Senator HIRONO. I have, Mr. Chairman, just one more item. I was told by the veterans that I have been talking with—many of them live on neighbor islands, so these are rural issues—I was told that even if they got vouchers to go out to get private care, the doctors on the Big Island and Maui would not take veterans so it would not help them. Have you heard that concern?

Mr. GIBSON. I would tell you there are issues around the PC3, Primary Care Close to the Community Contract, that we have got with two different national providers for specialty care, and we do find instances where I think we have got room for improvement. PC3 is a new program, just launched earlier this year, and I do not think we are executing it as well as it needs to be executed. There are discussions going on this week, today, with the leadership of those two programs to make sure that we address those issues.

I get that feedback from staff and from veterans, as well, when I am out in the field.

Senator HIRONO. The main thing, you are addressing that issue also.

Mr. GIBSON. Yes, ma'am.

Senator HIRONO. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Hirono.

Senator Johanns?

Senator JOHANNS. Mr. Chairman, thank you.

Mr. Secretary, in your request for more money, a lot more money, one of the things that you mentioned was new facilities, and the idea behind that is that new facilities may improve productivity and hopefully that results in better services to veterans, that sort of thing. You mentioned that there were eight facilities that would be construction projects. How did you pick those eight? I know of a list out there that if you have a need for a facility, a new hospital say, it makes its way up the list. Did you just pick the top eight? And if you want to toss it over to Philip, that is fine, too.

Mr. GIBSON. I am going to toss this one to Philip, if I could, please.

Mr. MATKOVSKY. Sure. We have a backlog of major construction projects, and these are in major construction items, not in minor construction or non-recurring maintenance. There is a prioritized ranking system that typically—not typically—has rated safety and security issues as the highest. So seismic corrections where we have got seismic deficiencies where, if there were an earthquake, the building would crumble; those have to get fixed. So, there are a number of those.

We also have longstanding space shortages. Every single one of our facilities has a space shortage in terms of meeting patient care needs. I think we need to understand that. These are not abstract numbers. There is not enough space.

But the vast majority of these, the eight projects—they are St. Louis, Louisville, American Lake, San Francisco, Palo Alto, West L.A., Long Beach—for the most part are safety and security high prioritized items because of structural deficiencies. Some of them do have patient care for additional space.

Senator JOHANNS. Would this top eight be the same top eight as the list of 20-some projects that are out there waiting to make their way?

Mr. MATKOVSKY. It is from that list, yes, sir.

Senator JOHANNS. OK. Would they match if I took that list and matched it with what you have just described for me?

Mr. MATKOVSKY. Are you talking about the 26 or 27——

Senator JOHANNS. Yes.

Mr. MATKOVSKY [continuing]. Major leases, or are you talking about——

Senator JOHANNS. No; it is not leases.

Mr. MATKOVSKY. I think you are talking about the historical projects that were ranked and prioritized. It would match, and it would match against that list for the most part. Yes.

Senator JOHANNS. OK. For the most part. What is the "most part" missing here?

Mr. MATKOVSKY. So, "for the most part," just to give you a direct answer, might be the ability to complete a project given the size of the required funding it would fit in, whereas somewhere else that might only be 20 percent of that project. That is what I mean.

Senator JOHANNS. OK. At the Committee's hearing in May, one of the things I talked about—and other Members did, too—is the expanded use of non-VA care to deal with the urgent treatment issues. You know, this is not an academic issue. It never was. It very definitely is not today because we know people died on the VA waiting list. And we know that throughout the system the list was gamed, intentionally and dishonestly, to the detriment of veterans.

Now, there are a lot of ways of handling that, and, Mr. Secretary, let me just be candid with you. I have sat on this Committee now nearly 6 years. Other members have sat on the Committee a lot longer. This Committee has been, I think, very, very generous to the VA. And I kind of find it remarkable—Republicans, Democrats, liberals, conservatives, it has kind of—when General Shinseki would come in, it was like, "What do you need, General?" And it was almost like we would salute when he said what he needed, and out the door he would go with more money, and always made the promise that we were doing better.

Here is my concern. This sounds so similar to what we have heard over the years: "I need more money. I need to be bigger, faster, grander. I need a bigger bureaucracy. I need to hire more people," and on and on and on.

Personally, I think what you need is competition. I think if somebody were biting at your backside because they were providing better care, faster care, honest waiting lists, et cetera, people would go, "Holy smokes, if we do not put our act together, we are going to lose out on this. If we do not see more patients during the day, we are going to lose out on this."

Just let me ask you, what am I missing here?

Mr. GIBSON. I do not know what you are missing. I know that millions of veterans turn to VA for their health care. And as a number of folks have mentioned at various points this morning, an awful lot of veterans continue to believe they get great care.

Access to care is a challenge for many, particularly for new patients, but there is a lot of great care that is being delivered every single day. The challenge is——

Senator JOHANNS. Here is what I would offer, because I am out of time. You know, and I hear this. But at the end of the day, these

veterans fight for our freedoms. Why don't they have the freedom to make their own choice about their health care? And maybe they would say, "By golly, I love the VA. I will stay with the VA until the day I die." But maybe they would say, "That hospital 20 minutes down the road from where I am at is just simply a better situation for me than the hospital that is 250 miles from where I am at, with a long waiting list."

I am totally out of time, and I do not want to impose upon the Chairman's patience, but I just think you guys need competition. And I feel very, very strongly about that. And if you cannot clean up your act, then guess what? You lose out. And that is what I think you need. I do not think you need more billions and billions of dollars.

Thank you.

Chairman SANDERS. Thank you, Senator Johanns.

Senator Begich did not make, as I recall, opening remarks, so we will give you a modest amount of additional time.

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much. I like the way you say that, Mr. Chairman.

Let me, if I can, thank you both for being here. I appreciate it. But, you know, it is amazing to me. I have been here now just about 6 years, but I am looking at a 2003 report, "Improve Health Care Delivery for Our National Veterans." Are you familiar with this report?

[Mr. Gibson nodding head.]

Senator BEGICH. If not, you should all read it. But I am really doing this for my colleagues, because when I turn to one page here—and why I am saying this, this is really part of your point. It says, "Although enrolled veterans technically have access to VA health care system, long waiting times for appointments with health care providers continue to be problematic for a significant number of veterans. As of January 2003, at least 236,000 veterans were on a waiting list of 6 months or more for a first appointment[...]—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care."

This is not new. It is just they did not get the funding years ago, and now we are playing catch-up, because you have also had 1.4 million net new VA patients. We did not do it. And I say "we." I was not here. Somehow people missed this report. I do not know. I would submit it for the record, Mr. Chairman. I think, you know, it is like somehow suddenly it is all a new problem, it just occurred yesterday. No. It is right here in this report. And because they were not funded properly, it built up and new patients were added to the list from the Afghanistan and Iraq wars. Maybe people missed that. I do not know. Pretty simple, third page of the report, not complicated. Done under a different administration.

So, I want to put that to the record because the issues you are bringing up are relevant.

[The report from May 2003 is in the Appendix under Senator Begich.]

Senator BEGICH. You know, do I think it is a lot of money? Yes. Is the money well deserved for our veterans? Absolutely. Because if they would have had it here, we might have been recruiting doctors back then, because the problem we are going to have, to Senator Hirono's question, is hiring 10,000 people. I agree. You have got a hiring system that is great. But to get mental health providers and primary care doctors? You do not just turn a switch. Every private hospital in this country is behind the curve getting doctors. Nurses are backed up. We do not have the capacity to fill these.

So, I want to make this clear because I think there are a lot of good bumper stickers being talked about today, and I get it. But this is a systematic problem that has been around for a decade or more. And yet it is now suddenly—thanks to the VSOs and others who have come forward and said, look—they have been fighting for this for years. And now we are finally figuring this out.

I will tell you—and I know the Chairman gets aggravated, not aggravated, but he knows I will bring it up all the time, and that is—what we are doing in Alaska. We have talked about this. We saw this problem. When I came into office in 2009, we said, "What are we doing?" We had 1,000 people on our waiting lists in Alaska with 120-day wait periods. So, what did we do? We did not go to the private sector because, honestly, all of us that go to the private sector get a doctor, it is hard enough to get appointments. Do you think we are going to add veterans to the system and clog it up some more? So what did we do? We looked at our current system of Federal tax dollars and how they are being used. Indian Health Services delivered by our tribes in Alaska, the federally qualified clinics, federally funded. So what did we do? We maximized the resources we have at our fingertips today.

What is our wait time in Alaska in the Northwest Region? It is one of the lowest in the country, because we now have access. As a matter of fact, in Anchorage, when you use the qualified Federal clinic there and/or the South Central Clinic—and, again, you have got to be on the list. You sign up, you get through the system, you get on the list. For non-major medical you get same-day care. That is pretty significant.

That is competition that actually works with the tax dollars we are all paying. But if we shove it out only to the private sector, some magic will happen—and I agree, with the Closer to Care program, as you know, which uses private sector resources. But that does not mean it is the panacea, that every veteran is going to get care overnight. We have to look at the systematic problems here that I know you and I have talked about—this idea and what we are doing in Alaska, which I think has been successful. We have some problems still. We have some logistic problems, billing problems still. We have some scheduling issues and how to make sure the records are transferred properly between Federal agencies and so forth, but I know we are going to figure this out.

Doesn't that seem like something we should be expanding and looking at around the country? I mean, federally-qualified clinics; the one reason you have certain pay levels for doctors so you have a controlled cost unit. In the private sector you are not going to have a controlled cost unit.

Now, it does mean we will still use private sector resources as we are doing in Alaska, along with federally-qualified clinics and our Indian Health Services, otherwise known as what we call it, the "Nuka" model, which is a very impressive model for the delivery of health care. Don't you think this is a model that we could use to actually go after some of this?

Again, I did not mean to get so aggravated about this. It just aggravates me when people tell me it is suddenly a new-found problem. People who have been here a lot longer than me should have read this report, not necessarily you two. I mean, Congressional people.

Senator BEGICH. Go ahead. Sorry. There is my rant. There was a question there.

Mr. MATKOVSKY. I will try to address it, sir. Very quickly, about the model in Anchorage, the Director there actually was a trailblazer for us. He actually established a number of the Tribal agreements with local Alaska Tribes——

Senator BEGICH. There are 26 of them now.

Mr. MATKOVSKY. Yes, phenomenal work that he did. I mean, he earned the trust. He literally extended the network of community providers into a seamless integrated system up there. It also allowed us to avoid folks having to travel long distances. I mean, the norm before used to be folks flying down to Washington State, if you recall——

Senator BEGICH. Yes, in Seattle.

Mr. MATKOVSKY [continuing]. So, they were able to stay local. So, it is remarkable work by the Director. Some of that has actually become sort of a pattern that we have used elsewhere in the country, with local Tribes and with IHS, signing the agreement with IHS to extend health care services. But most importantly, with the Tribes, in the Dakotas, in Oklahoma, across the country, we have Tribal agreements in place where we can reimburse for care. It is not perfectly seamless, but it is something that has really taken root for us.

Senator BEGICH. And, you did not need new rules to do that?

Mr. MATKOVSKY. No, we did not. We used our sharing agreement authority.

Senator BEGICH. Right.

Mr. MATKOVSKY. We have certain authorities in Title 38 that we use, you know——

Senator BEGICH. And you can do that, also, with federally-qualified clinics.

Mr. MATKOVSKY. We can——

Senator BEGICH. Yes.

Mr. MATKOVSKY [continuing]. Under sharing authority.

Senator BEGICH. Right. In Alaska, we are doing that with a couple which—one just went from a private to a federally-qualified clinic to deliver care in Seward, AK, because there is no veteran care down there, which is a great example of how you can do this with your existing rules.

Let me ask you, on having the VA utilize—and we talked about this or I may have sent a letter to General Shinseki on this—regarding positions that the Indian Health Services use, which are some of the Corps being used for their medical delivery system, and

seeing if the VA can do the same thing. It is actually in the bill of how to fund some of these folks. In other words with the Health Care Corps, can you tell me if your regulations allow you—I know we talked about this briefly; I do not know if you had time to check on that. I think this is a resource of over 5,000 medical professionals sitting there, ready to go.

Chairman SANDERS. Mark, are you talking about the National Health Service Corps?

Senator BEGICH. Yes. I am.

Chairman SANDERS. Yes. The National Health Service Corps.

Mr. MATKOVSKY. Yes. I mean, I think we would have to look at some credentialing and privileging issues that would allow us to credential and privilege and share those authorities to treat in our system, as well. I would have to take that back and look at it to tell——

Senator BEGICH. Can you do that for me?

Mr. MATKOVSKY. I will.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MARK BEGICH TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. VHA has the ability to enter into agreements with other government agencies to temporarily assign professionals with critical skills. Inter-Governmental Personnel Act (IPA) agreements are one method endorsed by the Office of Personnel Management. To date, VHA has not pursued an IPA with the Public Health Service as VHA has been engaged in ongoing discussions with them regarding detailing medical professionals, particularly for mental health care, to VHA. The discussions presently are exploring the creation of an Interagency Agreement (IAA), which would define the terms, costs and skills of assigning 100 mental health professionals from PHS to VHA temporarily.

Senator BEGICH. And then the last thing is on—I have a bill which Senator Murray talked about, and that is reimbursements for doctors in the sense of serving our VA system, and I have a bill on mental health providers, psychiatric care, which is a huge gap, and doing loan forgiveness. Have you had a chance to look at that bill, and if not, can you give us some feedback on that at an appropriate time?

Chairman SANDERS. Mark, if you will yield to me for a second——

Senator BEGICH. Yes.

Chairman SANDERS. The issues that Senator Begich is raising are very important, and that has to do with how we not raid other facilities and steal doctors and psychiatrists, but develop more.

Mr. MATKOVSKY. Right.

Chairman SANDERS. And, the issues are that you guys have a Health Education Assistance Program, which: (A) needs to be reauthorized; and (B) needs to be significantly increased. Right now, the maximum you can provide is only $60,000, which does not do anything for somebody graduating $200,000 in debt. That is what you are talking about, right, Mark?

Senator BEGICH. Exactly. As a matter of fact, under ACA, the Affordable Care Act, for other professions, it is up to $100,000 for 2 years' service. So, the question is, have you had a chance to look at that bill, and do you support this concept?

Mr. MATKOVSKY. I think we support the concept. We just have to look at the funding requirements associated with it. But, in prac-

tice, it is something that would allow us to recruit and retain highly qualified staff.

Senator BEGICH. Very good.

Mr. Chairman, I have some other questions. I will submit them for the record. But, I appreciate you allowing me to ask questions. It is just very frustrating when I see a report like this and people suddenly think it is a newfound problem when it has been around for 10 years. We just need to get after it and deal with it, and it is going to take years to change it.

Thank you, Mr. Chairman.

Chairman SANDERS. OK. Thank you, Senator Begich.

Senator Heller, you will have additional time, as well, because you did not make opening remarks.

STATEMENT OF HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. You know, what I may want to do, Mr. Chairman, is just submit my opening remarks for the record. That way, I will go back to having 5 minutes and keep this hearing timely.

[The prepared statement of Senator Heller follows:]

PREPARED STATEMENT OF HON. DEAN HELLER

Thank you Chairman Sanders and Ranking Member Burr for holding this hearing today. I believe this Committee must continue conducting this vigorous oversight at a very troubling time in the Department's history. It is also important that the Conference Committee works quickly to reach an agreement so Congress can pass a bill to help Veterans get the care they need immediately.

In a short number of months, Congress, Veterans, and the American public have had a glimpse into the failure of the VA to provide quality care to Veterans across the Nation, and it is disturbing to say the least that many of our Veterans went without health care because a few employees decided to cheat the system.

Every time I am home, I repeatedly hear from Nevada veterans about their individual stories and difficulties they've faced with the VA, and many of them are doubtful it will ever improve.

I share their frustration. Our veterans are entitled to a VA system that delivers the benefits and care they have earned in a timely manner. But today, the VA is not meeting that standard.

I have a timeline here showing the progression of this scandal, and every week there has been a new revelation about failure to provide quality care, another VA official resigning due to a lack of accountability, or whistleblowers being punished for doing the right thing.

It is unfathomable so many problems existed at the VA for years and management at some level allowed it to continue.

That's not going to be the case anymore, and I expect the nominee for VA Secretary to prove to this Committee that he will bring a dedicated and unrelenting approach to fixing this broken agency.

Veterans in my home state of Nevada are also facing significant problems that I expect to be resolved.

At the Las Vegas VA Hospital, more than 6,700 Veterans were forced to wait more than 30 days for an appointment.

And just last year, a blind female veteran waited nearly 6 hours in the Emergency Room before being seen by a nurse or doctor.

I have spoken with the VA Hospital Director Duff about improving these wait times and better meeting the demand of Veterans in the area, and I expect this hospital to provide the best care possible moving forward.

Over in Pahrump, 6,000 Veterans have waited more than two years for a clinic to be built. Despite promises of progress, construction of this facility has not started, and VA officials have not even provided a timeline for final approval of this facility.

Pahrump Veterans have waited too long for this clinic to be built, and I would like to see the VA break ground on this facility before the fall so construction can begin and Pahrump Veterans can finally receive the care they waited for.

In Northern Nevada, the Reno VA Hospital is still waiting for a director to be hired. As the VA works to bring greater accountability and transparency to its health system, I want to ensure any new director is committed to this goal.

Unfortunately, the challenge with the VA health care system is not the only issue facing Nevada Veterans. These same problems with management and accountability are also an issue in the Veterans Benefits Administration, which processes the disability claims for veterans.

The VBA continues to struggle to eliminate the veterans' disability claims backlog as it operates under a 1940s system in the 21st century.

On a local level, Nevada's Veterans are facing the worst of the claims backlog. Not only does Nevada have the longest wait in the Nation at 340 days for a claim to be processed, but the VA Regional Office in my state was recently audited by the Inspector General with less than satisfactory results.

The IG found that 51 percent of disability claims they reviewed were inaccurately processed, and many of the problems at this VARO persisted due to poor management.

The VA has been given enough chances to fix the backlog for Nevada's Veterans, but has failed to produce adequate results. What Veterans need now is for Congress to take action to reform the outdated claims processing system. That is why Senator Casey and I introduced the bipartisan 21st Century Veterans Benefits Delivery Act to address three areas of the claims process: Claims submission, VARO practices, and Federal agency responses to VA requests.

Just as Congress needs to address the quality and timeliness of our veterans' health care, Congress must also work to improve the delivery of their benefits, which is why I have continued to encourage Chairman Sanders to re-schedule a legislative hearing so the Committee can consider this important bill.

Again, thank you Acting Secretary Gibson for testifying today. I look forward to hearing about what the VA is doing to improve care and benefits for Nevada and our Nation's veterans.

Thank you, Mr. Chairman.

Chairman SANDERS. One of the few Senators who wants less time than being offered.

Senator HELLER. Yes. But, having said that, if I go over, please do not cut me off. [Laughter.]

Having said that, thank you very much for holding this hearing, for both the Chairman and the Ranking Member.

At risk of irritating you, like Senator Begich claimed, you know that I will be talking about backlog statistics. I would certainly appreciate a rescheduling of the hearing on the backlog information, and I will talk about that in just a minute.

But, I am looking at the latest statistics; and I want to thank both of you for being here, Secretary, and the smartest guy in the room, Philip here, for taking some time. But, I am looking at the latest average days of completion in the VARO in Reno, which I bring up because Reno has the worst VA Regional Office in the country. I have been hitting on this and hitting on this, and I think it is a management problem. I do not think the rank and file in that office are at fault. I truly do believe it is a management problem and I am certainly hoping and have called for changes in that particular office.

The average days to complete now a pending claim is about 340 days. I have been harping on this for 5 years, and they are making slow progress. In 5 years they have reduced it by 10 days. That is it. We have gone from 350–351 days down to 340 days over 5 years—5 years! You have got to imagine, it is pretty frustrating. And, I am not frustrated for myself. I am frustrated for every veteran in the State of Nevada that truly needs the help, the benefits, and the health care that they deserve.

On top of that, we had an Inspector General report that found that 51 percent—51 percent of the disability claims that were reviewed in this VARO were inaccurate.

I have to tell you, I appreciate your opening statement, your openness and concern for openness. I think that is important. Transparency is important.

Senator Bob Casey and I, because he has similar problems in Pennsylvania, worked together. Our staffs worked very, very hard. We came up with this VA Claims Backlog Working Group, submitted legislation on that. Are you familiar with the information in this——

Mr. GIBSON. I would tell you that I am aware of it. It would be a stretch for me to say that I am familiar with it.

Senator HELLER. OK. OK. Fortunately, I will be able to meet with the nominee tomorrow——

Mr. GIBSON. Good.

Senator HELLER [continuing]. And get an opportunity for him to also address or take a look at it, because I think it is very clear, the concerns, the problems that we have. I think this legislation does address some of those problems. Legislation is available.

What is good news is Senator Moran and Senator Tester from this Committee are also cosponsors of this legislation. I think it would go a long way so that we do not, in 5 years, have a 10-day improvement, that, hopefully, in less than a year, we could see perhaps a much greater improvement.

I want to get on another topic real quickly, if you do not mind, and that is an issue that we have in the State of Nevada. There is a small city in Southern Nevada called Pahrump. Pahrump has about 6,000 veterans down there, and you are shaking your head, Philip. I am glad to see that. They have been waiting for a VA clinic for several years now. The Director in Las Vegas, Director Duff has approved it. They are now waiting for the national VA officials here in DC to get this done. What is the status?

Mr. MATKOVSKY. I have to get back on the detailed status. We have had some issues with, if I may, our lease authorities that we have been trying to work through, and I think some folks here may be familiar with that, that have resulted in some delays in getting leases enacted. We had some challenges on the procurement side of that, as I think your staff has been briefed over the years. Right now we are working through trying to make sure that we can exercise our lease authority in the current environment. That is the challenge we have, sir.

Senator HELLER. Do you have any timeline for approval of this clinic?

Mr. MATKOVSKY. I do not right now. It is not an issue of approval. It is an issue of actually effecting a lease agreement.

Senator HELLER. Do you think we can get an answer perhaps by this fall or something to——

Mr. MATKOVSKY. I will get it to you sooner than fall, sir.

Senator HELLER. If you would, please——

Mr. MATKOVSKY. I will personally go in and look at it.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DEAN HELLER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. VA Southern Nevada Healthcare System (VASNHS) has developed plans to expand the clinic, which is too small for the Veteran workload in this area.

- The current clinic is in a modular building which is not feasible for expansion.
- In May 2013, an Out-of-Cycle SCIP proposal was approved for a new expanded Pahrump CBOC.
- VASNHS has solicited proposals for a larger clinic, which would be built to VA specifications and leased back.
- There are viable proposals which are currently under review in VA's contracting process, with final approval expected in the next few months.
- The costs of the proposals exceeded the threshold for local approval and will require Secretary Veteran Affairs approval.
- Once a bid is approved and funds are obligated, the estimated construction timeframe is between 12 to 18 months.
- The current Pahrump CBOC provides primary care, women's health, mental health, telehealth and social work services. The new clinic will expand these services and add space for radiology and pharmacy services.

Senator HELLER. I want to talk about—I have got just another minute here—about the face-to-face audits, reviews, and the problems. We have scheduling. We had an audit. The first phase was released on June 9, and this is with the Las Vegas VA Hospital, Southwest VA Clinic in Nevada, and they said that it needs further review. Do you know if those reviews have been completed?

Mr. MATKOVSKY. We have referred all of those cases to the Inspector General, and we have prepared a detailed set of briefings. I think we are trying to schedule it now with the Committees and with Delegations to walk through the audit findings as well as why someone would have wound up on a further review list.

Senator HELLER. OK.

Mr. MATKOVSKY. I know it has taken us a while to do that. I want to apologize for the amount of time.

Senator HELLER. I just want to make sure there is not a—we don't miss the follow-up. I would not anticipate that you would. But, do we have any timeline into when those——

Mr. GIBSON. I would tell you, the question there—somebody mentioned earlier that the IG is in over 70 different locations——

Senator HELLER. Sure. I am sure.

Mr. GIBSON. Any location where the IG is working, we are not able to go in and do any additional review. We have created Accountability Audit Teams to go into all of those where the IG is not, and those are scheduled to be completed, I think, by mid-August. But, in the meantime, we are going to provide some briefings on what the findings were and what we know.

Senator HELLER. Thank you very much.

Mr. GIBSON. I am going to be in Reno in August. I have to go out there to speak. We will get you the dates.

Senator HELLER. If you would, please.

Mr. GIBSON. I will make sure these guys get you the dates when I am going to be there and I will go visit the RO while I am there.

Senator HELLER. If you would. Thank you very much.

Mr. Chairman, thank you.

Mr. GIBSON. And, last, we appreciate the opportunity to provide some technical input on the leasing issue.

Senator HELLER. Great.

Mr. GIBSON. I think we have furnished some of that information to the staff, Mr. Chairman, which would be very helpful for us to be able to move forward.

Chairman SANDERS. Thank you.

Senator Blumenthal, you have 8 minutes, and I alert the members that there will be a vote, as I understand it, at 12:20. Senator Blumenthal, 8 minutes.

STATEMENT OF HON. RICHARD BLUMENTHAL, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you very much, Mr. Chairman. I really appreciate your holding this hearing and your leadership, along with Ranking Member Burr; and thank you, Mr. Gibson and Mr. Matkovsky, for your service to our Nation.

I think you folks are in a difficult, if not impossible, position, because you are temporarily before us without the head of an agency, and my hope is that there will soon be a Secretary of the VA. But, right now, in effect, there is an empty desk where the buck should stop and I think that situation has to be remedied as soon as possible, and that is on us, not on you.

Leadership has to include an overhaul, top to bottom, of the people who run the agency. Very simply, my view is that there has to be accountability for what is done in the past, but also a change in leadership which you are commendably seeking, as well, top to bottom, across the country.

My experience over the last few months has been that the failure of the agency to be more responsive and accurate in some of what it is saying to the public is actually aggravating its credibility and trust problems. Senator Burr raised one instance earlier with the press release that he mentioned. I have found that there simply have been no answers to some of the questions that I have posed in letters to the agency, letters asking for site-specific information about the audits that were performed.

The VA officials locally, and the audits seem to confirm that there have been no problems in Connecticut with these delays and destruction of documents and manipulation of waiting lists, and yet we have found in recent data released by the VA that, in fact, wait times have increased over the May-to-July period. In fact, those wait times have tripled. What is the meaning of that data?

So, I have asked not only for the site-specific information resulting from the audit that was performed as a result of General Shinseki's order, but also for an explanation of those wait times, and I have yet to receive responses from the agencies that are really complete and satisfactory, in writing, to the questions that I have posed.

Now, I understand you have a lot going on, but I would suggest that that kind of responsiveness in providing information is part of the mission that is all the more important. It has always existed, but it is all the more important now. So, I would like a commitment from you that the agency will respond to my inquiries in writing as soon as you are able to do so, and that you will respond in the future to the inquiries that I pose.

Mr. GIBSON. Two quick comments. First of all, the answer is, we absolutely will. It might even be more effective for us to arrange

to come in and deliver a briefing, walk through the wait time data, also walk through, as Philip just mentioned a second ago, briefing material around the access audits that is being provided. You have not had the opportunity to hear other comments, but we have been pushing information out the door as fast and as hard as we can over the last 6 weeks. That openness and transparency, to your very point, is an essential part of earning back trust.

Last thing. I told the President of the United States when he tapped me to be the Acting Secretary, I said, do not expect me to behave like the word "acting" is in front of my title. So, if anybody has seen any behavior out of me that looked like I was serving as a caretaker, please let me know what it was so that I can try to explain what maybe you were looking at.

Senator BLUMENTHAL. Well, I welcome that comment and I second it and support it.

Can you tell us anything about the ongoing inquiry internally, what its status is, when you expect it to be completed, and second, about the Department of Justice investigation. I called for a criminal investigation by the Department of Justice with great reluctance and regret, but I do think that criminal responsibility has to be applied if there was obstruction of justice, destruction of documents, fraud in reporting, because those crimes, even with an agency as important as the VA, or perhaps especially because of its very important mission, has to be implemented where necessary.

Mr. GIBSON. There was a mention earlier of the fact that the IG has reviews underway at 70-some locations across the organization. I should explain more here. Before the IG goes into any location to do any kind of a review for any purpose, they inform the FBI. And, at any point during the course of their review of activities they uncover evidence of criminal wrongdoing, those routinely get referred to the Department of Justice. In fact, there is a Criminal Investigation Division of VA's IG. So, routinely, there are criminal investigations undertaken and completed and prosecutions that occur as a result of IG investigations. So, it is a routine matter.

I would tell you, of the 70-some-odd locations that the IG has been reviewing, at the end of June I got the first set of reports on the first location, so, we have been working. With more than a thousand pages of transcripts of sworn testimony, it turned out that we actually needed some additional information, so we dispatched an official fact-finding group to go to that particular location. We have reviewed hundreds, if not thousands, of e-mail traffic. And, I expect by the end of this week to have proposed personnel actions on my desk for that—for a number of individuals at that one particular location.

There is nobody that wants to see this process move faster—move forward faster than I do. It is painstaking.

You know, I would say the other general category here of issues have to do with the referrals coming from the Office of Special Counsel. I have met directly with Carolyn Lerner. We are expecting a substantial number of those to come to us very quickly, and we have agreed on some expedited processes that we will work through to ensure that the whistleblowers are properly protected, and then to launch the appropriate personnel actions in the wake of that.

Senator BLUMENTHAL. My time is about to expire, so I apologize. I am not going to have more questions in this setting. I would like to follow up on the Department of Justice investigation—I know you cannot really comment in this setting about it—and, most important, about protection for whistleblowers. I think one of the unexplored areas here has been the potential for retaliation against whistleblowers. I would like to know from you, in the form of a future briefing, what has been done to protect them.

Just one last comment. There is nothing routine about what happened here. You said that, routinely, the FBI is involved. There is nothing routine about what happened here and I think the FBI should be fully engaged and the Department of Justice involved. Thank you.

Thanks, Mr. Chairman.

Chairman SANDERS. Senator Boozman, you will also have additional time.

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

Senator BOOZMAN. Thank you, Chairman Sanders and Ranking Member Burr, for having this very, very important meeting. And I want to thank you all for being here. I know that you are working very, very hard to try to resolve these things.

I also want to commend you, Mr. Gibson, for getting out to the places that are really struggling, and also the places that are doing well, trying to figure out best practices and then, again, why others are struggling so much.

Dr. Perlin, I think, is important in the situation of bringing him on as an advisor. I think that was really a very good move.

In regard to your request as far as additional personnel and things like that, is that based on current practice or is that based on reforms in the future that are going to significantly change things, hopefully?

Mr. MATKOVSKY. The methodology we used is largely framed in the current context, Senator Boozman. So, what we looked at is looking at our current appointment volume, looking at our current delays in care, forecasting those through the years, and trying to attenuate them year on year. So, it is not any subsequent reform. It is in our current context.

Senator BOOZMAN. Right. You know, I had the opportunity to serve with Tom Osborne over in the House, the great coach from Nebraska. People used to talk to him about winning and he would say, "We did not ever talk about winning. What we talked about was doing the little things." And, one of the little things that has to be done—which I am a little bit concerned, because you said it would take 2 years, though in terms of VA, that is probably more like 4 or 5—is the scheduling.

That is one of the little things. My understanding is they do not call people the day before and tell them they have got an appointment. You could cut your "no show" rate significantly just by doing that and then taking somebody that is on a backlog and sticking them into those slots. That is just common sense practice that is done throughout the country with anybody in the private sector. So, you have to get the scheduling under control, and there is no

reason not to do that rapidly, particularly targeting the areas that are having problems. You know your facilities that are doing OK right now by whatever standards you are measuring. But, it does seem like you could put that in place right away.

Mr. GIBSON. You may have mentioned—missed the comments earlier. There are actually four different major initiatives underway on scheduling. One has to do with fixing existing issues. There are 11 of those fixes in process right now. There are four separate applications under development to make it easier for schedulers to interface with the system as well as to give veterans the ability to directly request schedules.

There is a contract that has already been let that will make major modifications to the existing scheduling system—was let on the July 11—and we expect that to bear fruit in the May through August time period next year, to deal with some of the toughest, some of the most difficult issues associated with the existing scheduling system.

All of that is in parallel while we are working to acquire a commercial, off-the-shelf——

Senator BOOZMAN. If there are good over-the-counter systems right now in place that major medical centers are using without any problem at all—that is the basis of medical practice.

Mr. GIBSON. Do you want to answer this one?

Mr. MATKOVSKY. Sure. I would agree with you, sir. I think that you have two comments. One of them is the underlying system, and I think there was a reference made to a prior system effort. I do not think we are looking to go build something from scratch this time. I think——

Senator BOOZMAN. No. I mean——

Mr. MATKOVSKY. Right.

Senator BOOZMAN [continuing]. I would hope not.

Mr. MATKOVSKY. We are not, no.

Senator BOOZMAN. I would say that that is something that people have been doing for years. I am an optometrist by training, so, again, that is the basis of your practice, scheduling.

You mentioned that you have one assistant per specialist right now in the VA system. I think you said two-and-a-half or whatever, which might even be a little bit low. What I would like to know is what is the relationship between—if you take a major VA medical center and you look at total staffing, you look at the staffing that it takes to support that medical center, what is the comparison with a major private entity as far as numbers?

Mr. MATKOVSKY. I do not have the exact percentages, but if you look at the overhead rate in the VA or the indirect rate in the VA for support staff, it is considerably lower in each one of our major areas: primary, specialty, and mental health. I do not have the specific counts.

Senator BOOZMAN. As far as the total numbers. I am talking about administration, the whole bit.

Mr. MATKOVSKY. I am looking just at the field costs, not looking at everything else for a blended overhead rate. I think we could come up with something like that, which would look at a blended rate and see where the different overhead and G&A charges come

in. But, in terms of what we have in our facilities, the labor share is lower in the VA for support than it is in the private.

Senator BOOZMAN. Not as dollars, but people.

Mr. MATKOVSKY. In terms of people, it is lower in the VA than it is in the private sector. What you may be asking, as well, would be, could we construct a blended rate that looked at the overall cost factors. We could. We have not done that.

Senator BOOZMAN. OK. I would like to see that. I think that would be interesting.

The other thing is that right now if you go to your Medicare doctor, if you are a veteran and you have a physical with a Medicare doctor who decides that you need high blood pressure medicine, then you go to the VA, instead of filling that prescription—which is a pretty good deal for the veteran—they have to have a physical in order for it to be filled.

Mr. MATKOVSKY. I understand——

Senator BOOZMAN. Why is that? I mean, is there any logical reason for that, as well? How many slots would that free up if you made that one change? How much money would that save?

Mr. MATKOVSKY. I am not a clinician, so I cannot in a learned way describe why that is the case, but there are certain reasons why that would be appropriate and why that does make sense. But, I will tell you that we are looking at things like referrals to audiology and where that could obviate—where we could bypass the primary care step as an additional item. But, we need to look at that carefully, and I think folks are looking at that now, audiology, optometry, ophthalmology, maybe some pharmacy, not all pharmacy. We need to be careful. But, we are looking at that, to your point.

Senator BOOZMAN. Now, I can see the scheduled drugs and things like that, but to me, it makes no sense at all that if a guy that is licensed and taking Medicare dollars, another entity that is licensed by the government, why a prescription cannot be filled for diabetes, high blood pressure, the vast majority of stuff that actually comes across. Could you look and see how many slots that would save——

Mr. MATKOVSKY. We will look at that. But, the one thing—just one point of caution would be not to over-correct in that direction. But, we do have folks looking at the pattern between primary care and certain specialty, the pattern between primary and pharmacy——

Senator BOOZMAN. How do you mean, over-correct?

Mr. MATKOVSKY. Just to not be vigilant for pharmacy-filled requests that would be coming in from the private sector. That is the only thing that I mean, just to make sure that we are determining the appropriateness of certain prescription fills. And, the examples that you have given, they seem pretty straightforward, but we just need to make sure that those are the only examples.

Mr. GIBSON. There is a large percentage of veterans that are served by both VA and Medicare.

Senator BOOZMAN. Yes.

Mr. GIBSON. And, so, part of this is understanding what the second and third order effects are of the kind of change that you are talking about. Clearly, one of the impacts would be that it would

free up primary care slots. Got it. That is a good thing. What are the second and third order effects, and that is, I think, Philip's point, about being thoughtful——

Senator BOOZMAN. Well, it probably would decrease the backlog.

Mr. GIBSON. Yes.

Senator BOOZMAN. I am sorry to run over Mr. Chairman. Thank you.

Chairman SANDERS. We have reached the end of what I think has been an important and productive hearing.

Mr. Acting Secretary, I want to thank you very much for stepping in, clearly unexpectedly, into a very important position in a very difficult moment in the history of the VA, and thank you very much for the work that you are doing.

And, Mr. Matkovsky, thank you very much for what you are doing. We look forward to working with you in the days, weeks, and months to come.

Thank you very much. The hearing is adjourned.

[Whereupon, at 12:20 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO U.S. DEPARTMENT OF VETERANS AFFAIRS

VA RESOURCES REQUIREMENT ACCESS

Question 1. What will be the impact on veterans if VA does not receive the funding that is being requested?

Response. Pub. L. 113–146, the Veterans Access, Choice and Accountability Act (VACAA), provided $10 billion for the new Veterans Choice program and $5 billion to improve access at VA health care facilities; however, VACAA also directs VA to accomplish several tasks that will incur costs but were not funded by the Act, which will have the impact of further decreasing VA funds available to provide health care to Veterans. These provisions include:

Sec. 201. Independent assessment of the health care delivery systems and management processes.

Sec. 202. Commission on Care.

Sec. 203. Technology task force on review of scheduling system and software.

Sec. 303. Clinic management training for employees at medical facilities of the Department of Veterans Affairs.

Sec. 402. Provision of counseling and treatment for sexual trauma by the VA to members of the Armed Forces.

Sec. 403. Reports on military sexual trauma.

Sec. 501. Extension of pilot program on assisted living services for veterans with Traumatic Brain Injury.

In addition, VA requested funds for increased costs above the budget request for Caregivers stipends and new Hepatitis C treatments. VA also requested a $368 million increase above the FY 2015 Advance Appropriation level for Veterans Health Care programs, but neither H.R. 4486 nor Senate Report 113–174 have provided the requested increase.

Question 2. What barriers does VA face when hiring additional health care professionals, especially primary care doctors—given our nationwide shortage of primary care doctors? What is VA doing to address such barriers?

Response. The barriers VA faces in hiring healthcare professionals include both systematic and local issues. On a macro scale, shortages specific to role (e.g. primary care, psychiatry) reflect national staffing challenges. There are also geographic considerations, in particular in rural and other underserved areas. To be successful VA must provide competitive salaries and benefits along with an environment that is conducive to a productive and rewarding work experience including work-life balance.

VA employs an aggressive, multifaceted strategy to recruit and hire physicians, Executive and clinical leaders at 150 medical centers assess physician staffing needs. Physician shortages or deficits at specific locations are addressed by increased marketing and recruitment efforts on a case-by-case basis. Marketing is also

targeted to academic affiliates, professional health care associations, the Department of Defense (DOD), Health and Human Services (HHS) and Office of Personnel Management (OPM).

VA's support of additional training positions and partnership with academic affiliates (who manage these residency positions), will help to increase the workforce in areas of high demand and limited capacity. Further, VA is in the early exploratory stage of examining novel programs and partnerships to expand training capacity, including the schools of Osteopathic Medicine and the Family Practice programs, as well as through the Federal Teaching Center model with Health Resources and Services Administration (HRSA).

Veterans Health Administration's (VHA) National Recruitment Program (NRP) provides an in-house team of skilled professional recruiters employing private sector best practices to the agency's most critical clinical and executive positions. The NRP has increased its targeted recruitment efforts for mission critical clinical vacancies that directly impact and, once filled, will improve access to care. These specialties include primary care, mental health, and critical medical subspecialties.

The national recruiters are attending conferences to showcase clinical practice opportunities to potential candidates. These include American College of Physicians; American Psychiatric Association and American Psychological Association. The team will also attend additional conferences through the end of 2014, targeting specialties such as Anesthesia, Gastroenterology, Family Medicine, Emergency Medicine, and Pharmacy.

VHA, in partnership with the Office of Academic Affiliations (OAA), pioneered the agency's first-ever recruitment outreach program targeting health professions trainees. The *Take a Closer Look Initiative* provides VHA with a standardized outreach strategy to recruit health professions trainees from VHA affiliate programs for employment upon completion of training. Residents and fellows receive attractive marketing throughout their programs with information on careers at VHA, as well as guidance on contacting and facilitating employment with a National Recruiter.

In addition to actively recruiting physicians, increasing and further incorporating nurse practitioners and physician assistants with specialized training and experience in primary care into care teams will increase Veterans access to care. Additionally, VA continues to recruit for a variety of administrative, technical and professional occupations to ensure the right mix of staff are available to provide safe, quality care to Veterans.

The national recruiters, all of whom are Veterans, work directly with Veterans Integrated Service Network (VISN) Directors, Medical Center Directors, and clinical leadership in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs. Since its founding in April 2009, VHA's NRP efforts resulted in filling 1,286 mission-critical vacant positions, as of 8/21/14, which increased access to care in rural communities and contributed to Title 38 Veteran hiring goals. In fiscal year (FY) 2014, as of 8/21/14, the recruiters have placed 482 health care providers:

- 91.49 percent are physicians;
- 30.91 percent are primary care physicians;
- 26.55 percent will go to rural/highly rural facilities; and
- 16.18 percent are Veterans

Sixteen of these Veteran hires will fill clinical and executive leadership roles at VA hospitals.

By filling long-standing vacancies, VHA's NRP is able to eliminate several multimillion dollar contracts for temporary provider staff. In one case, the team staffed a full anesthesiology department in the Northern California Health Care System, and in another, a full surgical team at the Texas VA Medical Center, translating into improved patient care and cost savings to VHA.

MENTAL HEALTH

Question 3. Would any of the funding VA is requesting be targeted toward VA's capacity to treat veterans who need mental health treatment?

Response. Yes, there is funding available through the FY 2015 budget request and the Veterans Access, Choice, and Accountability Act to expand mental health provider capacity. The additional staffing under consideration for mental health (MH) would help to achieve the proposed overall staffing ratio of 7.72 MH providers per 1,000 MH patients.

CONSTRUCTION

Question 4. What are the infrastructure needs envisioned by the additional $6 billion and how would they impact VA's capacity to provide care to veterans?

Response. VA is in the process of developing a spend plan for the $5 billion provided in Section 801 of the Veterans Choice Act and will submit it to the Committees as soon as it is finalized.

As specified in the law, these funds will be used to increase the access of veterans to care and to improve the physical infrastructure of the Department. This mixture of investments will help ensure VA is increasing its capacity to meet the current and projected future demand for services.

Question 5. What is the specific importance of leasing to VA's ability to deliver medical care?

Response. Leasing is an essential vehicle that allows VA to provide care to Veterans at the right place at the right time. Leasing allows flexibility in that VA can reassess local Veterans' needs as they exist at the end of the lease term. As the needs and demographics of Veterans change and develop over time, VA is able to adapt and respond in a more agile manner than if VA owned the facilities. Additionally, VA can vacate aging facilities at the end of the lease term.

Question 6. Why does VA need its own leasing authority for medical facilities?

Response. VA continues to work to respond to this question and will follow up with the Committee as soon as possible.

DATA QUALITY

Question 7. What steps has VA taken to address criticisms to trustworthiness of data produced by the Department in order to ensure Congress and the public can have faith in information provided by VA?

Response. VA has taken several first-steps to ensure data integrity and transparency, and restore the trust of Veterans, of our elected representatives, and all Americans:

- Suspended all VHA senior executive performance awards for FY 2014.
- Removed the 14-day access measure from all individual employee performance plans to eliminate motives for inappropriate scheduling practices or behaviors. In the course of completing this task, over 13,000 performance plans were amended.
- Updating the antiquated appointment scheduling system—in the short-term, enhancing existing systems. Working toward a comprehensive, state-of-the-art, "commercial, off-the-shelf" scheduling system. Expanding digital technology to free-up more people to care for Veterans. Adding more clinic hours in facilities.
- Contracting with an outside organization to conduct a comprehensive, independent audit of scheduling practices across the entire VHA system, beginning early fiscal year 2015.
- Every medical center and VISN Director are now conducting monthly, in-person inspections of all their clinics, including interacting with scheduling staff to assess scheduling practices and identify obstacles to timely care for Veterans. So far, over 2,450 of these visits have been conducted.
- Taken action on all of the IG's recommendations in the May 2014 Interim Report on Phoenix and responded to OIG's recommendations in the final report with action plans to be implemented during FY 2015.
- VA has set a goal to improve forecasting to better align available resources with identified demands.
- Building a more robust, continuous system for measuring patient experiences, to provide real-time, site-specific information on patient satisfaction.
- Improving communications between the field and the central office, between employees and leadership, and between VA and Veterans Service Organizations and stakeholders.

ADDRESSING CULTURE

Question 8. Outline the actions VA has taken to ensure employees who take the courageous step of coming forward to expose wrongdoing, waste, fraud or abuse are not intimidated, punished, or face retaliated against for such action?

Response. VA recognizes the dedication and courage shown by employees who report violations of law, wrongdoing, waste, fraud, and abuse. VA is committed to protecting whistleblowers from retaliation. VA is working collaboratively with the U.S. Office of Special Counsel (OSC) to review allegations of retaliation, and VA will make a whistleblower whole where there has been a finding of retaliation. This may include, but is not limited to, placing the whistleblower back into his or her position, or assigning the whistleblower to a new supervisor or position. In addition, VA will, as appropriate, take disciplinary action against employees who have committed substantiated acts of retaliation.

On July 11, 2014, VA registered for the OSC Section 2302(c) Certification Program. This Program will allow VA to meet its statutory obligation to inform its employees about the rights and remedies available to them under the Whistleblower Protection Act, the Whistleblower Protection Enhancement Act, and related civil service laws.

On October 7, 2014, VA received that certification from the OSC. This is an acknowledgement of the seriousness, commitment, and resources the VA is directing toward fundamental change in VA's systems and culture.

Under the OSC certification process, VA:

1. placed informational posters regarding prohibited personnel practices (PPP), whistleblowing, and whistleblower retaliation in a public setting at VA facilities and VA personnel and equal employment opportunity offices;
2. provided and will continue to provide new hires with written materials on PPP, whistleblowing, and whistleblower retaliation;
3. developed a Web site on PPP and whistleblower rights and protections; and
4. developed, in cooperation with the OSC, supervisory training on PPP and whistleblower rights and protections. VA executives, managers, and supervisors must complete this training on a biennial basis.

One of the requirements of the Program is that all supervisors in the agency complete training on whistleblower rights and protections and prohibited personnel practices. To that extent, VA has worked closely with the OSC to develop specialized training for VA executives, managers, and supervisors on whistleblower rights and protections and prohibited personnel practices. VA executives, managers, and supervisors were required to complete this training by September 30, 2014, and biennially thereafter.

To reinforce the above, VA leadership sent a message to all VA employees regarding the importance of whistleblower protection, emphasizing that managers and supervisors bear a special responsibility for enforcing whistleblower protection laws. VA Leadership meets with employees at VA facilities across the country to reemphasize that message.

VA's Office of Diversity and Inclusion (ODI) is also conducting on-site and virtual training for facility leadership on workplace inclusion, prevention of workplace harassment, and whistleblower protections. ODI also recently issued communications on whistleblower rights and protections through its Diversity@Work Newsletter and Diversity News Broadcast, accessible on ODI's Webpage, http://www.diversity.va.gov.

As part of VA's commitment to whistleblower rights and protections, VA has established a whistleblower Webpage, http://www.diversity.va.gov/whistleblower.aspx, accessible from VA's internet home page, http://www.va.gov. VA's whistleblower Webpage outlines employee and supervisor rights and responsibilities, including avenues of redress for complaints, informational posters and materials, and whistleblower training resources.

Additionally, VA has established the Office of Accountability Review (OAR) to ensure leadership accountability for improprieties related to patient scheduling and access to care, whistleblower retaliation and related matters that impact public trust in VA. As of September 26, VA has announced the proposed removal of four senior executives following investigations by the OAR and the VA Office of Inspector General.

VA will continue to take additional steps in creating a cultural shift within the organization and ensure its employees have a safe channel for disclosing whistleblower information.

Question 9. Following the release of Acting Secretary Gibson's June 13, 2014, letter to staff regarding whistleblower protections, has there been a distinct increase in employees who have raised concerns or suggestions with individuals in leadership positions across the system?

Response. Given that whistleblower disclosures may be made to any employee in VA or to OSC, we are unable to determine whether there was an increase in the number of employees who raised concerns or suggestions following Deputy Secretary Gibson's message to all employees on June 13, 2014, regarding the importance of whistleblower rights and protections. We continue to encourage employees to disclose wrongdoing, violations of law, fraud, waste, or abuse.

Question 10. How doe VA intend to create an accountable, safe, and transparent department focused on caring for veterans?

Response. VA is conducting multiple simultaneous investigations on patient scheduling issues, questions of record manipulation, appointment delays, patient deaths, and whistleblower retaliation. Based on the findings of those investigations, VA will take corrective and/or disciplinary action. To help regain Veterans' trust,

Congress' trust, the trust of the American people, and the trust of our employees, when we do hold employees accountable we are going to transparently share information as appropriate and while respecting an employee's privacy rights. For cases involving senior executives, the Veterans Access, Choice, and Accountability Act of 2014 allows us to take expedited action when VA has determined that a senior manager has committed misconduct or has performed poorly. VA's newly established Office of Accountability Review (OAR) is monitoring the progress of all ongoing OSC and Office of Inspector General (OIG) investigations, and as they are completed, will help VA leadership determine appropriate accountability measures.

As discussed in response to question eight, VA has mandated online training for all VA executives, managers and supervisors on whistleblower rights and protections and prohibited personnel practices. This training, along with existing mandatory training on equal employment opportunity, diversity and inclusion, and prevention of workplace harassment, conflict management training for supervisors, and mandatory Workplace Harassment/No FEAR training helps to create an atmosphere that welcomes accountability, safety, and transparency.

As Secretary McDonald described in a message to all employees sent on August 28, 2014, sustainable accountability in a high performing customer service organization is more complex than just firing employees. It includes a productive discussion of accountability, ensuring all employees, from top to bottom, understand how their daily work supports VA's mission, values, and strategic goals. VA has strong, institutional values—mission-critical ideals that must profoundly influence our day-to-day behavior and performance: Integrity, Commitment, Advocacy, Respect, and Excellence. On his first day in office, Secretary McDonald asked all VA employees to join him in reaffirming their commitment to these core values.

Question 11. Further, what steps has VA taken to ensure problems, investigations, and recommendations are elevated to the appropriate level of leadership for thorough evaluation and immediate corrective action?

Response. Employees are encouraged to disclose wrongdoing, violations of law, fraud, waste, or abuse. If the information being disclosed pertains to a possible or actual criminal violation, employees must report the information to VA's OIG.

In VA's training for executives, managers, and supervisors on whistleblower rights and protections and prohibited personnel practices, VA reemphasizes the importance of investigating disclosures of wrongdoing, violations of law, fraud, waste or abuse. VA also emphasizes that all executives, managers, and supervisors who receive these disclosures should notify a senior executive (an employee in the Senior Executive Service (SES) or a Title 38 SES-equivalent employee) supervisor about the disclosure.

PERSONNEL ACTIONS

Question 12. How many personnel actions were issued under Acting Secretary Gibson of Veteran's Affairs Department?

Response. The term "personnel actions" within the VA describes a variety of actions. These actions include, but are not limited to, reassignments, conversions in career status, realignments, and transfers. Between the time period of May 30, 2014, and July 29, 2014, when Deputy Secretary Gibson served as VA's Acting Secretary, a total of 104,009 personnel actions were issued. Of those 104,009 actions, 1,062 were adverse personnel actions.

Question 13. If firing does not send a clear message regarding accountability regarding the care and management of veterans, how does VA intend to hold individuals accountable for wrong doing?

Response. Secretary McDonald has demonstrated his commitment to serving Veterans by directing focus on VA's core values: Integrity, Commitment, Advocacy, Respect, and Excellence. VA will continue to use all tools available to correct misconduct and improve performance in accordance with applicable laws, rules, and regulations.

HOLDING SENIOR LEADERS ACCOUNTABLE

Question 14. VA announced new administrative procedures would be triggered when concerns are identified during an audit. This is a bit vague and the Committee in its oversight capacity would like to understand these procedures in detail. Please describe in detail the triggers that are used to employ these new administrative procedures?

Response. The Department's OAR has initiated a series of leadership interviews designed to elicit testimony regarding the actions VHA facility leaders took, and are continuing to take, to ensure that scheduling and wait list protocols are being followed throughout their facilities. If those interviews unearth senior leader mis-

conduct or serious failure of oversight, disciplinary procedures may be triggered. If the interviews demonstrate that a facility's leaders exercised appropriate oversight with respect to scheduling and wait lists, the audit process will be closed out with respect to that facility.

Question 15. Who is involved in activating these so-called "triggers" and what is the line of communication from audit staff to work center?

Response. VHA leaders are working collaboratively with the Department's OAR—an interdisciplinary team of attorneys, employee relations specialists, and other subject matter experts—to identify facilities requiring review and to carry out interviews and any necessary disciplinary actions.

Question 16. Have these new "triggering procedures" been rolled out and how have the procedures been utilized to hold leaders and managers accountable to date?

Response. Leaders of approximately eight VHA facilities have been interviewed, with several dozen additional interviews in the works. The team will likely interview leaders at all VHA facilities when the VA OIG completes its ongoing investigations into scheduling and wait list-related misconduct.

Question 17. What are some of the ways you are refocusing your leaders and managers on the mission of veteran's health and well-being?

Response. Veteran's health and well-being has always been a focus for the vast majority of VA's leaders and managers. In any cases where this is found not to have been true, appropriate fact-findings and/or administrative investigations are taking place and for any substantiated findings, disciplinary measures will be taken.

Additionally, Secretary McDonald recently sent out a mandate for all of VA to reaffirm commitment to mission and core values. The Secretary directed that by August 22, 2014, all Under Secretaries and Assistant Secretaries confirm that they and their employees have reaffirmed their commitment to the ICARE core values.

NON-VA CARE

Question 18. In the written testimony submitted to the Committee it was indicated that between May 15 and June 30, VA had made over 430,000 referrals for veterans to receive care in the private sector. Is VA tracking the average wait time for these veterans to receive care? If not, what are the challenges preventing VA from doing this?

Response. VA does not have specific data on the timeliness of the 430,000 referrals. However, VA has recently developed a management report that will assist in the reporting of non-VA care appointment timeliness. The field will be expected to adhere to specific referral procedures in order for VA to accurately track wait times. The reliability of the tracking will be dependent on the procedural input from the field. All sites were provided training on the procedures during the national rollout of the Non-VA Coordination model. The challenge remains to ensure that the facilities are properly following the procedures.

Since January 2014, VA has tracked appointment timeliness for Patient Centered Community Care referrals using a combination of VA data and contract data. The following average appointment metrics are reported:

Consult request to Authorization Created	16.2
Authorization sent to Contractor to Authorization Accepted	5.6
Accepted Authorization to Appointment Scheduled	3.3
Days to Scheduled Appointment	12.5

Nationally, the average days from Consult to Scheduled Appointment is 37.6 days.

SCHEDULING PRACTICES

Question 19. In VA's efforts to better understand issues surrounding scheduling, it has directed an independent external audit of VHA's scheduling practices. Can you please provide further detail regarding VA's expectations of this audit and any details of the project's timeline?

Response. The Joint Commission is VA's accreditation vendor and provides accreditation services for all VHA medical facilities, Community Based Clinics and Consolidated Mail Outpatient Pharmacies. VHA has requested that The Joint Commission (TJC) provide special focused reviews of internal VHA scheduling and other processes that could cause delays in care. Specifically, TJC will review the standards for regulatory compliance that align with how VHA schedules appointments, and if the scheduling is timely, accurate, and results in the prevention of delays in care for Veterans. Additional reviews may also be conducted if TJC becomes aware

of newly provided services at facilities or for other reasons for which TJC believes that the safety and quality of patient care is vulnerable.

TJC does not perform audits, but instead examines standards and reviews the connected processes. The Joint Commission will perform reviews at all VHA facilities. The reviews began on September 18, 2014 and will continue through FY 2015 until all visits are completed.

BEST PRACTICES

Question 20. Acting Secretary Gibson noted in his written testimony that VHA is looking to develop a process to share best practices from high performing facilities in order to offer suggestions those facilities that require improvement. Please provide additional detail regarding this effort. In particular, what high performing facilities have you identified.

Response. A VHA Steering Group has begun the process of determining how to measure the performance of facilities to find those that achieve excellent performance in their particular environment. This may allow for example, a small facility in a highly rural area to be paired with a like-facility with better performance. Specific facilities in each domain have not yet been identified by the Steering Group.

Question 21. How do you intend to share these best practices across the VHA system; and 3) what is the project's timeline?

Response. VA has a variety of models in which best practices have been spread across the larger health system. The VA Health Services Research and Development's (HSR&D) Quality Enhancement Research Initiative (QUERI) program's mission is to implement best practices into routine care. HSR&D/QUERI also identifies best practices through the Evidence Synthesis Program (ESP) Centers, including a recent rapid review of VHA wait times. A strategic goal of the QUERI program is to also identify which systems-level models work best, especially in high-performing facilities, to spread clinical best practices across different settings. A key program (Blended Facilitation) has been adopted by VHA national program offices to enhance the uptake of PTSD and related treatments. QUERI has applied innovative models to promote the uptake of primary care-mental health integration, e-health, anticoagulation treatment, and population management strategies especially for vulnerable Veteran populations, and is currently developing a Lean evaluation center in collaboration with the QSV Veterans Engineering Resource Center to promote best practices across a variety of facilities. HSRD is also leading a series of studies focused on best practices in disclosing adverse events to Veterans in a way that lessens Veterans' anxiety and distress and increases their confidence and trust in VA.

HSR&D also shares lessons learned from research through various dissemination efforts such as its Cyberseminars program. For example, recent sessions included: "Telemental Health in VA: Opportunities for Improving Access to Cognitive Behavioral Therapy for Pain" and "Using Lessons for VA to Improve Primary Care for Women With Mental Health and Trauma Histories."

The National Center for Patient Safety (NCPS) uses "Lesson Learned" as well as Patient Safety Alerts to improve system-wide performance. VA also uses a bundle approach to improve performance on certain common hospital acquired conditions. Bundles are developed to make it easy for common and standard approaches to be used to combat hospital infections. These bundles are paired with measurement of performance and feedback on that performance to drive down infection rates. Subject matter experts in infectious diseases, critical care, and others also provide consultation to facilities. To further enhance updates NCPS uses Breakthrough Series to encourage facilities to enhance uptake of best practices. Using these techniques, VA has seen dramatic decreases in rates of catheter-associated urinary tract infection, ventilator associated pneumonia, methicillin-resistant staphylococcus aureus (MRSA) infections, and other hospital-acquired conditions. It is anticipated that these and other models will be used to share best practices between facilities.

A Steering Group has been chartered and we anticipate a more detailed strategy will be developed to better assess facility performance, determine areas requiring attention within some facilities, create an action plan for improvement, and then matching facilities to enhance and sustain improvements.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 22. According to a study published in the Annals of Family Medicine, the average non-VA primary care provider has an average panel size of 2,300 patients compared to VA's current target of 1,200 patients per primary care provider.

A. What steps has VA taken to evaluate the appropriateness and effectiveness of the primary care panel size?

Response. The Department of Veterans Affairs (VA) has taken several steps to evaluate the appropriateness of primary care panel size:

- Comparison with external agencies and review of relevant medical literature using capitated models (Department of Defense (DOD), Kaiser Permanente, etc.) show comparable panel sizes;
- Evaluation of the range of VA panel sizes to ensure that outcomes, such as Ambulatory Care Sensitive Conditions admissions and Emergency Department visits do not deteriorate as panel sizes reach the top decile for VA; and
- An evaluation of primary care team burn-out and stress as a function of rising panel size is currently underway.

B. In July 2004, VA issued a directive on primary care panel size, which expired on May 31, 2008; has VA updated this guidance?

Response. The Guidance on Primary Care Panel Size Directive was replaced by the Primary Care Management Module Handbook, published on April 21, 2009. This is currently undergoing revision and is expected to be published in FY 2015. The guidance regarding panel size is currently unchanged from the earlier Directive.

Question 23. In a recent House Committee on Veterans' Affairs hearing, Dr. Lynch stated that, on average, VA primary care physicians see 10 patients each day compared to non-VA primary care physicians who see an average of 22 patients each day. He further stated that the number of patients seen daily by VA primary care physicians may range from 6–22 patients.

A. Why do VA primary care physicians see roughly half the amount of patients per day as those outside VA?

Response. The number of patients that VA physicians see per day varies from clinic to clinic and from facility to facility depending on the physician's specialty, the age and complexity of the patients they treat, and factors such as the number of available examination rooms and clinic support staff. VA patients tend to be elderly (mean age 63) with complex comorbidities compared to many health care organizations in the private sector and private practices. It is important to note that not all clinical encounters are equal—more complex patients require more time. This universally-recognized variation in the complexity of clinical encounters is accounted for by the use of "relative value units" (RVUs) that consider the time and intensity of the service delivered by the provider during a given encounter. Within Veterans Health Administration (VHA), we calculate and monitor the RVU-based productivity of our providers.

The largest component of VHA's physician workforce is the Internal Medicine specialty (largely primary care), representing over 5,000 full-time equivalent employees or approximately 25 percent of our total physician workforce. Internal medicine physicians tend to be assigned older Veterans and those with multiple medical problems in their patient panels. The average number of appointments a typical internal medicine specialist sees ranges from 7 to 22 patients per day across all VHA sites, with the overall average being about 10 patients per day. A survey conducted by the nonprofit group Physicians Foundation and reported in the Washington Post indicates that 39.8 percent of U.S. doctors see between 11 and 20 patients per day.

In addition, the re-organization of primary care into Patient Aligned Care Teams (PACT) featuring more comprehensive and coordinated health care requires more face-to-face time with the provider at each visit. With the advent of PACT, primary care teams were encouraged to offer different venues of care to meet the preferences, convenience, and specific health care needs of Veterans. A greater reliance on health care via telephone, group visits, and secure messaging is encouraged, allowing a reduction in face-to-face clinic visits with a commensurate increase in virtual patient encounters.

B. What steps has VA taken to evaluate the number of patient appointment slots to ensure that VA is maximizing their resources?

Response. VistA Scheduling, the software tool currently used to schedule appointments with providers, is not adequate to maximize resources because of the design of the nearly 30 year old software. A report called the Clinic Utilization Statistical Summary is available to each site, but can be very difficult to understand and interpret. To improve the situation, VA has produced a report nationally called the Access Index. The Access Index, available for every VA Clinic Profile, allows users to measure and understand the relationship between patient appointments and clinic slots. This report measures both the utilization of the schedule (how much of the available schedule was booked) and utilization of slots (how many available slots were used) for that individual profile. It also allows clinicians to understand the relationship between appointment length and slot length, which can be different. In

addition, VA clinicians commonly have multiple profiles, (for example Mental Health providers have an average of 7 profiles), which makes overall assessment of evaluation the maximization of resources more challenging. To resolve this situation, VA is pursuing acquisition of a modern commercial off-the-shelf package that will enable better resource management.

Question 24. Mr. Secretary, in your testimony, you state that, in facilities identified during the Nationwide Access Audit as having problems, VA will begin administrative procedures to determine the appropriate personnel actions needed.

A. What personnel actions has VA taken either at the facility, VISN, or Central Office?

Response. We are in the midst of a nationwide accountability audit, in follow—up to the access audit, to determine which supervisors, managers and employees may have intentionally directed or carried out inappropriate scheduling practices. Nine scheduling-related personnel actions have been proposed to date and we expect others may be necessary as our accountability investigations continue.

B. Has anybody directly related to the improper scheduling practices been fired?

Response. All proposed disciplinary actions are still in progress. Some of the proposals do involve termination of employment.

Question 25. On June 18, 2014, Secretary Gibson, you announced that VA medical facilities Directors would conduct monthly in-person reviews of scheduling practices. While this is an important step to ensuring that correcting inappropriate scheduling practices remains a top priority, I am concerned that the "corrosive culture" and whistleblower retaliation will make it unlikely that VA employees will accurately portray additional barriers to access.

A. Secretary Gibson, do you share my concerns, and if so, how does the organization overcome these issues?

Response. VA recognizes the dedication and courage shown by employees who report violations of law, wrongdoing, waste, fraud, and abuse. VA is committed to protecting whistleblowers from retaliation. VA is working closely with the U.S. Office of Special Counsel (OSC) to investigate allegations of retaliation, and VA will take corrective action where there has been a finding of retaliation. This may include, but is not limited to, placing the whistleblower back into his or her position, or assigning the whistleblower to a new supervisor or position. In addition, when substantiated, VA will, as appropriate, take disciplinary action against employees who have committed acts of retaliation.

On July 11, 2014, VA registered for the OSC Section 2302(c) Certification Program. This Program will allow VA to meet its statutory obligation to inform its employees about the rights and remedies available to them under the Whistleblower Protection Act, the Whistleblower Protection Enhancement Act, and related civil service laws.

On October 7, 2014, VA received that certification from the OSC. This is an acknowledgement of the seriousness, commitment, and resources the VA is directing toward fundamental change in VA's systems and culture.

Under the OSC certification process, VA:

1. placed informational posters regarding prohibited personnel practices (PPP), whistleblowing, and whistleblower retaliation in a public setting at VA facilities and VA personnel and equal employment opportunity offices;
2. provided and will continue to provide new hires with written materials on PPP, whistleblowing, and whistleblower retaliation;
3. developed a Web site on PPP and whistleblower rights and protections; and
4. developed, in cooperation with the OSC, supervisory training on PPP and whistleblower rights and protections. VA executives, managers, and supervisors must complete this training on a biennial basis.

One of the requirements of the Program is that all supervisors in the agency complete training on whistleblower rights and protections and prohibited personnel practices. To that extent, VA has worked closely with the OSC to develop specialized training for VA executives, managers, and supervisors on whistleblower rights and protections and prohibited personnel practices. VA executives, managers, and supervisors were required to complete this training by September 30, 2014, and biennially thereafter.

To reinforce the above, VA leadership sent a message to all VA employees regarding the importance of whistleblower protection emphasizing that managers and supervisors bear a special responsibility for enforcing whistleblower protection laws, and meets with employees at VA facilities across the country to reemphasize that message.

VA's Office of Diversity and Inclusion (ODI) is also conducting on-site and virtual training for facility leadership on workplace inclusion, prevention of workplace har-

assment, and whistleblower protections. ODI also recently issued communications on whistleblower rights and protections through its Diversity@Work Newsletter and Diversity News Broadcast, accessible on ODI's Webpage, http://www.diversity.va.gov.

As part of VA's commitment to whistleblower rights and protections, VA has established a whistleblower Webpage, http://www.diversity.va.gov/whistleblower.aspx, accessible from VA's internet home page, http://www.va.gov. VA's whistleblower Webpage outlines employee and supervisor rights and responsibilities, including avenues of redress for complaints, informational posters and materials, and whistleblower training resources.

Additionally, VA has established the Office of Accountability Review (OAR) to ensure leadership accountability for improprieties related to patient scheduling and access to care, whistleblower retaliation and related matters that impact public trust in VA. Since September 26, VA has announced the proposed removal of four senior executives following investigations by the OAR and the VA Office of Inspector General.

Other actions include a memo to all employees from Secretary McDonald reaffirming the importance of VA's Core Values (Integrity, Commitment, Advocacy, Respect, and Excellence or I CARE).

VA will continue to take additional steps in creating a cultural shift within the organization and ensure its employees have a safe channel for disclosing whistleblower information.

Question 26. On June 23, 2014, the Office of Special Counsel sent a letter to the President regarding the "Continued Deficiencies at Department of Veterans Affairs' Facilities." This letter confirms the well-known cultural problems within the Department and VA's lack of responsiveness to problems that have been identified by independent investigative agencies. Secretary Gibson, you took immediate steps after receiving this letter, calling for a review of the Office of Medical Inspector and referring all hotline cases to the Office of Inspector General.

A. Has the comprehensive review of the Office of Medical Inspector been completed? Please provide the Committee with the results of this internal review.

Response. In response to the OSC's June 23, 2014, letter to the President that included criticisms of the Office of the Medical Inspector (OMI), the Acting Secretary of Veterans Affairs directed an immediate review and subsequent restructuring of OMI to better serve Veterans. He announced that this restructuring would create a strong internal audit function to ensure that health care quality and patient safety remain a primary and constant focus. On July 10, 2014, an Interim Director of OMI was appointed from outside the office to spearhead the restructuring effort. The Acting Secretary determined a clear need to revise the policies, procedures, and personnel structure by which OMI operates, and has directed a restructuring of the organization.

VA reviewed and is in the process of restructuring OMI to better serve Veterans. This restructuring creates a strong internal audit function to include risk assessment capabilities to ensure that health care quality and patient safety remain a primary and constant focus.

B. Would you please provide the Committee with a timeline for a path forward with respect to the restructuring of the Office of Medical Inspector?

Response. Since July 2014, OMI has made significant progress in restructuring the policies and procedures by which it operates. OMI's status as an independent, objective advisor to the Under Secretary for Health (USH) was reaffirmed in a memorandum signed by the USH in September 2014. After a two-month hiatus on accepting new cases, OMI resumed conducting OSC whistleblower investigations in September with a renewed focus on both health care quality and accountability. OMI's investigators have likewise adopted a revised standard for judging whether substantiated whistleblower allegations represent a threat to public health and safety.

OMI is working closely with VA's new Office of Accountability Review (OAR) as well as the Office of General Counsel before, during, and after its investigative site visits to VA medical facilities. Because of these closer working relationships and increased leadership oversight within both VHA and VA, a shared understanding has developed that VA's responses to OSC referrals represent the work of the entire Agency, not just OMI. In addition, OMI has established a more collaborative working relationship with OSC. More frequent communication allows OMI to clarify whistleblower allegations, encourage whistleblower cooperation (where necessary) with investigations, and share preliminary findings with OSC weeks before OSC receives VA's official written report.

Among other procedural changes, OMI provides a "Notice of Witness Obligations and Protections" to each witness to inform them of their responsibilities and rights, including protection from reprisal. In the area of personnel restructuring, each team of OMI investigators is now augmented by a human resources (HR) expert identified by OAR. This H.R. expert becomes an integral team member, in most cases traveling with other investigators to each site, where they are able to address instances of potential individual wrongdoing and advise the lead investigator on personnel matters, including disciplinary procedures. OMI is also hiring three additional senior, experienced Title 38, Nurse V program managers to expand its ability to manage the growing number of case investigations.

In addition, OMI conducted benchmarking activities in recent weeks with several external organizations within both the Federal Government and the private sector. This benchmarking has served to inform VA about internal audit procedures and standards used elsewhere in the health care industry, and provided new ideas and helpful reference materials. As a first step toward developing the desired internal audit function, VHA is realigning the Office of Compliance and Business Integrity (CBI), which performs financial audit, compliance, and business oversight activities, with OMI. By working together, these two offices can leverage CBI's auditing capability and OMI's clinical expertise to create the synergy needed to audit both business and clinical processes.

Further restructuring will continue in the coming months. VA would be happy to provide periodic updates.

C. How does the Department plan to ensure that all oversight offices, including the Office of Special Counsel and VA's Inspector General, are cooperating with VA's internal offices and working collaboratively to address systemic issues and potential patient harm?

Response. The mandate to review OMI's current environment served as a catalyst for a broader organizational assessment of VHA's capacity for maintaining effective oversight. In conjunction with OIG, VHA has implemented multiple processes that facilitate open, collaborative, and regular communications about systemic issues and potential patient harm. VHA and OIG use both informal and formal methods of communication: phone calls are common, frequent emails, and structured entrance/exit conferences and briefings.

VHA program office leadership meets monthly with Assistant Inspectors General (AIG) for Audit and Evaluation, Health Care Inspections, and Criminal Investigations. The purpose of the monthly meeting is to candidly exchange information about concerns by either party regarding upcoming or ongoing audits or inspections, hotline allegations of care deficiencies, early notification on significant findings from active reviews, VHA internal information about health care issues, and process improvements.

OMI also meets monthly with the AIG for Health Care Inspections to review cases and health care issues both groups are addressing to better inform future investigations. The two organizations also share information about planned inspections in an effort to avoid duplication and overlap and to benefit from any investigative activity that has already occurred.

In addition, OMI meets regularly with OSC to review the status of whistleblower investigations, and to discuss schedules for reports and other deliverables. These meetings should go a long way toward improving communication between OSC and VA on investigative findings, ensuring complaints are thoroughly examined and that whistleblower's receive the protections they are entitled to under the law.

The VA has also established an accountability review office, located within the Office of the Secretary and independent of VHA, to ensure that appropriate leadership accountability actions are taken when facility leaders are implicated in findings by OIG, OMI, or other investigative bodies. The accountability review office functions collaboratively with OIG, OSC and OMI to improve Departmental leaders' visibility over issues raised by various oversight entities.

This improved cooperation will help overcome some of the organization's current challenges in providing effective health care oversight, and should support efforts to restore Veterans' and the public's trust.

Question 27. At the hearing, Acting Secretary Gibson indicated that VA processes a quarter million non-VA care referrals per month and each referral includes, on average, seven appointments. For fiscal year 2013 and fiscal year 2014 to date, please provide a breakdown of the referrals by specialty and the average number of appointments per unique veteran by specialty.

Response. Attached in the Excel spreadsheet are authorizations per Category of Care (COC), as of 8–22–14, for Fee Basis Claims Systems authorizations by COC and noted is the arithmetic mean and median for each category.

FBCS Authorizations by Category of Care FY 2014 to present				
Category of Care	**# of authorizations**	**Average # of visits**	**Median**	**# of unique Veterans**
ACUPUNCTURE	8,816	9.66	8	7,179
ADULT DAY HEALTHCARE	285	65.41	36	137
ALLERGY AND IMMUNOLOGY	8,374	15.81	2	6,881
AMBULANCE	1	1.00	1	1
AMBULANCE MB	67	0.03	0	67
AMBULANCE UA	815	1.83	1	686
AQUA THERAPY	6	18.83	17	6
AUDIOLOGY	43,089	2.70	1	38,193
BIOFEEDBACK	73	8.45	1	68
BOWEL AND BLADDER	236	145.79	87.5	202
BRACHYTHERAPY	1	5.00	5	1
CARDIOLOGY	32	5.38	2	24
CARDIOLOGY CATH	2,142	2.24	1	1,960
CARDIOLOGY IMAGING	1,110	1.50	1	1,024
CARDIOLOGY REHAB	4,902	23.82	26	4,639
CARDIOLOGY STRESS TEST	4,350	2.12	1	4,210
CARDIOLOGY TESTS, PROCEDURES, STUDIES	29,371	2.17	1	22,735
CHEMOTHERAPY	1,047	11.74	1	885
CHIROPRACTIC	27,474	8.54	8	21,329
COLONOSCOPY	44,646	2.17	1	42,260
COMP & PEN - MENTAL HEALTH	10,263	1.48	1	9,533
COMP & PEN - AUDIO	23,647	0.92	1	21,980
COMP & PEN - MEDICAL	75,832	4.54	1	67,986
COMP & PEN - SPECIALTY	9,418	0.92	1	8,851
CONTRACT DIALYSIS	2	1.00	1	2
CT SCAN	4	1.00	1	2
DENTAL	72,897	1.11	1	50,540
DENTAL - CLASS II	8	0.88	1	4
DENTAL TESTS, PROCEDURES, STUDIES	11,305	4.25	1	8,586
DERMATOLOGY	33,657	3.39	2	29,071
DERMATOLOGY TESTS, PROCEDURES, STUDIES	12,497	4.57	3	11,433
DIALYSIS	10,633	36.78	6	7,613
EMERGENCY ROOM MB	16,308	0.00	0	11,355
EMERGENCY ROOM UA	4,984	0.00	0	3,543
EMG	2	1.00	1	2
ENDOCRINOLOGY	2,404	3.02	2	1,985
ENDOCRINOLOGY TESTS, PROCEDURES, STUDIES	568	2.80	2	535
ENT	13,255	2.31	1	11,130
ENT, TESTS PROCEDURES, STUDIES	5,120	2.66	1	4,511

Category of Care	# of authorizations	Average # of visits	Median	# of unique Veterans
ER VISIT/URGENT CARE	103,514	1.01	0	78,301
EYE PHOTOS	8	1.75	1	6
FEE ID CARD	8	24.88	24	8
GASTROENTEROLOGY	36,103	2.84	2	31,175
GASTROENTEROLOGY TESTS, PROCEDURES, STUDIES	22,761	1.96	1	20,399
GENETIC TESTING/COUNSELING	835	3.39	1	753
GYNECOLOGY	5,630	2.89	1	4,693
GYNECOLOGY TESTS, PROCEDURES, STUDIES	3,749	2.47	1	3,029
HEMATOLOGY/ONCOLOGY	13,783	11.35	1	9,006
HOME HEALTH OT	1	5.00	5	1
HOME HEALTH PT	20	10.40	9	17
HOME HEALTH RN	150	27.07	9	117
HOME HOSPICE	6	144.83	169.5	4
HOME INFUSION	8	73.13	0.5	8
HOMEMAKER/HOME HEALTH	1,918	116.49	52	1,299
HOSPICE	5	136.00	95	5
HYPERBARIC THERAPY	649	13.50	3	456
INFECTIOUS DISEASE	1,027	3.63	2	901
INFUSION THERAPY	11	61.09	6	9
INTERVENTIONAL RADIOLOGY	6	2.33	1	4
IV THERAPY/INFUSION, CLINIC	1,539	12.86	3	1,251
LAB AND PATHOLOGY	21,437	4.47	1	17,181
MEDICINE NOS	24,573	19.17	4	19,657
MENTAL HEALTH	22,928	19.80	8	16,959
NEPHROLOGY	8,984	17.24	2	6,875
NEUROLOGY	21,931	2.14	1	18,655
NEUROLOGY TESTS, PROCEDURES, STUDIES	18,798	3.01	1	15,753
NEUROPSYCH TESTING	881	2.40	1	836
NEUROSURGERY	47	1.60	1	41
NEWBORN CARE	456	4.49	0	436
NIC ADULT DAY CARE	8,017	77.33	50	6,083
NIC BOWEL AND BLADDER	2,550	143.54	80.5	1,947
NIC HOMEMAKER/HOME HEALTH AID	104,271	66.10	32	63,898
NIC HOSPICE/PALLIATIVE CARE	9,171	67.14	46	7,739
NIC IV THERAPY/INFUSION	6,888	22.66	9	5,610
NIC RESPITE CARE	19,487	19.13	8	12,846
NIC SKILLED HOME CARE	39,596	13.41	7	30,319
NIC SKILLED NURSING	74,655	14.69	6	52,662
NIC SPINAL CORD CARE	67	206.93	365	59
NIC TOTAL LTC/PACE, PILOT	36	3.58	1	32
NUCLEAR MEDICINE	6,399	1.07	1	6,007
NUTRITION/DIETITIAN	300	48.02	18	249

Category of Care	# of authorizations	Average # of visits	Median	# of unique Veterans
OBSTETRICS	7,924	13.00	3	6,400
OCCUPATIONAL THERAPY	1	18.00	18	1
OPHTHALMOLOGY	53,464	4.48	1	44,779
OPHTHALMOLOGY TESTS, PROCEDURES, STUDIES	23,135	3.53	1	19,841
OPTOMETRY	120,943	1.57	1	116,962
ORTHOPEDIC	38,198	3.37	1	29,174
ORTHOPEDIC TESTS, PROCEDURES, STUDIES	19,469	3.03	1	15,508
PAIN MANAGEMENT	32,225	4.78	3	25,009
PHARMACY	1,038	4.40	1	657
PHYSICAL THERAPY	120,320	10.02	8	100,632
PLASTIC SURGERY	2,798	3.02	1	2,328
PODIATRY	18,038	3.16	2	15,845
PRIMARY CARE	71	12.87	2	57
PSYCHOLOGY	67	32.67	12	42
PULMONARY	10,822	2.72	2	9,555
PULMONARY REHAB	1,950	22.18	24	1,859
PULMONARY TESTS, PROCEDURES, STUDIES	5,435	1.84	1	5,080
RADIATION THERAPY	22,808	17.96	2	16,071
RADIOLOGY CT SCAN	17,901	0.98	1	15,330
RADIOLOGY DEXA SCAN	2,453	0.75	1	2,395
RADIOLOGY MAMMOGRAM	84,692	1.84	1	72,683
RADIOLOGY MRI/MRA	56,500	1.39	1	48,849
RADIOLOGY NOS	49,167	2.10	1	40,976
RADIOLOGY PET SCAN	8,186	0.84	1	6,753
RADIOLOGY ULTRASOUND	32,619	1.04	1	29,356
REHABILITATION MEDICINE	8,415	9.77	7	7,429
RESPIRATORY THERAPY	713	1.02	0	590
RESPITE CARE	83	24.33	30	70
RETINAL SURGERY	10	2.70	1	8
RHEUMATOLOGY	3,048	3.24	3	2,673
SKILLED NURSING	272	28.45	15	241
SLEEP STUDY/POLYSOMNOGRAPHY	50,240	1.43	1	46,194
SPEECH THERAPY	1	1.00	1	1
SURGERY GENERAL	29,334	2.35	1	22,824
TRANSPORTATION	2,839	5.92	0	2,230
UROLOGY	21,399	2.97	2	17,166
UROLOGY TESTS, PROCEDURES, STUDIES	10,242	3.78	3	8,436
VASCULAR	5,770	2.69	1	4,808
VASCULAR STUDIES	6	2.50	1	6
VASCULAR SURGERY	12	3.25	2.5	9
VASCULAR TESTS, PROCEDURES, STUDIES	5,409	2.44	1	4,651
WOUND CARE	2,012	11.01	4	1,603

FBCS Authorizations by Category of Care FY 2013				
Category of Care	**# of Authorizations**	**Average # of visits**	**Median**	**# of unique Veterans**
ACUPUNCTURE	5,374	8.91	7	4,302
ADULT DAY HEALTHCARE	703	79.82	36	348
ALLERGY AND IMMUNOLOGY	6,930	20.20	3	5,127
AMBULANCE	26	1.85	1	23
AMBULANCE MB	61	1.02	1	59
AMBULANCE UA	513	1.26	1	448
AQUA THERAPY	25	19.24	18	20
AUDIOLOGY	43,611	1.72	1	38,429
BARIUM ENEMA	1	1.00	1	1
BIOFEEDBACK	103	5.95	1	94
BOWEL AND BLADDER	373	183.82	136	305
BRACHYTHERAPY	2	4.00	4	2
CARDIAC SURGERY	7	3.71	3	5
CARDIOLOGY	265	4.29	2	246
CARDIOLOGY CATH	2,102	1.84	1	1,942
CARDIOLOGY IMAGING	1,611	1.20	1	1,577
CARDIOLOGY REHAB	3,996	22.00	24	3,783
CARDIOLOGY STRESS TEST	3,948	1.31	1	3,799
CARDIOLOGY TESTS, PROCEDURES, STUDIES	22,064	2.44	1	17,902
CHEMOTHERAPY	913	12.71	1	770
CHIROPRACTIC	20,338	8.58	8	15,300
COLONOSCOPY	40,336	1.82	1	38,665
COMP & PEN - MENTAL HEALTH	8,730	1.77	1	7,723
COMP & PEN - AUDIO	17,806	1.49	1	16,779
COMP & PEN - MEDICAL	63,089	1.77	1	56,143
COMP & PEN - SPECIALTY	11,121	12.99	1	9,112
COMP & PENSION	34	4.74	1	28
CONTRACT DIALYSIS	88	109.34	156	71
CT SCAN	20	1.30	1	12
DENTAL	59,996	1.67	1	40,401
DENTAL - CLASS II	47	2.28	1	43
DENTAL TESTS, PROCEDURES, STUDIES	9,674	2.86	1	7,767
DERMATOLOGY	27,754	3.57	2	23,336
DERMATOLOGY TESTS, PROCEDURES, STUDIES	9,853	4.66	2	8,760

Category of Care	# of Authorizations	Average # of visits	Median	# of unique Veterans
DIALYSIS	16,703	49.74	12	9,022
ECHOCARDIOGRAM	5	1.80	1	5
EEG	2	1.00	1	2
EMERGENCY ROOM MB	12,599	0.82	1	8,924
EMERGENCY ROOM UA	4,142	0.81	1	3,047
EMG	44	2.80	3	44
ENDOCRINOLOGY	1,125	2.48	1	901
ENDOCRINOLOGY TESTS, PROCEDURES, STUDIES	529	4.05	3	484
ENT	11,496	2.06	1	9,216
ENT, TESTS PROCEDURES, STUDIES	3,756	2.37	1	3,311
EPS	3	1.00	1	3
ER VISIT/URGENT CARE	93,814	1.47	1	69,728
EYE PHOTOS	47	1.13	1	22
FEE ID CARD	12	37.25	36	10
GASTROENTEROLOGY	25,499	1.78	1	22,239
GASTROENTEROLOGY TESTS, PROCEDURES, STUDIE	18,397	2.04	1	16,307
GENETIC TESTING/COUNSELING	813	1.92	1	745
GYNECOLOGY	5,523	3.57	1	4,482
GYNECOLOGY TESTS, PROCEDURES, STUDIES	3,442	3.33	1	2,781
HAND	11	1.91	1	9
HEMATOLOGY/ONCOLOGY	12,103	12.15	1	8,037
HOME HEALTH OT	8	3.38	1	8
HOME HEALTH PT	92	13.67	15	78
HOME HEALTH RN	628	20.84	8	553
HOME HOSPICE	42	102.33	90	28
HOME INFUSION	46	22.61	1	26
HOMEMAKER/HOME HEALTH	4,878	93.96	52	3,029
HOSPICE	46	160.24	125	34
HYPERBARIC THERAPY	659	14.76	5	474
INFECTIOUS DISEASE	782	4.49	2	650
INFUSION THERAPY	31	30.68	6	26
INTERVENTIONAL RADIOLOGY	31	3.03	1	16
IV THERAPY/INFUSION, CLINIC	1,747	13.20	3	1,408
LAB AND PATHOLOGY	28,306	4.14	1	21,622
MEDICINE NOS	15,954	6.11	1	12,706
MENTAL HEALTH	16,658	20.88	6	13,205

Category of Care	# of Authorizations	Average # of visits	Median	# of unique Veterans
NEPHROLOGY	8,778	20.34	3	6,172
NEUROLOGY	16,902	2.08	1	14,082
NEUROLOGY TESTS, PROCEDURES, STUDIES	13,964	1.79	1	11,670
NEUROPSYCH TESTING	540	1.61	1	526
NEUROSURGERY	173	2.86	1	145
NEWBORN CARE	333	3.32	1	323
NIC ADULT DAY CARE	7,506	86.90	52	4,977
NIC BOWEL AND BLADDER	2,342	169.97	122	1,769
NIC HOMEMAKER/HOME HEALTH AID	77,920	68.75	36	45,778
NIC HOSPICE/PALLIATIVE CARE	8,795	67.80	45	7,402
NIC IV THERAPY/INFUSION	6,790	25.12	10	5,451
NIC RESPITE CARE	15,298	24.48	13	10,431
NIC SKILLED HOME CARE	29,105	13.17	8	23,126
NIC SKILLED NURSING	60,883	15.84	7	46,118
NIC SPINAL CORD CARE	47	14.62	6	47
NIC TOTAL LTC/PACE, PILOT	13	23.54	12	13
NUCLEAR MEDICINE	4,900	0.95	1	4,666
NUCLEAR STUDY	9	1.00	1	9
NUTRITION/DIETITIAN	367	32.39	29	236
OBSTETRICS	7,311	14.26	3	5,859
OCCUPATIONAL THERAPY	14	8.79	6	13
OPHTHALMOLOGY	54,524	2.51	1	44,358
OPHTHALMOLOGY TESTS, PROCEDURES, STUDIES	21,609	2.35	1	17,087
OPTOMETRY	97,877	1.47	1	93,020
ORTHOPEDIC	32,702	2.71	1	24,264
ORTHOPEDIC TESTS, PROCEDURES, STUDIES	12,128	3.03	1	9,868
PAIN MANAGEMENT	23,367	3.93	2	16,722
PHARMACY	1,098	2.45	1	851
PHYSICAL THERAPY	95,171	9.41	8	78,755
PLASTIC SURGERY	1,973	3.01	1	1,672
PODIATRY	14,708	3.02	2	13,252
PRIMARY CARE	181	2.80	2	128
PSYCHOLOGY	198	18.26	12	87
PULMONARY	9,522	2.39	2	8,212
PULMONARY REHAB	1,482	20.91	18	1,384
PULMONARY TESTS, PROCEDURES, STUDIES	5,170	1.50	1	4,776

Category of Care	# of Authorizations	Average # of visits	Median	# of unique Veterans
RADIATION THERAPY	23,118	15.66	1	16,241
RADIOLOGY CT SCAN	13,109	1.06	1	11,592
RADIOLOGY DEXA SCAN	2,249	1.17	1	2,192
RADIOLOGY MAMMOGRAM	90,520	1.57	1	76,034
RADIOLOGY MRI/MRA	46,027	1.08	1	40,130
RADIOLOGY NOS	48,913	1.18	1	40,977
RADIOLOGY PET SCAN	7,609	1.01	1	6,228
RADIOLOGY ULTRASOUND	27,827	1.16	1	24,949
REHABILITATION MEDICINE	7,563	10.83	8	6,644
RESPIRATORY THERAPY	1,284	8.42	1	1,025
RESPITE CARE	469	18.44	12	403
RETINAL SURGERY	51	2.43	1	25
RHEUMATOLOGY	1,902	2.93	2	1,613
SKILLED NURSING	161	13.71	1	140
SLEEP STUDY/POLYSOMNOGRAPHY	44,608	2.68	1	41,477
SPEECH THERAPY	21	16.95	11	18
STERIOTACTIC BIOPSY	2	1.00	1	2
SURGERY GENERAL	21,257	2.32	1	16,354
TRANSPORTATION	5,834	2.05	1	4,335
UROLOGY	13,302	2.64	1	10,651
UROLOGY TESTS, PROCEDURES, STUDIES	5,457	2.69	1	4,686
VASCULAR	4,351	2.09	1	3,731
VASCULAR STUDIES	27	1.52	1	25
VASCULAR SURGERY	50	4.08	1	43
VASCULAR TESTS, PROCEDURES, STUDIES	4226	2.5156176	1	3534
WOUND CARE	1,781	9.17	4	1,412

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 28. What is your response to those who say the VA's workforce shortages are a myth, and that the real problem is VA medical personnel who are not working hard or fast enough? Why is it unproductive to point to the number of patients seen in a day or year by doctors in the private sector, and demand the VA meet those same numbers? Would establishing such benchmarks help veterans?

Response. Veterans Health Administration (VHA) has a physician workforce of more than 18,000 full-time equivalent employees representing over 30 sub-specialties. The largest proportion of VHA's physician workforce is composed of Internal Medicine (largely primary care) and Mental Health (psychiatrists), representing nearly half of the physician workforce. The majority of VHA's physicians are salaried, with approximately 10 percent of the physician workforce working in a VA facility on a fee-basis or under another contractual type arrangement. Primary Care (PC), the largest component of the Department of Veterans Affairs (VA) physician workforce (34 percent), has been employing a panel model for standardizing productivity and staffing in PC since 2004. Mental Health, the second largest component of VA's physician workforce (14 percent) has developed a productivity model that was implemented in June 2013. As of July 2014, 91 percent of all specialties have productivity and staffing standards in place and the remaining specialties will be completed by September 30, 2014.

It is unproductive to point to the number of patients seen by doctors in the private sector and demand the VA meet those same numbers because some private sector doctors tend to be financially rewarded for the number of patients they see in a day. However, not all patients need face-to-face visits with a physician in order to meet their needs. By contrast, VA doctors are encouraged to have flexible schedules to meet urgent needs. As well, since 2010, VA primary care workforce has embraced the patient centered medical home model that uses a diversified approach to providing patient care. Patient Aligned Care Teams utilize multiple diverse interdisciplinary team members to provide care to each patient. This allows the team to efficiently customize patient care to meet the individual and unique needs of our Veterans. Although some Veterans require frequent face-to-face visits with their provider, many benefit more from telephone interactions, secure messaging, or care from other team members including nurses, behavioral therapists, clinical pharmacists, and social workers. Following PACT implementation, providers often see a decrease in scheduled face-to-face visits with their patients, but patients will have an increased number of contacts (face-to-face and non-face-to-face) with their entire provider team. Providers are able to use this time to manage their panel of patients by processing clinical reminders, managing clinical computer alerts, performing telephone and virtual visits and interacting with their primary care team members. Providers are actually encouraged to keep 10–20 percent of their daily visit slots unscheduled to allow flexibility to manage urgent needs for their patients, with a goal toward reducing reliance on urgent care and emergency department utilization. Therefore, approximating provider workload by monitoring number of face-to-face visits alone ignores the complexity of managing all of the "ways in" that are visible to a patient: face-to-face, telephone, secure messaging, team member visits, etc. The overall team effort adds value to our Veterans' health and well-being.

Question 29. I understand that the VA just enacted a hiring freeze for the VHA Central Office and VISN offices in order to put more emphasis on increasing personnel at medical facilities. Can you elaborate on this decision—why was it made and what are the early results? Has the VA seen any gains in personnel? Moving forward, are the VHA Central Office and VISN offices improperly staffed?

Response. Per the attached June 9, 2014, press release, bullet #3 cites the specific language then-Acting Secretary Gibson used to announce and explain the hiring freeze. The hiring freeze enables Human Resources staff to focus on hiring for mission critical positions which directly support Veterans' access and care. The Department is assessing the organization and staffing of VHA Central Office and VISN HQs. The hiring freeze ensures we retain our focus on operational hiring in the field, while the evaluation of a more streamlined headquarters management structure continues.

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FOR IMMEDIATE RELEASE

June 9, 2014

VA Releases Data on Quality, Access to Veterans Healthcare

1Acting Secretary Gibson Provides Transparency, Announces Further Actions on Timely Healthcare Access

WASHINGTON—Today, the Department of Veterans Affairs (VA) released the results from its Nationwide Access Audit, along with facility level patient access data, medical center quality and efficiency data, and mental health provider survey data, for all Veterans health facilities.

Full details made public at VA.gov follow Acting Secretary of Veterans Affairs Sloan Gibson's commitment last week in Phoenix, Arizona and San Antonio, Texas to provide timely access to quality healthcare Veterans have earned and deserved.

"It is our duty and our privilege to provide Veterans the care they have earned through their service and sacrifice," said Acting Secretary Gibson. "As the President has said, as Secretary Shinseki said, and as I stated plainly last week, we must work together to fix the unacceptable, systemic problems in accessing VA healthcare.

"Today, we're providing the details to offer transparency into the scale of our challenges, and of our system itself. I'll repeat—this data shows the extent of the systemic problems we face, problems that demand immediate actions. As of today, VA has contacted 50,000 Veterans across the country to get them off of wait lists and into clinics. Veterans deserve to have full faith in their VA, and they will keep hearing from us until all our Veterans receive the care they've earned."

Acting Secretary Gibson announced a series of additional actions in response to today's audit findings and data, including:

- **Establishing New Patient Satisfaction Measurement Program**
  Acting Secretary Gibson has directed VHA to immediately begin developing a new patient satisfaction measurement program to provide real-time, robust, location-by-location information on patient satisfaction, to include satisfaction data of those Veterans attempting to access VA healthcare for the first time. This program will be developed with input from Veterans Service Organizations, outside health care organizations, and other entities. This will ensure VA collects an additional set of data—directly from the Veteran's perspective—to understand how VA is doing throughout the system.

- **Holding Senior Leaders Accountable**
  Where audited sites identify concerns within the parent facility or its affiliated clinics, VA will trigger administrative procedures to ascertain the appropriate follow-on personnel actions for specific individuals.

- **Ordering an Immediate VHA Central Office and VISN Office Hiring Freeze**
  Acting Secretary Gibson has ordered an immediate hiring freeze at the Veterans Health Administration (VHA) central office in Washington D.C. and the 21 VHA Veterans Integrated Service Network (VISN) regional offices, except for critical positions to be approved by the Secretary on a case-by-case basis. This action will begin to remove bureaucratic obstacles and establish responsive, forward leaning leadership.

- **Removing 14-Day Scheduling Goal**
  VA is eliminating the 14-day scheduling goal from employee performance contracts. This action will eliminate incentives to engage in inappropriate scheduling practices or behaviors.

- **Increasing Transparency by Posting Data Twice-Monthly**
  At the direction of the Acting Secretary, VHA will post regular updates to the access data released today at the middle and end of each month at VA.gov. Twice-monthly data updates will enhance transparency and provide the most immediate information to Veterans and the public on Veterans access to quality healthcare.

- **Initiating an Independent, External Audit of Scheduling Practices**
  Acting Secretary Gibson has also directed that an independent, external audit of system-wide VHA scheduling practices be performed.
- **Sending Additional Frontline Team to Address Phoenix**
  Following his trip to Phoenix VA Medical Center last week, Acting Secretary Gibson directed a VHA frontline team to travel to Phoenix to immediately address scheduling, access, and resource requirements needed to provide Veterans the timely, quality healthcare they deserve.
- **Utilizing High Performing Facilities to Help Those That Need Improvement**
  VA will formalize a process in which high performing facilities provide direct assistance and share best practices with facilities that require improvement on particular medical center quality and efficiency, also known as SAIL, performance measures.
- **Applying Immediate Access Reforms Announced in Phoenix to Most Challenged VA Facilities**
  Last week, Acting Secretary Gibson announced a series of measures to address healthcare access problems in Phoenix. Today, Acting Secretary Gibson announced he'll apply the same reforms to facilities with the most access problems from the results of the audit, including:
  - **Hiring Additional Clinical and Patient Support Staff**
    VA will deploy teams of dedicated human resource employees to accelerate the hiring of additional, needed staff.
  - **Employing New Staffing Measures**
    VA's first goal is to get Veterans off wait lists and into clinics. VA is using temporary staffing measures, along with clinical and administrative support, to ensure these Veterans receive the care they have earned through their service.
  - **Deploying Mobile Medical Units**
    VA will send mobile medical units to facilities to immediately provide services to patients and Veterans awaiting care.
  - **Providing More Care by Modifying Local Contract Operations**
    VA will modify local contract operations to be able to offer more community-based care to Veterans waiting to be seen by a doctor.
  - **Removing Senior Leadership Where Appropriate**
    Where appropriate, VA will initiate the process of removing senior leaders. Acting Secretary Gibson is committed to using all authority at VA's disposal to enforce accountability among senior leaders.
  - **Suspending Performance Awards**
    VA has suspended all VHA senior executive performance awards for FY 2014.
- **Future Travel**
  Over the course of the next several weeks, Acting Secretary Gibson will travel to a series of VA facilities across the country. He will hear directly from Veterans and employees about obstacles to providing timely, quality care and how VA can immediately address them.

National audit and patient access data available at www.va.gov/health/access-audit.asp.

Medical center quality and efficiency (SAIL) and mental health data available at http://www.hospitalcompare.va.gov/.

# # #

Question 30. Is there a national standard for how long patients should wait to get primary care or mental health care? What is that standard? How frequently are those standards met? To what extent does the VA hold itself to those standards?

Response. There is no U.S. national standard within primary care in regard to wait times. At VA, patient needs often can be met via non-face-to-face communication or by visits with members of the Patient Aligned Care Team (Primary Care team), as well as Primary Care Provider appointments. The goal is to meet the patient's need in the most timely and clinically appropriate way possible.

Though there is not one U.S. national standard for mental health access, VA has attempted to measure mental health access based on Veteran preference and need

for the initial appointment and provider/Veteran agreed upon next visit date for follow-up visits.

VA's long-term goal for mental health oversight and metrics is the development of a finite number of composite measures that can help to "signal" when an organization is at risk of departing from a stated patient care or access goal, with recommended actions to address a given signal. However, short-term, VA is monitoring the number of new Veteran appointments seen in mental health, the number of Veterans departing inpatient mental treatment (including residential care) who are seen in outpatient care after discharge from such care, and aggressive monitoring of the Electronic Wait List as an indicator for delays in care.

Individual health care systems create their own goals and have a variety of methods to measure progress toward their goals. Merritt Hawkins, a physician staffing firm, polled five types of offices across the country about several types of non-emergency care wait times for new patient appointments. They found patients waited an average of 29-days nationally to see a dermatologist for a skin exam, 66-days to have a physical in Boston and 32-days for a heart evaluation by a cardiologist in Washington. The New York Times recently published an article on the issue: The Health Care Waiting Game: Long Waits for Doctors' Appointments Have Become the Norm (5 July, Elisabeth Rosenthal, New York, NY)

Because of recent experience with manipulation of wait-time measures at certain sites of care, VA is exploring ways to ensure validity and reliability in its access standards, including how to appropriately measure timely access to care, and is working to report patient ratings of access to care. See question 42 below.

Question 31. We are all well aware that the VA's scheduling system is outdated, far too easily manipulated and inadequate for both VA employees and veterans. I recently chaired a hearing of my Federal workforce subcommittee at which Stephen Warren testified that the VA is now moving forward quickly to solicit a new system. What is the latest update in obtaining the new system? When would such a system be operational and deployed?

Response. On August 25, 2014, VA announced its plan to issue a Request for Proposal (RFP) for a new Medical Appointment Scheduling System, which will replace the legacy scheduling system. The new system will improve access to care for Veterans by providing medical schedulers with cutting-edge, management-based scheduling software. A draft RFP was made public on September 17, 2014, and eligible vendors have a window to provide feedback. A final RFP is expected to be released by the end of October and vendors will have 30 days to respond from the day of issuance. Even as the VA issues an RFP to replace the existing system, efforts are underway to enhance the current scheduling system. Some of the enhancements include:

- VA recently awarded a contract to improve the existing scheduling interface, providing schedulers a calendar view of resources instead of the current text-based, multiple-screen view. This update is scheduled to begin roll out beginning in January 2015;
- VA is also developing mobile applications to allow Veterans to directly request certain types of primary care and mental health appointments (scheduled to begin deployment December 2014). Another application under development will give VA schedulers an easier-to-use interface to schedule medical appointments (scheduled to begin deployment December 2014); and
- VA is also rolling out new clinical video tele-Health capabilities in October 2014 to further enhance access to care.

As part of the current RFP preparation process, VA is working with Veterans Service Organizations (VSO) to incorporate the groups' feedback on requirements important to Veterans focusing on user experience and business process documentation. Additionally, the VA's acquisition process will comply with recently established legislative requirements related to the Department's scheduling software.

Question 32. To what extent does the VA currently offer evening and weekend appointments? Does the VA currently have sufficient staffing to expand this option to more veterans?

Response. Primary Care—VHA Directive 2013–001, *Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics*, explains in detail extended hour requirements for Primary Care and Mental Health Clinics. Weekly, extended hours for Primary Care Clinics must be available no less than one weekday and one weekend day per facility; these clinics must also cover the full range of general mental health services as defined in the Directive. Very large Community Based Outpatient Clinics are required to

have extended hours at least one day per week. Extended-hour clinics are defined as anytime outside of 8:00am–4:30pm Monday through Friday.

In FY 2013, VA primary care providers (PCP) conducted 119,573 in-person encounters during extended hours (23,253 week-end and 96,320 week-day). In FY 2014, VA PCPs conducted 195,039 in-person encounters during extended hours (67,167 weekend and 127,872 weekday).

Mental Health—VA is committed to providing mental health services to Veterans in a manner that may mitigate time of appointment as a barrier to such care. In FY 2013, VA delivered 121,096 in-person mental health encounters during extended hours on weekdays and 21,651 encounters during extended hours on weekends. The corresponding numbers for FY 2014 to date are 115,707 and 34,644.

Question 33. Last month, the VA announced plans to reorganize the Office of the Medical Inspector (OMI). Can you elaborate on the proposed changes? What is the expected completion of this reorganization? What led to the proposed changes?

Response. Please refer to the response to questions 26A and 26B.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 34. The twice-monthly data updates will enhance transparency and provide the immediate information to Veterans and the public on Veterans access to VA health care. According to the 3 July version Alaska has some of the shortest New Patient wait times in America. In fact our new patient average for Mental Health counseling is the 2nd fastest in the Nation. I believe this is a testament to the partnerships that our VA has established with Indian Health Services. What is the VA's plan to expand the Tribal Agreements?

Response. Based on the geographical and rural status of Alaska and because of the limited Department of Veterans Affairs (VA) presence in Alaska, VA's reimbursement agreements with Alaska Tribal Health Programs (THP) cover reimbursement for direct care services provided to eligible Alaska Native American Indian (AN/AI) Veterans as well as non-AN/AI Veterans. This along with the number of Veterans in Alaska in comparison to areas with a higher Veteran population may have indeed contributed to the shorter wait times for new patients. Currently, VA's national reimbursement agreement with the Indian Health Service (IHS) and reimbursement agreements with THP in the continental United States cover only eligible AN/AI Veterans. For Native Veterans, VA is expanding the number of agreements with tribal health care facilities. There are currently 59 signed agreements with another 63 in progress, as of August 6, 2014. In accordance with section 102(c)(2) of Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014, VA and IHS will assess the feasibility and advisability of expanding VA's agreements with IHS and THP (outside of Alaska) to cover Non-Native Veterans.

Question 35. VA has suspended all VHA senior executive performance awards for fiscal year 2014 and increased accountability for senior leaders. Do you expect to bring back these awards in 2015? If not, what is the plan to attract and retain superior executive leadership in the future?

Response. The Secretary is the final deciding official for senior executive performance ratings and awards. At this time, it is too early to determine the process for fiscal year 2015. However, VA's Senior Executive Service performance appraisal system is certified by the U.S. Office of Personnel Management, which allows VA to be competitive with other Federal agencies that are certified regarding individual pay and aggregate total compensation limits. In addition, VA still has the ability to offer incentives, such as retention incentives when competing for top talent.

Question 36. As you know in order for non-VA providers to provide care and services to veterans they need to have the right credentials, how will the VA work with non-VA providers to facilitate the delivery of telemedicine services across state lines?

Response. In 2006, the Office of General Counsel provided an opinion on Federal Supremacy and State medical licensing issues in Telemedicine contracts. In this opinion it states that, "VA can determine that contractors who are licensed in 'a' State are qualified to provide VA with teleradiology services in any State. Such contractors do not need to be licensed in the State(s) where the services are performed, including the State(s) they enter electronically using telemedicine." VHA Handbook 1100.19, Credentialing and Privileging was modified accordingly to state:

(a) Contracts for telemedicine and/or teleconsultation services need to require that these services be performed by appropriately-licensed individuals. Unless otherwise

required by the specific contract or Federal law (such as the Federal Controlled Substances Act), contract healthcare professionals must meet the same licensure requirements imposed on VA employees in the same profession whether they are on VA (Federal) property or not when providing telemedicine or teleconsultation services.

(b) Some states do not allow telemedicine and/or teleconsultation across state lines, unless the provider is licensed in the state where the patient is physically located. In these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged by VA. Prior to the commencement of services by the contract practitioners providing telemedicine and/or teleconsultation or remotely monitoring physiology data from Veteran patients, the State regulatory agency in the state in which the practitioner is physically located as well as the state where the patient is physically located, must be consulted. When dealing with Federal entities, additional licenses that authorize the provision of telemedicine and/or teleconsultation services in the relevant states may not be required. The opinion of the Regional Counsel needs to be sought in these matters.

The burden is on the contractor to address any issues that may be identified by the State regulatory agency in the state where the contractor is located as well as the State where the Veteran patient is located as well as the contractor's medical malpractice carrier. VA accepts any appropriately licensed health care provider.

Question 37. In the Veterans Access to Care thorough Choice, Accountability, and Transparency Act included is increased care to vets by non-VA providers, what policies are you implementing to increase sharing of electronic medical records between these providers and the VA?

Response. The Veterans Health Administration (VHA) has established a Virtual Lifetime Electronic Record (VLER) Program for electronic health information exchange (HIE) in accordance with national standards and specifications as described by the Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. Through VLER HIE, VHA now has the capability to exchange Veteran health data with private sector hospitals and clinics.

VLER provides secure and seamless access between Electronic Health Records in structured, standardized formats using national specifications. This Exchange is accomplished through several push and pull programmatic mechanisms, known as Direct and Exchange. Sharing of these records ensures that enrolled Veterans receive coordinated care between their VA clinicians and Non-VA health care providers.

There are many other health information sharing platforms that may be used by the HIE community in information sharing. VA is in the process of developing a VHA Directive that will provide guidance to VA health care facilities considering participating in local community HIE organizations. This same Directive will give guidance about using community HIE portals to view non-VA health information for Veterans.

Section 101(l)(2) of the Veterans Access, Choice, and Accountability Act provides that to the extent possible, medical records submitted by non-Department providers shall be submitted electronically. Furthermore, subsection 101(n) of the act requires that the Secretary prescribe interim final regulations on the implementation of subsection 101 of the Act; the sharing of electronic medical records will be considered in the drafting of such regulations.

Question 38. Given the Veterans Administration's need to increase access to high quality health care, how would implementation of the VHA Nursing handbook, and recognition of the Full Practice Authority of APRNs working in the VHA, help increase capacity and improve access for Veterans?

Response. The Office of Nursing Services began the development of a VHA nursing handbook in 2009 to establish policy for the process of care delivery and the elements of practice for nursing. All VA program offices provided input in 2012 utilizing the internal concurrence process. Since that time, the VHA Under Secretary for Health has conducted meetings with several internal and external stakeholders including a variety of professional organizations, as well as Veterans Service Organizations. The proposed change is being driven by the efficacious use of resources and to decrease variability in care provided by Advanced Practice Registered Nurses (APRN) throughout the VA system.

The 2010 Institute of Medicine (IOM) landmark report, "The Future of Nursing: Leading Change, Advancing Health," recommended removal of scope-of-practice barriers to allow APRNs to practice to the full extent of their education, training and certification. This evidenced-based recommendation by the IOM prompted VHA to propose Full Practice Authority (FPA) for APRNs. Thus, VHA's proposed Nursing Handbook is consistent with the IOM recommendation to remove barriers including

the variation in APRN practice that exists across VHA as a result of disparate state regulations.

The VHA's proposed policy is consistent with the National Council of State Boards of Nursing Consensus Model and includes all APRN roles. Model APRN regulation is aimed at public protection by ensuring uniformity across all jurisdictions. Uniformity of national standards and regulation not only allows for the mobility of nurses, it also serves the public by increasing access to care. Within the nursing handbook, VHA is proposing the authorization of FPA for APRNs, without regard to their individual State Practice Acts, except for the dispensing, prescribing and administration of controlled substances. This proposed change to nursing policy would standardize APRN practice throughout the VA system. As an integrated Federal health care system, the proposed policy parallels current policy in the Department of Defense (DOD). Implementation of FPA in VHA would enable Servicemen and women transitioning from DOD to VA, to receive the same level of care from APRNs in both systems.

A significant number of states have approved full practice authority for APRNs, with many VA medical centers successfully utilizing APRNs to the full extent of their education and training. The proposed nursing policy would not authorize APRNs to replace or act as physicians; the proposed nursing policy would authorize FPA within the field of nursing. Implementation of FPA for APRNs would increase patient access by alleviating the effects of national health care provider shortages on VA staffing levels, as well as, enabling VA to provide additional health care services in medically underserved areas.

The VA released an audit in early June 2014 showing that more than 57,000 Veterans have had to wait at least 3-months for initial appointments. There has been a large influx of new enrollees in the VA Health Care System and VA statistics demonstrate a consistent upward trend in enrollment numbers since 2000. Over the past 3 years, primary care appointments have increased by 50 percent, yet the primary care physician staff has increased by

9 percent. Many nurse practitioners are working in these clinics, but are not able to function to the full extent of their education and training, due to barriers created by disparate state regulations.

Implementation of FPA would allow APRNs to function at the top of their education, training and certification, resulting in increased access to VA primary care services in states where scope of practice barriers currently limit an APRN's ability to practice. VHA would be able to utilize APRN providers to improve patient access for Veterans in need of timely Primary Care services and to decrease waiting time for new patient appointments. FPA may also result in cost savings to VA by decreasing the need to outsource care to the community.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 39. Given the Veterans Administration's need to increase access to high quality health care, how would implementation of the VHA Nursing handbook, and recognition of the Full Practice Authority of Advanced Practice RNs working in the VHA help increase capacity and improve access for Veterans?

Response. Please see response to Question 38 above.

Question 40. Given the need to hire more clinicians and in the spirit of exploring all options, have you considered reaching out to former employees who recently retired or those who left the VA in the last year or two to see if they would be able to help assist to increase the capacity at the VA? Because they already know the system they could become fully productive faster than someone not familiar with the VA.

Response. As staffing needs vary across the Veterans Health Administration (VHA) system, facilities are encouraged to pursue the hiring of critical staff utilizing whatever means that would yield the most success (considering local labor markets and hiring trends). This includes hiring re-employed annuitants (retired Federal employees) and hiring former staff to perform work on a fee basis (per procedure).

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 41. Acting Secretary Gibson, in your prepared testimony you speak to removing the 14-day scheduling goal from VA policy. Do you anticipate another numeric goal being put in its place? If so, any thoughts on what it will be; did current

VA health schedulers have any ideas for a better target? I know you have met with private sector health providers; did these private providers have any thoughts on scheduling metrics or suggestions for a new system?

Response. The Department of Veterans Affairs (VA) is building a more robust, continuous system for measuring access and patient satisfaction, to provide real-time, robust, site-specific information on patient satisfaction. VA will augment our existing Survey of Health Experiences of Patients (SHEP) survey with new questions and larger sample size in the coming year, to capture more Veteran experience data using telephone, social media, and on-line means. Our effort includes close collaboration with the Veterans Service Organizations (VSO), with whom we have already met to begin planning our efforts. VA is also contracting for an independent assessment of the "current state" of clinic management infrastructure in addition to establishing a benchmark for access levels from the body of evidence and from other healthcare organizations.

The 14-day access measure has been removed from all individual employee performance plans to eliminate any motive for inappropriate scheduling practices or behaviors. In the course of completing this task, over 13,000 performance plans were amended—from then-Acting Secretary Gibson's prepared remarks before the Veterans of Foreign Wars Annual Convention July 22, 2014. VHA Schedulers have many comments on ways to improve the current process for scheduling including entering required time-stamp information, including Desired Date (DD). These ideas are in the process of being consolidated in a memo that will clarify existing policy and practice. Private sector practices tend to use capacity measures (such as the time to the third open slot) to measure access. VA has limited capability to use capacity measures because of legacy VistA scheduling software limitations. However, the Choice Act requires VA measure individual patient waiting times rather than capacity measures. VA has therefore proposed using the Veterans Preferred Date (formerly called the Desired Date) to meet the intent of the law. In order to improve the reliability of this measure, VHA anticipates adopting many elements of the new procedures suggested by schedulers, defining the clinic management role better, and standardizing the training of the clinic manager, including schedulers. While the waiting time goals have been removed from performance standards, the timeliness information will be need to comply with elements of the Choice Act. VA is exploring ways to ensure validity and reliability in its access standards, including how to appropriately measure timely access to care.

Question 42. Has the new patient satisfaction measurement program been put in place? Who will oversee that program? Will there be outreach to veterans to ensure they know their input is appreciated and crucial to future success of the system?

Response. The Department of Veterans Affairs (VA) is building a more robust, continuous system for measuring access and patient satisfaction, to provide real-time, robust, site-specific information on patient satisfaction. VA will augment our existing Survey of Health Experiences of Patients (SHEP) survey with new questions and larger sample size in the coming year, to capture more Veteran experience data using telephone, social media, and on-line means. Our effort includes close collaboration with the Veterans Service Organizations (VSO), with whom we have already met to begin planning our efforts. VA is also contracting for an independent assessment of the "current state" of clinic management infrastructure in addition to establishing a benchmark for access levels from the body of evidence and from other healthcare organizations.

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ways to ensure validity and reliability in its access standards, including how to appropriately measure timely access to care.

Question 43. I certainly appreciate the approach of looking at well performing medical centers and taking those best practices and using them at those places that need help and improvement to provide timely, quality care to our veterans. Are you able to say which VAMCs are the high performing facilities you will be looking at and some examples of the best practices you will try to spread from these places?

Response. VHA has formed a Steering Group to begin the process of determining how to measure the performance of facilities to find those that achieve excellent performance in their particular environment. This may allow for example, a small facility in a highly rural area to be paired with a like facility with better performance. Specific facilities in each domain have not yet been identified, nor which specific areas of vulnerability will need to be targeted. Further, best practices should be informed by the medical or business literature which may require additional research to ensure the validity of some practices.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DEAN HELLER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 44. It is my understanding the VA has not yet authorized construction for a new Community Based Outpatient Clinic (CBOC) in Pahrump, Nevada. The Director of the VA Southern Nevada Healthcare System, Isabel Duff, has indicated this proposal is awaiting approval by VA Central Office. To date, a timeline or any indication for approving this project has not been released. I respectfully request the VA provide a timeline for approving this clinic's construction so that the facility can break ground before Fall 2014.

Response. The lease package for the Pahrump, Nevada Community Based Outpatient Clinic was approved by the Under Secretary for Health on August 8, 2014, and subsequently by the Secretary on August 22, 2014. A copy of the signed approval memorandum was provided to the Veterans Integrated Services Network Capital Assets Manager on August 22, 2014. The Department of Veterans Affairs (VA) began the acquisition process, to include working with the General Services Administration (GSA), for this lease on August 22, 2014. VA anticipates a lease award for this site by the end of the calendar year.

Question 45. I respectfully request a timeline for expected completion of the second phase of the VA's face-to-face audits.

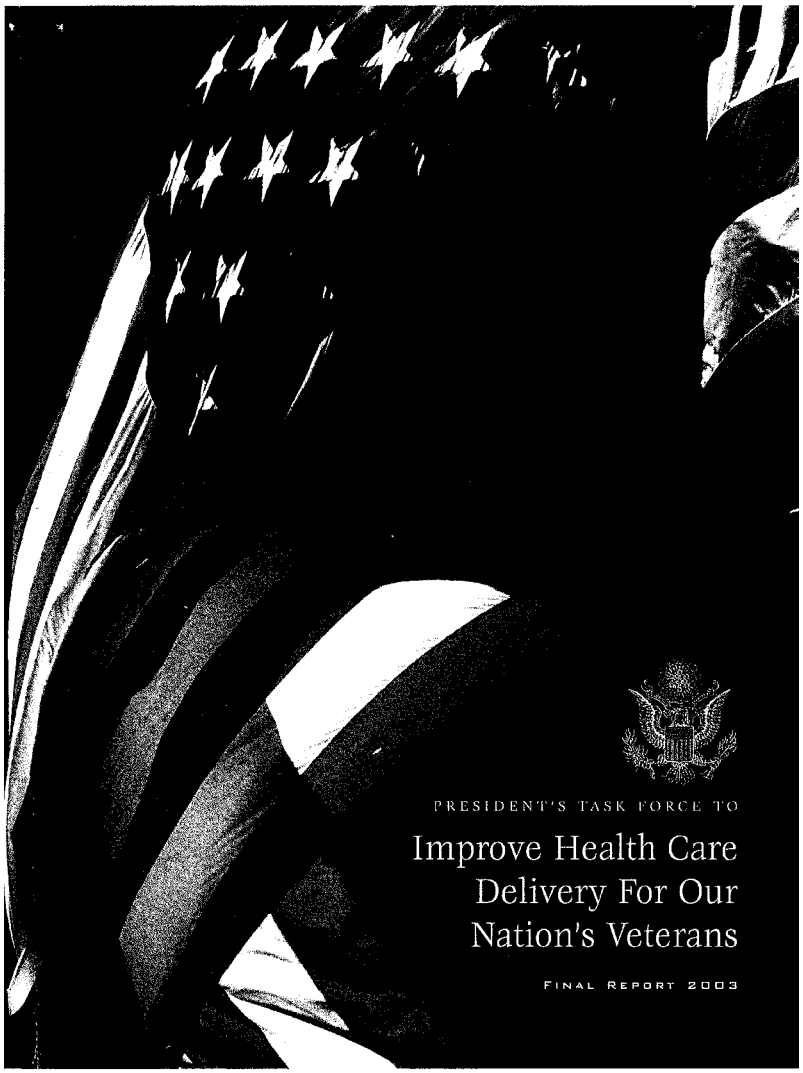
Response. The second phase of VA's face-to-face access audit concluded on June 4, 2014.

Question 46. During the hearing, you informed me that you would be visiting Reno, NV, in August 2014, and assured me that you would visit the Reno VA Regional Office during the trip. I respectfully ask for the dates of this trip and a complete list of the VA facilities in Nevada that you will visit.

Response. On Tuesday, August 19, 2014, Secretary McDonald conducted site visits to the Reno Nevada VA Regional Office and the Reno Nevada VA Medical Center.

A P P E N D I X

REPORT SUBMITTED BY HON. MARK BEGICH DATED MAY 2003 FROM THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS



President's Task Force To Improve Health Care Delivery For Our Nation's Veterans

FINAL REPORT

MAY 2003

President's Task Force To Improve
Health Care Delivery For Our Nation's Veterans

May 26, 2003

The President
The White House
Washington, DC 20500

Dear Mr. President:

We take great pleasure in presenting this *Final Report* of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. This report is submitted in accordance with the provisions of Executive Order 13214, dated May 28, 2001, and is dedicated to the memory of former Congressman Gerald B. Solomon, an original Task Force Co-Chair, a genuine patriot, and a staunch advocate for veterans.

As cited in our *Interim Report*, the Task Force was created to recommend bold, practical, and specific reforms in the delivery of health care to beneficiaries of the Department of Veterans Affairs and the Department of Defense. This report reflects the collective thinking of 15 Members with a wide diversity of viewpoints on how to improve beneficiary health care delivery. Task Force Members share a common desire to identify and address barriers to collaborative efforts between the Departments and offer this report as an alternative to the status quo in veterans' health care. The Task Force believes the recommendations in this report represent strategies for use in addressing barriers to collaboration and, when implemented, will complement and enhance your management agenda for VA and DOD.

As we submit this report, we express our appreciation for the cooperation and openness displayed by leaders and employees in both Departments, and in numerous field activities around the Nation. Many dedicated and enthusiastic people in VA and DOD have helped shape our findings and recommendations. Additionally, we have received great support from veterans' service organizations and military advocacy groups. We sincerely hope our recommendations will facilitate ongoing efforts to enhance the delivery of health care for our Nation's veterans.

Respectfully:

Gail R. Wilensky

GAIL R. WILENSKY, Ph.D.
Co-Chair

John Paul Hammerschmidt

JOHN PAUL HAMMERSCHMIDT
U.S. Congress, 1967-1993
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Harry N. Walters Former Administrator of VA under Reagan
Principal of the General Partnership
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Josh S. Weston
Honorary Chairman
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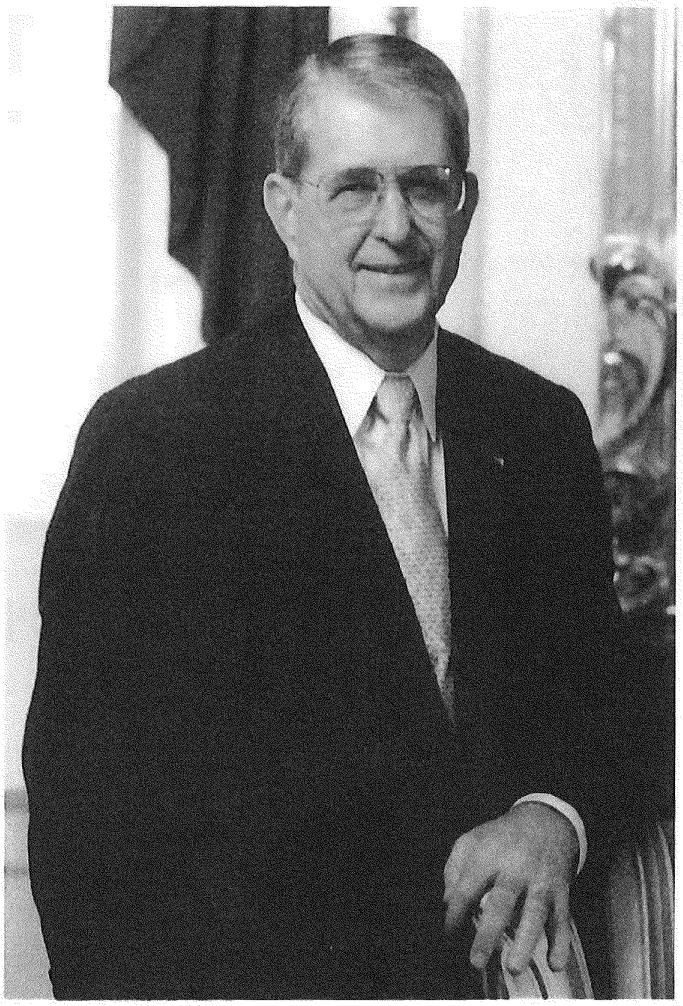
IN MEMORIAM



GERALD BROOKS HUNT SOLOMON

AUGUST 14, 1930 – OCTOBER 26, 2001

WAS Co-Chair

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. The charge to the Task Force was to identify ways to improve health care delivery to Department of Veterans Affairs (VA) and Department of Defense (DOD) beneficiaries through better coordination and improved business practices.

For more than two decades, there have been numerous efforts by Congress and the Executive Branch aimed at increasing collaboration and sharing between the two Departments in order to improve the efficiency and cost effectiveness of health care delivery for beneficiaries. Providing all enrolled veterans, including military retirees, with timely access to the full range of health benefits earned through service to their country is a national obligation, whether during their military service or once they have achieved veteran status.

As the Task Force visited numerous VA and DOD health care facilities around the country, conducted focus groups with individual beneficiaries, and met with many beneficiary organizations, it became clear that the current mismatch in VA between demand and available funding not only impedes collaboration efforts with DOD but that, if unresolved, the resultant delay in veterans' access to care could threaten the quality of VA health care.

Although enrolled veterans technically have access to the VA health care system, long waiting times for appointments with health care providers continue to be problematic for a significant number of veterans. As of January 2003, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care. While the overall number of veterans eligible for care in VA facilities is expected to decrease over the coming years, the actual number of beneficiaries seeking VA care is projected to increase because of factors outside of VA.

A confluence of events over the past decade—economic, budgetary, and structural—has created increased demands for, and pressures on, the VA and DOD health care systems. With the rising cost of health care and insurance premiums, veterans have been seeking alternative ways to pay for their health care. This phenomenon, along with the absence of an outpatient

pharmacy benefit under Medicare, appears to be causing significant numbers of veterans to seek health care from VA.

Finally, legislative, administrative, and structural changes have increased demand for VA care. Following the passage of the Veterans' Health Care Eligibility Reform Act of 1996, VA's mission moved from primarily treating veterans with service-connected disabilities and indigent veterans to offering a comprehensive health benefit to all enrolled veterans. The Veterans' Millennium Health Care and Benefits Act, enacted in 1999, further increased demand by expanding benefits. Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner.

Organizing Principles

In developing this report, the Task Force established four principles on which to organize its analyses and recommendations:

1. Committed leadership is essential to achieve VA/DOD collaboration to improve health care to veterans, including military retirees.
2. To provide timely, high-quality care, it is important to have seamless transition of information across the full lifecycle of health care for each veteran, especially at the point when he or she moves from military service to veteran or retiree status.
3. VA and DOD collaboration can improve quality, access, and efficiency of health care delivery by pooling resources, eliminating administrative barriers, and implementing change.
4. Despite the importance of collaboration in overcoming modest or temporary capacity shortfalls or surges in demand, the mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. Thus, the only effective way to address the growing problem of access in VA is to reduce the apparent mismatch between demand and funding.

Leadership

The Task Force is pleased with the current VA/DOD efforts on collaboration and sharing and with the organizational structures created to facilitate such efforts. Senior leadership of the Departments are clearly engaged, especially through the interagency leadership

committee. It is the responsibility of the leadership of the two Departments, starting with the Secretaries, to continue to demand actions that will ensure the success of VA/DOD collaboration.

VA and DOD leadership need to clearly and jointly articulate what is expected as the end state of collaboration and sharing. The goal is not collaboration for mere collaboration's sake, but rather, through such activity, to improve access to care and reduce the overall cost of furnishing services. There can be no ambiguity in the description of clear and measurable goals for improved cooperation.

Once those in leadership positions have communicated their directives, the Departments should issue plans in a timely manner, including performance expectations, measurements, and time lines. These plans should be communicated in a consistent manner to all levels of the two Departments and should be regularly reviewed for outcomes. To foster ongoing accountability, there should be an annual report from the interagency leadership committee to the Secretaries on the results of performance in the area of collaboration and sharing and next year's goals, including progress in implementing the recommendations in this report.

Seamless Transition to Veteran Status

VA and DOD responsibility for an individual's health begins as soon as the individual enters the Armed Forces. An important first step would be to gather baseline medical information upon entry into the military and capture it in an electronic medical record that would, at a later point, be able to readily and easily exchange appropriate health information with VA in mutually understood and usable formats. As no such capability exists today, the two Departments must collaboratively develop appropriate electronic medical records that can function in an interoperable, bi-directional manner.

During military service, information relevant to a service member's deployments, occupational exposures, and health conditions should follow the service member through his or her military career. Better recording, tracking, and reporting of occupational health data will improve the research base for understanding the etiology of service-related disorders, assist in benefits determinations, and improve the overall health of today's veterans as well as those who will follow them.

Once an individual separates from military service, the process for determining eligibility for veterans' benefits, assessing health status, and receiving care through the VA health care system should be seamless, timely, and accurate. These goals can only be accomplished through systems that are standards-based and coordinated between

VA and DOD. When an individual is separated from military service, he or she is issued a DD214, which is needed to access health care services in the VA system. VA has identified untimely access to the service member's DD214 as a major factor delaying determination of benefits. To ease the transition from service member to veteran status, VA and DOD should:

- implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process; and
- expand the "one-stop shopping" process to include, at a minimum, a standard discharge exam, full outreach, claimant counseling, and when appropriate, referral for a VA Compensation and Pension examination and follow-up claims adjudication and rating. Upon a service member's separation, DOD should transmit an electronic DD214 to VA.

Both VA and DOD will continue to face significant issues in dealing with veterans who develop health conditions as a result of possible occupational exposures and hazards during military service. VA and DOD should:

- expand their collaboration to identify, collect, and maintain data needed to: 1) recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and 2) conduct epidemiological studies to understand the consequences of occupational exposures and hazards;
- by fiscal year 2004, initiate a process for routine sharing of each service member's assignment history, exposures to occupational hazards, location, and injuries information; and
- jointly issue a publicly available annual report on Force Health Protection.

In addition, the President should direct VA and DOD to implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events.

Removing Barriers to VA/DOD Collaboration

Significant institutional barriers to collaboration arise from the ways VA and DOD—and the three Military Departments—develop and deploy their resource plans. These include the budgeting process, health care delivery plans, acquisition plans, and facility plans.

The PTF makes a series of recommendations to remove barriers and improve collaboration, including:

- revise health care organizational structures to provide more effective and coordinated management of the two health care systems, enhance overall health care outcomes, and improve structural congruence;
- integrate clinical pharmacy initiatives through the coordinated development of a national joint core formulary and a single, common clinical screening tool by fiscal year 2005;
- work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization in order to facilitate additional joint contracting initiatives;
- identify functional areas where the Departments have similar information requirements in order to re-engineer, where necessary, business processes and develop the specific functional information technology requirements needed to support them;
- implement facility lifecycle management practices on an enterprise-wide basis;
- declare that joint ventures are integral to the standard operations of both Departments and use the existing joint venture organizations as laboratories for developing future inter-departmental policy frameworks; and
- work together to identify and address staffing shortfalls, develop consistent clinical scopes of practice for non-physician providers, and ensure that the two provider credentialing systems can interface.

Eliminating the Mismatch Between Demand and Funding

Although the measures described above might help staff and facilities in some areas overcome modest or temporary capacity shortfalls or surges in demand, and standardization and compatibility of information systems and medical records between VA and DOD will provide lasting improvements in health care delivery to veterans, the apparent mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. The PTF is concerned that this mismatch affects the delivery of timely health care and impedes efforts to improve collaboration between VA and DOD.

In recent years, because of the entrance of veterans with income levels above VA's means test threshold with no compensable service-related disabilities (former Priority Group 7) into the VA health care system, and with funding not keeping pace with demand, many veterans in VA's traditional constituency, those veterans with service-connected disabilities and indigent veterans (Priority Groups 1 through 6), have been unable to obtain health care within VA's established access time frames. This situation is unacceptable.

The PTF developed recommendations in two separate but inextricably related areas: funding delivery of care within the access standard for Priority Groups 1 through 7 (new) and the need to clarify eligibility and benefits for Priority Group 8.

Congress and the Executive Branch must work together to provide full funding to meet demand, within VA's access standards, for Priority Groups 1 through 7 (new). The Task Force offers examples for consideration to modify the process used to fund health care delivery for these veterans. The Task Force also recommends that VA be accountable for meeting its established access standards; when appointments cannot be offered within the standard, the Department should be required to offer an enrolled veteran an appointment with a non-VA provider.

The Congress and the Executive Branch must resolve the status of veterans with income levels above VA's means test threshold with no compensable service-related disabilities (Priority Group 8).

For many years, there has been little disagreement on the need to improve collaboration and sharing between the two Departments. The structures needed to organize and implement collaboration and sharing are now in place, and current leadership has demonstrated a commitment to furthering this goal. What is needed is the will and focus to implement and sustain change.

CHAPTER ONE

Introduction and Background

Past Congresses and Presidents have honored the service and sacrifice of those who served in our Nation's Armed Forces by enacting legislation to provide military personnel and eligible veterans with access to quality health care. As a result of sustained federal support, the Departments of Veterans Affairs (VA) and Defense (DOD) have grown to become two giants in the health care industry. With combined annual health care budgets of nearly $50 billion, they offer care at a total of more than 1,600 sites nationwide. There are over 300,000 personnel in both systems, treating nearly 12 million beneficiaries. Both systems face the challenges of health care systems everywhere—new practices, techniques, and tools, changing demographics, aging infrastructure, and increasing costs. At the same time, access to health care is a growing concern for many Americans, and the health services provided through VA and DOD to beneficiaries are an increasingly important resource. Indeed, for some veterans, VA may be their only health care option.

All veterans, whether injured in military service or not, deserve clarity and fairness in the policies and practices related to benefits received following their service to the Nation. However, these individuals have not always been treated fairly, equitably, or appropriately when seeking access to health care. Eligibility requirements have changed over time, as have benefits. And, although enrolled veterans theoretically have access to the VA health care system, in reality long waiting times for appointments with health care providers continue to be an impediment for a significant number of enrollees. As of January 1, 2003, over 236,000 enrolled veterans were on waiting lists of more than six months for a first appointment or for an initial follow-up for health care from VA—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care.

As of January 1, 2003, over 236,000 enrolled veterans were on waiting lists of more than six months for a first appointment or for an initial follow-up for health care from VA.

CHAPTER FIVE

Timely Access to Health Services and the Mismatch between Demand and Funding

Access to health care is important to all Americans. It is especially important to and deserved by those who have served in the Armed Forces and suffered injuries as a result or who later experience health problems associated with their service. However, many of those who have made the commitment to defend our country have not always received fair, equitable, or appropriate access to health care once their military service is completed. The Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions. Based on PTF site visits and information provided by VA and veterans service organizations, there is persistent concern about the inability of VA to provide care to enrolled veterans within its established access standards. Although enrolled veterans theoretically have access to the VA health care system, in reality long waiting times for appointments with health care providers continue to be a problem for a significant number of enrollees.

The apparent mismatch between demand for access and available VA funding to meet this demand is too large to be solved by collaboration and sharing alone.

Chapters 3 and 4 of this report focus on the need to increase sharing and other collaborative efforts between VA and DOD and on the need for productivity improvements. Despite the importance of these efforts, it became apparent to the PTF that increased collaboration and sharing alone cannot improve access because neither system has sufficient excess capacity. Collaboration might help facilities in some areas overcome modest or temporary capacity shortfalls or surges in demand, and standardization and compatibility of information systems and medical records between VA and DOD will provide lasting improvements in health care delivery to veterans. However, the apparent mismatch between demand for access and available VA funding to meet this demand is too large to be solved by collaboration and sharing alone.

In recent years, with the entrance of the former Priority Group 7 veterans into the system, many veterans in Priority Groups 1 through 6 have been unable to obtain health care within VA's established access time frames (see Box 5.1 and Appendix F for more information on priority groups). This situation, in which the traditional users of the VA health care system—veterans with service-connected conditions and indigent veterans—must wait a long time for appointments and care, is unacceptable.

In this chapter, the PTF makes recommendations on ways to ensure full funding for the comprehensive benefit for Priority Groups 1 through 7 (new) within VA's access standards and emphasizes the need to clarify and address the status of Priority Group 8 veterans.

The Growing Mismatch Between Funding and Demand

In the past seven years, a number of events have coincided to create the current mismatch between demand for VA health care and funding. Some have been external to the VA system (see Box 5.2), and others have been a direct result of legislative and administrative actions.

Box 5.1 New Enrollment Priority Groups

Under law, VA assigns enrolled individuals to one of eight priority groups, with the highest priority given to veterans who have the most serious service-connected disabilities (see Appendix F for a description of priority groups). One of VA's historical missions is to treat indigent veterans. To meet the needs of this constituency, VA classified as Priority Group 5 those veterans with non-service connected disabilities and incomes below VA's established means test threshold ($24,644 for a single veteran and $29,576 for a veteran with one dependent). Veterans in this group are not required to pay for health care. However, Congress was also concerned about those veterans living in high-cost areas and earning only marginally more than the threshold. Although categorized as Priority Group 7 veterans, it was evident that these individuals needed relief to cushion the effects of required co-payments. As a result, in January 2002, the President signed the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107-135), creating a new category of veterans that acknowledges the high costs of living in many parts of the United States.

To implement the law, VA created two new priority groups to replace the old Priority Group 7. Veterans in the new Priority Group 7 must have incomes that exceed VA's national income threshold, but are below a geographically-adjusted means test—an income level set by the U.S. Department of Housing and Urban Development for over 3,000 counties across the country. This redefined Priority Group 7 qualifies for a reduction in co-payments. The new Priority Group 8 veterans are those with incomes either at or above the new geographic means test threshold. According to VA, about one-third of the former Priority Group 7 veterans will remain in the redefined Priority Group 7 and the remainder will be moved into Priority Group 8.

On the legislative front, two significant events have expanded the breadth and depth of the VA health care program. First, the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, hereinafter the Eligibility Reform Act) expanded the population of veterans who might receive VA care by allowing veterans to enroll whose incomes are above the established VA means test threshold and who do not have compensable service-connected conditions. Rather than create a new entitlement, Congress granted VA the authority to limit the population that could be enrolled in a given year and thus the means to stay within its annual appropriation.

In addition, the law greatly expanded access to outpatient care. Prior to 1996, most veterans were not authorized outpatient care unless they had recently been discharged from an inpatient setting or had a significant service-connected disability. Through this change, along with other actions to eliminate barriers to access—particularly access to primary care through the creation of more than 600 Community-Based Outpatient Clinics—VA intended to provide more care to more veterans, with the additional goal of increased cost-effectiveness. Other structural changes in VA's resource allocation methodology also have affected access and demand since the passage of the Eligibility Reform Act (see Box 5.3).

As required by the Act, to ensure that all enrolled veterans have access to the same level of health care, VA developed a comprehensive and uniform benefits package[1] that is offered to all enrollees, thus institutionalizing a comprehensive benefits package for

Box 5.2 VA Health Care in a Changing Environment

The increased demand for VA services is set against a backdrop of changes in the overall health care system. The shift from inpatient to outpatient care has made new demands on infrastructure and resources, while the increased use of expensive technologies and pharmaceuticals has added significantly to costs. In addition, since the late 1990s, premiums for employer-based health care coverage have increased steadily, and a growing number of employers are responding by shifting some of that cost to their employees (Henry J. Kaiser Family Foundation, May 2002). In some cases, costs have risen as benefits decreased (Kaiser/Hewitt Survey, 2002), while in others, employers have eliminated or reduced retiree benefits. These trends are likely causes of the increasing number of veterans (particularly in the former Priority Group 7) seeking health care from VA. Another likely factor is the absence of an outpatient pharmacy benefit under Medicare; this component of demand could shift if and when Medicare provides an outpatient drug benefit. As a public institution, VA has greater difficulty in adjusting to this changing environment than its private sector counterparts. Many of VA's responses require legislative or regulatory changes and because of the nature of annual appropriations, long-term planning is difficult.

[1] VA's health benefit package provides outpatient medical, surgical, and mental health care, including care for substance abuse, inpatient hospital care, and prescription drugs; benefits also include over-the-counter drugs and medical and surgical supplies.

Box 5.3 The Veterans Equitable Resource Allocation System

Since 1997, VA has used a capitated budget model known as the Veterans Equitable Resource Allocation (VERA) system to allocate to its 21 VISNs the health care budget appropriated by Congress. This system was designed to reflect changes in veteran demographics and geographic distribution over time as well as regional differences in health care needs and costs. VERA periodically adjusts allocations based on these factors as well as projected demands based on enrollment. Reviewers have generally concluded that VERA is fairer than the previous practice of allocating funds to VA facilities based on their historical expenditures or bed levels (GAO, February 28, 2002 and RAND, September 2002). However, the mismatch between demand and resources within VA is exacerbated by the fact that the VERA system distributes resources based only on Priority Groups 1 through 6 enrollee workload.

The VERA system omits explicit funding for Priority Groups 7 and 8, in part because VA anticipated that first- and third-party collections would cover a significant part of the cost of care provided to these veterans. However, revenues to date from these sources only cover approximately 24 percent of the associated costs. Since July 1997, facilities have been allowed to offset the costs of delivering care by retaining collections from third-party reimbursements, co-payments, per diems, and certain torts. However, because projected collections are incorporated into the budget calculation, the request for appropriated funds is reduced, thereby nullifying any net gain.

VERA provides a financial incentive for each VISN to increase enrollments, thereby increasing demand. In addition, VA's CARES program, which realigns future investment dollars to ensure appropriate infrastructure coverage across the country, requires that VISNs prepare gap analyses and demand projections based on enrollments and users. Thus, CARES serves as another internally driven incentive to increase enrollment and users, and thus, future demand.

the first time. Enrollees are eligible for any medically needed care or services that will promote, preserve, or restore health—regardless of whether or not the condition is service-connected.

Further expanding the benefit in 1999, the Veterans' Millennium Health Care and Benefits Act (Public Law 106-117) mandated new benefits for certain veterans, including both non-institutional and institutional long term care, and emergency care in non-VA facilities in certain situations.

Between October 2001 and September 2002, VA enrolled 830,000 new veterans, resulting in an unprecedented surge in demand for health care services. This trend is expected to continue, absent change in eligibility for enrollment,[2] exceeding VA's capacities for both primary and specialty care.

There has long been a tension between demand for VA services and the funds available under discretionary appropriations. This tension has increased in recent years as appropriators have been bound by a ceiling on discretionary spending. This means Congress could increase funding for care for veterans only if it reduced funding for other discretionary programs. In a world in which what is demanded and what is funded are

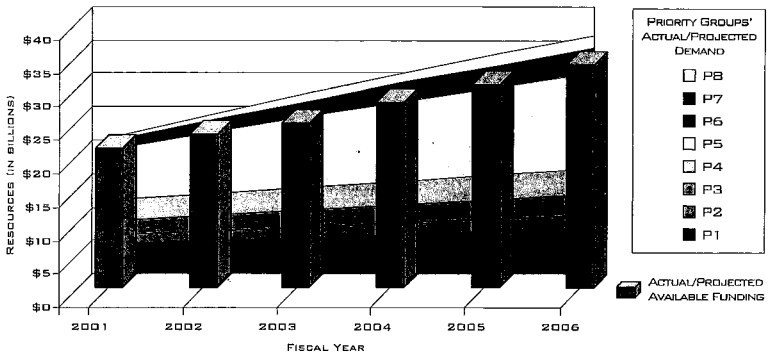
[2] As noted earlier, effective January 17, 2003, VA stopped enrolling Priority Group 8 veterans.

seldom the same, VA's ability to limit enrollment has been the equilibrating mechanism to reduce any mismatch.

Under the Eligibility Reform Act, when annual funding is not sufficient for VA to furnish the benefit to all veterans within the access guidelines it has established for itself, the Secretary has the authority to decide on an annual basis whether VA will continue offering enrollment to veterans in all priority groups. In the past, the presumption has been that enrollment would be available to VA's traditional constituency, those veterans in Priority Groups 1 through 6. Historically, however, VA's obligation authority has not supported demand and is not likely to do so in the future without a resolution of the mismatch between funding and demand (see Figure 5.1).

Figure 5.1 VA RESOURCES VS. DEMAND

(Projected demand is exceeding actual/projected available funding even with a projected 10% annual increase over FY 2004 for FY 2005 and FY 2006)



SOURCE: VA MODEL ESTIMATES IN SEPTEMBER 2002

Despite the funding shortfall, until very recently, enrollment remained open for all Priority Groups since the enactment of the Eligibility Reform Act. Thus, although it has been theoretically possible to make funding meet demand, in reality political difficulties have prevented it, and have resulted in increased waiting times for enrolled veterans. Yet timely access is essential to meeting patient care needs, encouraging patient compliance with prescribed treatment, and ensuring continuity of care.

Although it has been theoretically possible to make funding meet demand, in reality political difficulties have prevented it, and have resulted in increased waiting times for enrolled veterans.

Because of the continuing large number of Priority Group 8 veterans[3] seeking care, on January 17, 2003, the Secretary for the first time invoked the enrollment authority and prohibited any additional enrollment of the newly created Priority Group 8 veterans. An alternative would have been to continue enrolling all veterans and maintaining them on a space-available waiting list for appointments. As of January 2003, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up. In carrying out the enrollment level decision, the Secretary clearly indicated the unacceptability of adding to the waiting list, as it negatively affects the timeliness and thus the quality of patient care.

Background on the Changing Nature of the VA Health Care System

VA's overall mission is to serve all veterans through a variety of benefits and services. However, the Nation's historic health care commitment to veterans has been to care for the wounds of war and other service-connected disabilities. The VA hospital system was created to fulfill that obligation. Having created a network of hospitals, it made sense to use these facilities to care for non-service-connected illnesses in indigent veterans when space was available. Thus, over time VA increasingly was providing care for non-service-connected conditions for indigent veterans. As American medical care has moved rapidly from hospitals into the outpatient arena over the last two decades, VA responded by downsizing its underutilized inpatient facilities. Veterans above the means test without compensable service-connected conditions were first added on a resource-available basis for inpatient care in 1986 (with the requirement that they pay a portion of their care), and initially comprised about two percent of patients. By 2002, these veterans, who were by then eligible for all care, represented 24 percent of VA's patients.

[3] As explained in Box 5.1 and Appendix F, new Priority Group 8 veterans are those veterans without compensable service-connected conditions whose incomes are above a geographically-adjusted means test. The group consists of approximately two-thirds of the former Priority Group 7.

In recent years, the combined effect of these and other factors has resulted in a large increase in demand for VA health care services, despite the fact that the overall veteran population has been declining and is projected to continue to do so.

Under the Eligibility Reform Act, all veterans are required to enroll for VA care, unless they have a disability rated at 50 percent or greater or are seeking care only for their service-connected disability. The requirement for enrollment was based on VA's need to know and be able to project the size of the population seeking care. In congressional hearings on legislation that led to the Act, VA officials also asked for the enrollment requirement to ensure that VA providers were adhering to statutory criteria, to provide a mechanism by which VA headquarters could hold field management accountable, and to allow VA leadership to design a more efficient system of care, within access standards and in anticipation of projected enrollments and the types of benefits veterans might be seeking.[4]

VA Access Standards

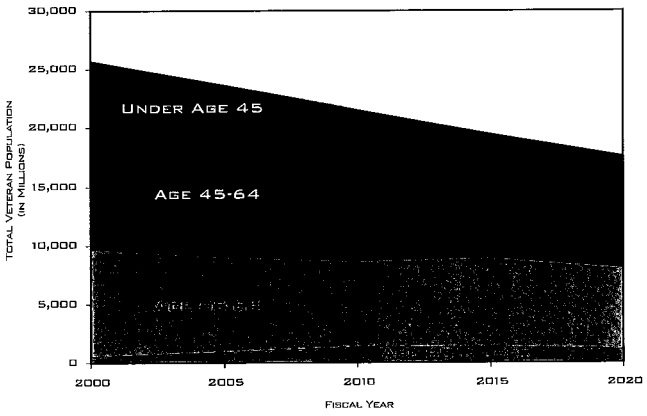
VA has had access standards since 1995 but has not been required to meet them. According to VA's fiscal year 2003 Performance Plan, a priority goal is to provide access to primary care appointments and specialty care appointments within 30 days of the desired date, with patients being seen within 20 minutes of their scheduled appointment. However, when an enrolled veteran seeks an appointment, VA has no obligation under current law to provide care within a specified time frame. VA's inability to provide veterans with a timely appointment in its own facilities also does not obligate it to purchase services from the private sector, as is the case for DOD enrolled beneficiaries in TRICARE, who are able to seek care in the civilian community when access standards cannot be met. Although VA may purchase private sector fee-for-service care for certain veterans in limited situations,[5] it cannot purchase care solely because of access issues, such as long waiting times. In addition, VA generally has been reluctant to become a purchaser, rather than a provider, of care.

VA's inability to provide veterans with a timely appointment in its own facilities also does not obligate it to purchase services from the private sector, as is the case for DOD enrolled beneficiaries in TRICARE.

[4] Statement by Kenneth W. Kizer, M.D., Under Secretary for Health, Department of Veterans Affairs, before the Committee on Veterans' Affairs, U.S. Senate, May 8, 1996.

[5] VA can purchase fee-for-service care for certain veterans when it determines that it cannot economically provide a needed service, that VA care is geographically inaccessible, or that the illness/debility of a patient makes travel difficult.

Figure 5.3 VETERAN POPULATION: AGE TRENDS, 2000–2020
(The total veteran population will decrease by 32% between 2000 and 2020)



VHA OFFICE OF POLICY & PLANNING, DATA SOURCE: VET POP 2001

Recommendations for Addressing the Mismatch

The PTF considered various questions in addressing the mismatch in VA between demand and available funding, including:

1) Should Congress provide an entitlement to care for all veterans, regardless of priority?

2) Should those veterans with service-connected disabilities or an inability to pay for care continue to be given priority treatment?

3) If funding for the veterans described in Question 2 is secure—that is, if appropriations match or exceed need—what health care services, if any, should be offered to veterans who do not fall within these categories?

4) Can the existing system of priority group classification and annual eligibility determinations be made clearer and more predictable?

The PTF considered several criteria as it evaluated these questions, including: recognition and support of VA's historical missions; need to target access for the most at-risk, vulnerable, and highly reliant veteran populations; cost to veterans; adherence to VA's traditional focus on producing rather than purchasing care; and possible effects on VA's triad of patient care, teaching, and research.

The PTF developed recommendations in two separate but inextricably related areas: funding delivery of care within the access standard for Priority Groups 1 through 7 (new) and the need to clarify eligibility and benefits for Priority Group 8.

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Fully Fund Enrolled Veterans

RECOMMENDATION 5.1

The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal.

The PTF identified two alternative approaches as illustrations as to how the Executive Branch and Congress might achieve full funding; other strategies might be equally appropriate.

1) Form an impartial board of experts, actuaries, and others from outside VA to identify the funding required for veterans' health care that must be included in the discretionary budget request. This part of the budget submission would be protected from the customary budget guidance provided by the Office of Management and Budget. An annual report to Congress describing this requirement, assumptions, and how it was developed would provide insight about, and justification for, funding for veterans' health care needs. The board would review demographic, utilization, and cost trends for the VA population and estimate the funding needed to meet access standards and support VA's traditional missions. Staggered appointments for board members, similar to those of DOD's TRICARE for Life board, would ensure continuity as well as familiarity with the VA system. This board could also review budgeted items involving VA/DOD joint ventures and other initiatives that support collaboration between the two Departments.

2) In recent years, legislation has been introduced to require mandatory funding for VA health care as a possible solution. This approach would require that VA be funded in a given year based on a capitated formula established in authorizing language. Funds would continue to be allocated as part of the Department's annual funding process; however the funding requirement would not be subject to the agency budget development process, but based instead on the number of veterans enrolled as of a given date. While this or a similar methodology would not guarantee access, it would most likely eliminate one of the major impediments to providing access: unpredictable or subjectively developed budget requests.

The lack of adequate coding and billing processes has been a significant challenge to collecting money owed to VA; however, the Department currently is focused on improving its first- and third-party collections.

Whatever funding changes occur, VA should continue to aggressively pursue first- and third-party collections under existing statutory authorities. All veterans should be required to provide information on insurance coverage. The lack of adequate coding and billing processes has been a significant challenge to collecting money owed to VA; however, the Department currently is focused on improving its first- and third-party collections.[8]

In addition, VA should continue to work with the Department of Health and Human Services (HHS) to clarify Medicare reimbursement issues for eligible veterans. VA has discussed Medicare reimbursement from the Centers for Medicare and Medicare Services for services provided at VA facilities to treat the non-service-connected conditions of Medicare-eligible veterans. Current law prohibits Medicare from reimbursing VA and DOD for care provided to beneficiaries with Medicare eligibility. However, the Secretary of Veterans Affairs has recently announced an agreement in principle with the Secretary of Health and Human Services for an undertaking that would allow Medicare-eligible veterans to choose VA as their provider under a managed care plan.[9]

[8] On April 30, 2002, VISN 10 initiated a demonstration to improve billing and collections from third-party insurers. In addition, in October 2002 VA initiated electronic billing for both inpatient and outpatient care and has plans for other system-wide improvements. Preliminary results have been impressive. In fiscal year 2002, VA collected $1.2 billion, up from $700 million in fiscal year 2001, representing a 71 percent increase. During the first quarter of fiscal year 2003, the Department is on track to continue this growth in collections.

[9] Technically, this would occur by VA receiving reimbursement from managed care contractors who will receive payment from Medicare.

Meet Access Standards

VA's health care delivery system is predicated chiefly on providing comprehensive health care services to an enrolled population at VA facilities, but the lack of timely access impedes the accomplishment of this goal. Today, the stated goal for both primary and specialty care appointments within VA is 30 days. VA policy is that veterans with emergency health conditions are seen immediately on a priority basis. If VA is to maintain itself as an integrated health care delivery system, access must be provided to those who are accepted for enrollment. Providing sufficient funding to VA will not by itself guarantee timely access to primary or specialty care appointments. If provided with full funding for Priority Groups 1 through 7 (new), and VA has made responsible enrollment decisions for Priority Group 8 veterans for the year in question, the Department must then hold itself accountable to enrolled veterans by making sure that they are provided appointments within the access standard.

VA's health care delivery system is predicated chiefly on providing comprehensive health care services to an enrolled population at VA facilities, but the lack of timely access impedes the accomplishment of this goal.

RECOMMENDATION 5.2

VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7 (new). In instances where an appointment cannot be offered within the access standard, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA.

Clarify the Status of Priority Group 8

Increasing numbers of Priority Group 8 veterans are relying on VA for all or part of their health care. This heightened reliance is exacerbating the mismatch between the demand for services in VA and available funding. As described earlier, Priority Group 8 veterans are those veterans without compensable service-connected conditions whose incomes are above a geographically-adjusted means test. These veterans have the lowest priority for enrollment and are required to pay for a portion of their care. In addition, for those with private health insurance, VA bills third-party insurers for the cost of some of their care. If eligible Priority Group 8 veterans continue to enroll at the projected rate, they will constitute 27% of enrolled veterans by fiscal year 2012. On January 17, 2003, the

Secretary of Veterans Affairs issued a decision, as required by the Eligibility Reform Act, that precludes additional enrollment of Priority Group 8 veterans because the demand for care by all veterans would have exceeded the available funding. This action confirmed that the current level of resources is not sufficient to allow open enrollment for all veterans.

The present status of Priority Group 8 veterans, a direct result of the Eligibility Reform Act and its implementation by VA, is unacceptable. Individually, veterans do not know from year to year whether they will have access to VA care, and as an organization, VA cannot effectively plan or budget, given the uncertainty. This situation results in less-than-optimal care for veterans with service-connected disabilities and indigent veterans who are unable to get timely care. This uncertainty should be resolved.

RECOMMENDATION 5.3

The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem.[10,11]

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[10] An alternate version of 5.3 was recommended by Member Spanogle and Members Walters and Fleming who have associated with this opinion:

Title 38, USC, defines a veteran as "... a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable."

Eligibility for veterans' health care is defined in the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). Veterans eligible and enrolled are placed in one of 8 categories.

The PTF reached consensus on a strong funding recommendation for Priority 1-7 (new), but failed to do so for Priority 8 veterans.

The VA enrolled Priority 8 veterans until January 17, 2003, when the Secretary of the VA suspended new enrollments based on an insufficient budget.

Therefore, we recommend:

- All enrolled Priority 8 veterans would be required to identify their public/private health insurer(s).
- VA would be authorized as a Medicare provider for Priority 8 veterans and be permitted to bill, collect and retain all or some defined portion of third party reimbursements from CMS for the treatment of non-service connected medical conditions.
- VA should be authorized to offer a premium-based health insurance policy to any enrolled Priority 8 veteran with no public/private health insurance.
- All enrolled Priority 8 veterans would be required to make co-payments for treatment of non-service connected medical conditions and prescriptions.
- All enrolled Priority 8 veterans with no public/private health insurance would agree to make co-payments and pay reasonable charges for treatment of non-service connected medical conditions.

Why not a "pay as you go system" for Priority 8's? Medicare subvention for VA is under active consideration by the VA and HHS. VA is seeking authority to require "proof of insurance." VA, like other federal agencies, could offer a health insurance plan. VA has had collection authority since 1986.

[11] Members Alvarez and Wallace support an expanded version of Recommendation 5.3 that will guarantee access and funding for Priority Group 8 veterans.

Conclusion

The apparent mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. Collaboration and sharing between VA and DOD are not likely to compensate for significant core under-funding in either Department. Moreover, the PTF is concerned that the mismatch between funding for the VA health care system and the demand for services from enrolled veterans affects the delivery of timely health care and impedes efforts to improve collaboration between VA and DOD.

Congress and the Executive Branch must work together to provide VA with full funding to meet demand, within access standards, for Priority Groups 1 through 7 (new). The PTF also recommends that VA be accountable for meeting its established access standards for Priority Groups 1 through 7; when appointments cannot be offered within the standard, the Department should be required to offer the enrolled veteran an appointment with a non-VA provider.

Finally, the current situation with regard to Priority Group 8 is unacceptable. The PTF recommends that the President and Congress work together to resolve the status of this group of veterans.

The PTF recommends that VA continue to improve collection of all revenues that are appropriate (e.g., first- and third-party collections) and should continue to work with HHS to further clarify Medicare reimbursement issues for eligible veterans.

PREPARED STATEMENT BY WOUNDED WARRIOR PROJECT

Chairman Sanders, Ranking Member Burr, and Members of the Committee: Recent scandals marked by widespread inability among VA medical facilities to provide initial treatment promptly, by cover-ups of problems in health care scheduling and delivery, and by recriminations against VA employee "whistleblowers," underscore the importance of this Committee's examining the state of VA health care.

These are grave problems that must not be dismissed. Problems of care-delivery in this system, however, are not insoluble. What is more challenging are practices that suggest that instead of a culture of caring for veterans, too many facilities have seemed caught up in a culture of cover-up. For too long, VA leaders over-emphasized a narrative of Department successes and relied heavily on performance "data" to measure those successes. Perverse incentives led some to falsify or skew data to meet required metrics. Yet even as this complex health care system is described as infected by a "toxic culture," we learn of clinicians at VA facilities who have long been working overtime and on weekends, voluntarily, to help the veterans under their care. This duality underscores that VA operates a complex system, one that—while marred by scandal—employs many very dedicated, compassionate health care professionals.

Many of the veterans we serve rely on that system for some or all of their care. We owe it to them to improve VA health care, not to dismantle the system or impose sweeping untested solutions. In that regard, with VA's problems in providing veterans an initial appointment within a then-required 14-day rule, it should be noted that lack of timeliness in providing care is not unique to VA. As reported earlier this month by the New York Times, "there is emerging evidence that lengthy waits to get a doctor's appointment have become the norm in many parts of American medicine, particularly among general doctors, but also for specialists."[1] While describing VA as reeling from revelations of long wait times, the Times reported that VA is one of the only health care systems in the Nation that openly tracks waiting times and has standards for what they should be.[2]

Wounded Warrior Project has not been hesitant over the years to critique VA timeliness of care, the effectiveness of certain VA services, its adherence to law and its own policies, and the consistency of its practices. That criticism and expectation has been directed to the high obligation the Department owes to those wounded, ill and injured in service—obligations reflected in laws the Department is charged to administer.

We commend to the Committee's attention a recent perspective co-authored by former VA Under Secretary of Health Ken Kizer, "Restoring Trust in VA Health Care."[3] The authors ask rhetorically, how "[a]fter the VA had gained a hard-won reputation for providing superior quality care 15 years ago, * * * did cracks ap-

[1] Elisabeth Rosenthal, "The Health Care Waiting Game," New York Times (July 6, 2014).
[2] Id.
[3] Kenneth W. Kizer and Ashish K. Jha, "Restoring Trust in VA Health Care," NEJM (June 5, 2014).

pear in its delivery of safe, effective, patient-centered care?" They offer three main causes:

> "* * * an unfocused performance-measurement program, increasingly centralized control of care delivery and associated increased bureaucracy, and increasing organizational insularity."[4]

While each is a critical flaw, an important starting point for this Committee would be to press VA to revisit its performance measures. As Kizer writes, the use of "hundreds of [performance] measures with varying degrees of clinical salience * * * not only encourages gaming but also precludes focusing on, or even knowing, what's truly important." Kizer's prescription in terms of first steps is sound:

> "First, after ensuring that all veterans on wait lists are screened and triaged for care, the VA should refocus its performance-management system on fewer measures that directly address what is most important to veteran patients and clinicians—especially outcome measures."[5]

This would represent a good initial step toward restoring trust. We urge the Committee to continue its oversight in that effort.

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[4] Id.
[5] Id.