STATEMENT OF THE HONORABLE DENIS MCDONOUGH
SECRETARY OF VETERANS AFFAIRS
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON VETERANS ACCESS TO CARE

SEPTEMBER 21, 2022

Introduction

Good afternoon, Chairman Tester, Ranking Member Moran and members of the Committee. Thank you for inviting me here today to discuss how VA is responding to what we are hearing from Veterans about accessing the timely, world-class, care they have earned through their service and sacrifices for our country. The Veterans Health Administration's (VHA) approximately 380,000 employees, one third of whom are Veterans, come to work every day with one goal in mind: to serve Veterans, their families, caregivers and survivors as well as they have served our country. The President has called this a sacred obligation with a mission that unites us all. For us, Veterans are our mission.

Our employees prove daily that we will face any challenge and go to any length, including during the worst pandemic in more than 100 years, to ensure Veterans receive the care and services they have earned and deserve. Despite the strain of the pandemic, VA employees worked tirelessly to ensure that Veterans received care, deferring time off and retirement out of their own sense of dedication, and this passion continues today. A recent study in The Lancet Regional Health found that our employees succeeded,[1] and that VA's strategy likely saved Veteran lives. Importantly, we know that some Veterans chose to defer routine care during the pandemic, and we continue to stand ready to help Veterans meet their individual health goals.

Hailing from communities across the Nation, the population of Veterans VA serves is unique with rich diversity, seniority in age, health challenges specific to military service and a high percentage of Veterans choosing to live in rural areas, among other factors. This requires VA to be exceptionally proactive and innovative to ensure meaningful access and outcomes for each Veteran in our care. Furthermore, the population we serve continues to evolve, with record numbers of women Veterans enrolling in VHA health care, and VA's work with Congress on military environmental exposures enables more Veterans to seek care for health concerns incurred during military service. We must cultivate a thriving health care system for current and future generations of Veterans across both direct and community care.

[1] Available online: https://www.sciencedirect.com/science/article/pii/S2667193X21000892#bib0011.

Impact of the VA MISSION Act on the Balance of Care between VA and the Community

Since the Veterans Community Care Program established by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) was implemented in June 2019, VA has observed several trends in how Veterans are accessing VA care and the extent to which they rely on it. While this analysis has been challenged due to confounding factors such as the impact of the Coronavirus Disease 2019 pandemic, there are several important takeaways that we have learned since this program was implemented.

Our analysis shows that the VA MISSION Act perpetuated and, in some cases accelerated, trends that have been observed over the last decade. First, while total enrollment has remained relatively stable, Veteran reliance on VA (direct care and community care) overall has been growing. Second, the use of VA direct care is growing, but use of community care is growing faster. Third, the growing use of VA care is not uniform across the country.

To put the growth of community care into perspective, community care accounted for 23% of the total workload, by relative value units (RVUs) of VA care in fiscal year 2018. Three years later, in fiscal year 2021, community care RVUs grew to 35% of the total workload. As RVUs represent a metric most relevant to costs, our community care spending has increased accordingly.

Additionally, when examining the balance of care VA provides as a function of outpatient appointments, VA community care represented approximately 24.8% of total Veteran appointments immediately prior to the implementation of the VA MISSION Act. Thus far in Pandemic Year 3, that figure is 27.9% (Table 1). Additionally, as shown below, 40.2% of all outpatient specialty care appointments provided to Veterans in Pandemic Year 3 are occurring in the community.

Table 1: Veteran Balance of Care by Outpatient Appointment Type .

	Direct Care Appointments				Community Care Appointments			
	All	Mental Health	Primary Care	Specialty Care and All Other	All	Mental Health	Primary Care	Specialty Care and All Other
Pre-Mission (Jun 2018 - May 2019)	89,209,415 (75.2%)	19,611,882 (96.1%)	21,496,129 (98.8%)	48,101,404 (62.9%)	29,442,003 (24.8%)	788,731 (3.9%)	255,327 (1.2%)	28,397,945 (37.1%)
Pre-Pandemic (Jun 2019 - Feb 2020)	66,688,731 (73.0%)	14,560,899 (95.1%)	16,319,135 (98.9%)	35,808,580 (60.1%)	24,725,998 (27.0%)	751,785 (4.9%)	188,360 (1.1%)	23,785,853 (39.9%)
Pandemic Year 1 (Mar 2020 - Feb 2021)	76,964,279 (71.5%)	16,052,971 (93.4%)	22,006,014 (98.9%)	38,905,292 (57.0%)	30,706,490 (28.5%)	1,126,561 (6.6%)	241,954 (1.1%)	29,337,975 (43.0%)
Pandemic Year 2 (Mar 2021 - Feb 2022)	85,281,354 (70.6%)	16,113,457 (94.1%)	22,817,396 (99.0%)	46,350,501 (57.5%)	35,463,648 (29.4%)	1,011,810 (5.9%)	219,589 (1.0%)	34,232,249 (42.5%)
Pandemic Year 3 (Mar 2022 - Aug 2022)	41,926,995 (72.1%)	8,196,845 (93.4%)	10,584,500 (99.0%)	23,145,650 (59.8%)	16,261,706 (27.9%)	583,405 (6.6%)	105,927 (1.0%)	15,572,374 (40.2%)

Note: Table 1 demonstrates appointments delivered. A single Veteran may have multiple appointments of various types in a given year.

Timeliness Trends after the VA MISSION Act and the Pandemic

It is important to note that the VA MISSION Act provided six eligibility criteria for when covered Veterans can elect to receive care in the community. Included in these criteria are designated access standards established by VA that incorporate average drive times and wait times. We have completed the required triennial access review and continue to evaluate the impact of the designated access standards on Veterans' access to care on an ongoing basis.

With this context in mind, Veterans' access to care is central to our mission and a top priority, whether or not Veterans receive that care in VA or in the community. Current Veteran Outpatient Trust levels are currently 90% nationally; however, we remain focused on initiatives to bolster staffing and recruitment, improve our workflows and technology and strengthen support for our VA clinicians and staff members to ensure we earn each Veteran's trust each day.

Within eight months of implementation of the VA MISSION Act and initial publication of the current, designated access standards, the COVID-19 pandemic took hold. This served as a significant confounder in determining the specific impacts of the VA MISSION Act. Initially, during the first 2 years of the pandemic, Veterans experienced decreased wait times for direct primary care and mental health services beginning in March 2020. This was largely the result of deferred primary and mental health care due to necessary curtailments in VA services to address the pandemic when care was not deemed necessary, Veterans choosing to postpone elective care, and increased use of virtual care options in lieu of in-person care.

Currently, VA is experiencing similar trends to those seen in health care across America, including increasing volumes of appointments due to the return of Veterans who previously delayed or deferred care needs; growing health care demands across the Veteran population; recruitment and retention challenges due to an increasingly competitive job market; and COVID-19's continuing impact on staffing levels as case rates ebb and flow across the United States. As a result of factors such as these, we have seen average wait times grow slightly in our direct care system in the past year.

Table 2: Veteran average wait times for new patient appointments for VA's direct care system.

	Average Wait Times for New Patient Appt in Direct Care (in days)			
	All	Mental Health	Primary Care	Specialty Care and All Other
Pre-Mission (Jun 2018 - May 2019)	23.6	13.2	21.1	24.7
Pre-Pandemic (COVID-19) (Jun 2019 - Feb 2020)	23.8	13.3	19.9	25.0
Pandemic Year 1 (Mar 2020 - Feb 2021)	22.1	11.0	14.0	24.4
Pandemic Year 2 (Mar 2021 - Feb 2022)	24.8	16.2	17.8	26.1
Pandemic Year 3 (Mar 2022 - Aug 2022)	27.9	19.2	23.6	28.9

Table 2 above displays the average wait times for new patient appointments in VA's direct care system over the same time periods as Table 1. Veterans are considered a new patient if they have not been seen by a provider or a clinical service at the same medical center for the same, or a related, health care need in the past 3 years. For new patient appointments with a referral, the referral date is the starting point used for measuring average wait times, and the end point is the date care is received. For new patient appointments without a referral, the average wait time starts with the earliest consistently-recorded date in the process of receiving care (typically the scheduler works with a Veteran to coordinate a future appointment) to the date care is received.

Table 3: Veteran average wait times for new patients for community care.

	Average Wait Times for New Patients in Community Care (in days)			
	All	Mental Health	Primary Care	Specialty Care and All Other
Pre-Mission (Jun 2018 - May 2019)	41.2	41.2	41.0	41.2
Pre-Pandemic (COVID-19) (Jun 2019 - Feb 2020)	39.4	41.7	42.9	39.3
Pandemic Year 1 (Mar 2020 - Feb 2021)	39.9	37.9	46.5	39.8
Pandemic Year 2 (Mar 2021 - Feb 2022)	39.6	42.2	45.2	39.4
Pandemic Year 3 (Mar 2022 - Aug 2022)	36.3	34.2	44.3	36.3

Table 3 above represents the average wait time for new patient referrals in community care. In the data above, the referral date is the starting point used for measuring average wait times, and the end point is the date of the scheduled appointment or the date it is scheduled to occur if not yet completed. When looking at the national average for community care wait times in Table 3, they have improved slightly in recent years.

It is important to note that average wait times for both direct VA care and community care will vary based on the type of care and geographic location. Additionally, due to data limitations, it is not possible to directly compare wait times between VA and community care. The average wait times do not include wait times for facilities that have implemented our new Electronic Health Record (EHR). For sites using the new EHR, VA now has the capability to measure the Third Next Available Appointment (TNAA) in a manner like others in the health care industry.

Targeting Access Initiatives to Unique Challenges in the Direct Care and Community Care Systems

VA understands the importance of listening to Veterans and gathering feedback from front-line field staff who engage with Veterans daily, as this information helps refine our access strategy. Local site visits by our Integrated Veteran Care team have shed light on unique, root cause challenges in both the direct care system and for community care. We have identified the longest parts of each process, affording us insights that have directed the efforts of VA's Office of Integrated Veteran Care.

Veterans are scheduled for care faster in the direct care system, but they often wait longer between the date they received their confirmed appointment and their actual appointment date. Our site visits have surfaced a few primary reasons for this: first, Veterans have been catching up on previously deferred or delayed care because of the pandemic, on top of baseline demand. Secondly, staffing challenges have been significant in the context of increased competition in the labor market. Third, we are navigating a competitive health care recruiting environment as well as the need to onboard new hires much more rapidly. Fourth, there is a continual need to ensure that our physical and virtual infrastructure best allows us to meet the access needs of Veterans. All of this has made clear that increasing the accessibility and availability of appointments would be the most impactful actions to improve access in the direct care system.

In addition to increased staffing, we are also focused on optimizing clinical productivity. In the coming months, providers will be expected to utilize 80% of their bookable clinical time with limited exceptions and with standardized appointment lengths for each service to ensure that we are optimizing available clinic time and consistently accommodating as many Veterans as possible.

We have created a roadmap to ensure all necessary steps are taken for successful implementation and are targeting full implementation prior to the end of the

calendar year. VHA directives and guidebooks are being updated to reflect the new standards. Across the system, VHA facilities have started implementing the standards, and preliminary results are promising with improvements in wait times for Veterans in certain areas. It is important to note that clinical work is a team effort and, to fully achieve the promise of this effort, we will need to ensure that we recruit and retain the employees necessary to support our clinicians in meeting these productivity goals.

The ability to expand health care access through telehealth services also continues to be a priority focus for increasing available appointments in the direct care system. Being able to meet specialty care needs through telehealth appointments increases access and availability across VA, especially when VA providers can provide care across State lines. VA is reinvesting in telehealth more broadly to reliably allow providers from across regions, and in some cases, across the country, to offer more appointments to Veterans in any given location.

In contrast to our direct care system, our analyses have revealed that the process for scheduling care in the community is often longer than the duration of time a Veteran waits between receiving a confirmed appointment and the date of their actual appointment. Various workflow, staffing and system challenges make the appointment process challenging for community care staff, including a lack of direct visibility into community care appointment availability. Therefore, we currently have a task force of experts reviewing our scheduling processes to identify opportunities for significant system improvements.

We also continue to closely monitor the performance of our Community Care Network (CCN) and the availability of community providers working with our third-party administrators to build capacity and address gaps. Today, CCN lessons learned from the last few years are being incorporated as we prepare for the next generation of CCN contracts timed for the fall of 2023.

Targeting our Access Initiatives Locally, with VISN and National Support

Finally, it is important to note that unique challenges that are specific to certain facilities and regions often account for some of the most significant barriers to access to care. We continue to place a focus on these challenges daily and are using lessons learned as we work to improve access to care across the country. VA remains committed to ensuring that feedback from Veterans and our frontline employees is central to driving improvements and innovations in how we deliver access to care for Veterans. In addition, we remain committed to leveraging the expertise and support at all levels of VA to ensure we are providing the assistance necessary to address Veteran access needs in every part of the country.

Conclusion

In conclusion, I want to reiterate how important this forum is for us at VA to not only share the actions we are taking to ensure Veterans have access to the timely,

world-class health care they rightly deserve, but also to listen and learn from each of you here today as partners in our mission. With that in mind, I look forward to answering any questions you or other members of the Committee may have today. Thank you.