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OUTPATIENT WAITING TIMES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

DECEMBER 12, 2007

Serial No. 110–62

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
39–648 WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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OUTPATIENT WAITING TIMES

WEDNESDAY, DECEMBER 12, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittees met, pursuant to notice, at 2:50 p.m., in Room 345, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee on Health] presiding.

Present from Subcommittee on Health: Representative Michaud.

Present from Subcommittee on Oversight and Investigations: Representatives Mitchell, Space, and Brown-Waite.

Also present: Representative Kennedy.

OPENING STATEMENT OF CHAIRMAN MICHAEL H. MICHAUD, SUBCOMMITTEE ON HEALTH

Mr. MICHAUD. I would like to call to order this joint hearing on the U.S. Department of Veterans Affairs (VA) outpatient waiting times.

I would ask unanimous consent that my full statement be included in the record. Hearing no objection, so ordered.

The focus of this hearing is waiting times for outpatient appointments in the Veterans Health Administration (VHA). Outpatient waiting times are one aspect of a much broader focus of the Subcommittee on Health, access to high-quality healthcare. "Access to healthcare" is defined as the ability to get medical care in a timely manner when needed. We know that access to healthcare is important for veterans. It improves treatment outcomes and the quality of life for those who have it.

Since the beginning of the 110th Congress, the Subcommittee on Health has taken broad action to increase veterans' access to healthcare. Today I hope that we will learn more about how the VA is doing, in seeing patients in a timely manner for initial and necessary follow-up appointments, and how the VA tracks this information. I would also like to learn how the VA is managing patient care to provide necessary preventative medicine.

In a system that handles 40 million outpatient appointments per year, it is clear that efficient and effective policy, training and followup is critical in achieving success. I hope that we can use this time to work toward a solution so that we can all achieve our primary goal, to improve the access to healthcare for all veterans. I am confident that, by working together, we will be successful. Timely access to quality healthcare is something that those who

have served our country have earned. We must work together to provide it for them.

I now would like to yield to Ms. Brown-Waite, the Ranking Member of the Subcommittee on Oversight and Investigations, for an opening statement.

[The prepared statement of Chairman Michaud appears on p. 29.]

OPENING STATEMENT OF HON. GINNY BROWN-WAITE, RANKING REPUBLICAN MEMBER, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

I want to thank Ranking Member Miller, who I know is on his way, along with the rest of the Members of the Subcommittee on Health for joining us for this important hearing on outpatient waiting times at the Department of Veterans Affairs.

As of October 2007, there were 7.9 million veterans enrolled in the VA healthcare system. Today there are more than 153 VA medical centers and 724 community-based outpatient clinics—we refer to them as "CBOCs"—available to serve the needs of our veterans. When a veteran or a physician calls to schedule an appointment in one of these clinics, they should be able to receive an appointment that is timely and appropriate to the medical needs of the veteran.

I am looking forward to hearing from our first panel of witnesses today as well as from the other panel as to how they feel outpatient wait times at the VA has affected them as well as any possible solutions that we can, as a legislative body, come up with to remedy the situation. I am also interested in hearing from the VA Office of Inspector General (OIG) on their perspective on the wait time issue. Finally, I expect to hear from the VA as to how they monitor wait times and what steps they are taking to improve the timeliness of services provided to our veterans.

On January 4, 2007, I introduced H.R. 92, the "Veterans Timely Access to Health Care Act," which would make the standard for a veteran seeking primary care from the Department of Veterans Affairs 30 days from the date the veteran actually contacts the Department. Unfortunately, the bill is needed because current practices do not meet that goal.

I monitor data in my area, which is part of Veterans Integrated Service Network (VISN) 8, from the Department of Veterans Affairs to determine the time new patients and existing patients wait to receive an appointment. While established patients wait less than 15 days for an appointment, the numbers for new patients happen to be much higher.

What I also found interesting, in looking over the data, is that there appears to be a decrease in the wait times at the major medical facilities; however, at the CBOC level, the community-based outpatient clinic level, wait times actually have increased. In the third quarter of fiscal year 2007, new patients had to wait an average of 45 to 50 days to receive an appointment at a VA clinic, while new patients waited an average of 22 to 25 days to receive an appointment at the VA medical centers. This simply is not acceptable.

I am also curious as to the dramatic decrease in the wait times at the VA medical centers in VISN 8. I question whether patients are being redirected to the CBOCs to reduce wait times at the medical centers. If veterans are having problems receiving their care within 30 days, then Congress needs to allow them to look for an alternative.

My bill is not—and I underline "not"—a scheme to move VA toward privatization. It simply ensures that veterans receive care in a timely manner.

The VA can and does provide a high level of care to all of the veterans who are enrolled in the system. However, if a veteran cannot be seen by a physician in a timely manner, what good does that do? The Department of Veterans Affairs' Web site states that it is the goal of the VA to, and I quote, "provide excellence in patient care, veterans benefits and consumer satisfaction." This hearing today is to determine whether the VA is meeting that goal with timely access to care.

As everyone knows, this issue is tremendously important to every American. Our veterans did not wait to answer the call of duty. They answered their Nation's call and took up arms to protect our freedom. They served, and many returned injured and in need of care.

I talk with veterans from my district on a daily basis about the issues that they have with the VA, and getting in to see a doctor in a timely fashion is at the top of their list. I do not believe that veterans' care should be a political issue. Instead, Members of Congress should work together to improve veterans healthcare so that it becomes the model for good governance and excellence in healthcare.

Again, I thank you, Mr. Chairman, and I yield back the balance of my time.

[The prepared statement of Congresswoman Brown-Waite appears on p. 30.]

Mr. MICHAUD. Thank you very much.

I now will recognize Mr. Mitchell, who is the Chairman of the Subcommittee on Oversight and Investigations, for an opening statement.

OPENING STATEMENT OF CHAIRMAN HARRY E. MITCHELL, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. MITCHELL. Thank you, Mr. Chairman.

You know, the Veterans Health Administration is one of the best healthcare providers in the country, yet our veterans can only take advantage of this healthcare if they get the appointments they need to access it. Unfortunately, too many of our troops are returning home and are encountering long waiting times.

When I was back in my district this past weekend, I met with a group of Arizona veterans. Many of those veterans expressed concerns about the long waiting times they have encountered to get doctors' appointments. One local veteran, John Tymczyszyn, tried to make an appointment for treatment for a service-related injury he suffered. John requested his appointment in December 2006, and his appointment was scheduled in late May of 2007, 6 months after his initial request. John told me that he continued to struggle

to make appointments with the VA, and because of that difficulty, he now relies on civilian providers for his healthcare. This is unacceptable.

When we tried to look into the problem to see what we could do to address it, we were unable to secure verifiable documentation of waiting times. According to a recent audit by the Department of Veterans Affairs Inspector General (IG), the waiting times reported by the VHA are both understated and incomplete. The VA reported to the Department of Veterans Affairs fiscal year 2006 performance and accountability report in November 2006 that 95 percent of veterans seeking specialty medical care were scheduled for appointments within the required 30-day period; however, the IG audit found sufficient evidence to support that only about 75 percent of veterans had been seen within 30 days of the requested appointment time. Furthermore, the IG audit found that schedulers were not following established procedures for making and recording medical appointments. This means that we do not even have a clear picture of how many veterans have requested appointments.

VHA's schedulers were supposed to act on a veteran's request within 7 days. If this appointment cannot be made within the required 30 days, the scheduler should place the veteran's request on an electronic waiting list. However, the IG found that a majority of schedulers are not trained to use this system, so they do not use the electronic waiting list. Perhaps more alarming are reports that schedulers have been instructed to reduce waiting times by not putting patients on the electronic waiting list. This attempt to reduce cases of long waiting times could lead to gaming of the scheduling process.

The VA has discounted the IG's report because it disagrees with how waiting times were calculated. This is unacceptable. I am not willing to walk away from this audit over a disagreement about methodology. This is a real problem that we must look into.

When our veterans encounter long waiting times, their conditions go undiagnosed, and serious diseases go untreated. Furthermore, until we have a clearer picture about waiting times, the VA cannot improve the situation because we cannot identify problem facilities or effectively allocate resources. We should not allow our servicemembers to encounter long wait times for doctors' appointments.

I look forward to hearing from our witnesses.

[The prepared statement of Chairman Mitchell appears on p. 29.]

Mr. MICHAUD. Thank you, Mr. Mitchell.

Now I would like to recognize a Member who is a very strong advocate for veterans' issues to introduce one of our first panelists. Mr. Zack Space.

OPENING STATEMENT OF HON. ZACHARY T. SPACE

Mr. SPACE. Thank you, Mr. Chairman.

If I might, very briefly, in advance echo the sentiments of my colleagues from both sides of the aisle. Clearly we have an obligation as a Nation to live up to the promises made to veterans and to provide them with the best and most efficient care that we can. Certainly part of what this hearing is about is to ensure that that happens, but part of this hearing is also to determine whether the very

numbers that the VA has calculated in terms of the delays are accurate.

As my Subcommittee Chairman, Mr. Mitchell from Arizona, has pointed out, there is a significant discrepancy between what the VA has reported compared to what the IG has reported. There is a significant discrepancy. The questions that I am hoping will be answered today are as to whether that discrepancy is the result of mere incompetence or is the result of intentional misconduct. To me, it would seem reprehensible that our veterans would be shortchanged at the expense of bureaucratic bookmaking.

So, with that in mind, I am delighted to have with us today our first presenter, Mary Jones, from Ohio's 18th Congressional District. Mary Jones served with the United States Army from May 1983 to May 1986. She served with the 101st Airborne Division at Fort Campbell, Kentucky, and she served with the 2nd Infantry Division at Camp Casey, Korea. Ms. Jones is a graduate of Kent State University and is currently serving as a Licking County Veterans' Service Officer. She has been with the office since 1995, and is accredited as a service officer with the American Legion, the Disabled American Veterans, the Veterans of Foreign Wars (VFW), the Governor's Office of Veterans Affairs, and with AMVETS. In that capacity, she directs an office of four accredited service officers working in a county with nearly 16,000 veterans.

Ms. Jones is a life member of the Disabled American Veterans chapter number 23, of the AMVETS post number 345, of the American Legion's post number 85, and of the VFW's post number 1060. She is currently serving as the Second Vice Commander of the Sixth District of the American Legion Department of Ohio, and is serving on the board of directors as the Secretary of the Licking County Veterans' Memorial and Educational Center. A native of Ohio, she and her husband Donald reside in Newark, which is in Ohio's 18th district. Ms. Jones, I am very happy to report, is also a member of my Veterans Advisory Board.

I thank you for being here today, Mary, and welcome.

Ms. JONES. Thank you.

Mr. MICHAUD. The second panelist is Kevin P. McCarthy, who is President and Chief Executive Officer of Unum.

Since the previous panel cut into about 45 minutes of our time, and since we will have votes, actually, within about 45 minutes, you will find Mr. McCarthy's impressive resume in our packets, and hopefully you will have a chance to look at that as well.

So, without any further ado, I will recognize Ms. Jones to begin her testimony. I want to thank both of you for coming here today, and I look forward to hearing your remarks.

So, Ms. Jones.

STATEMENTS OF MARY C. JONES, LICKING COUNTY VETERANS' SERVICE OFFICER, LICKING COUNTY VETERANS' SERVICE COMMISSION, NEWARK, OH; AND KEVIN P. MCCARTHY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, UNUM US, PORTLAND, ME

STATEMENT OF MARY C. JONES

Ms. JONES. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for providing me with this opportunity to testify regarding issues of outpatient waiting times.

I have worked as a County Veterans Service Officer for the past 12 years, and in that capacity I have had an opportunity to enjoy a great relationship with the staff at both the Columbus VA Outpatient Clinic and the Newark Community-Based Outpatient Clinic, and I feel privileged to be able to have this relationship. I use the VA healthcare system as my primary provider of medical care for my service-connected conditions.

My concern with outpatient waiting times is our inability to get veterans into an appointment in a timely manner. Their appointments are scheduled so far out, often 2 to 3 months, that their condition worsens, and they are left angry and frustrated at a system that is supposed to be in place to care for those who have given so much to our great Nation. As examples of the problems created by these wait times, I offer to you some experiences from our office.

We see many veterans shortly after their return home. They have been promised dental care within 90 days from their discharge. One veteran's first available appointment was scheduled almost 90 days from the date of his request. When he got to the dental clinic, he was told that his appointment needed to be canceled and rescheduled. They did not have any appointments available within that 90-day period, and he was, therefore, not seen.

Female veterans have unique healthcare concerns and face difficult wait times to see gynecologists, often as long as 6 to 8 months. Please keep in mind that most of the women who we are working with do not have other viable options for healthcare. Many are wartime veterans on a nonservice-connected pension and are, therefore, very low income. They are unable to get Medicaid treatment for preventative or diagnostic medical care. Pap tests and mammograms are increasingly important as we get older and often are life-saving diagnostic tools, but waiting as long as 6 months for the initial exam, and then often even longer to get the test scheduled, can lead to greater problems if a cancer exists.

I mentioned earlier that I am a service-connected veteran, that I use the VA outpatient clinic myself. I was having health concerns and tried to schedule an appointment with my physician and was told the earliest appointment I could get was in 6 months. Because I am a county employee and have medical insurance through my employment, I was able to see a doctor outside of the VA system within 3 weeks and ended up needing major medication changes and a heart catheterization. I hate to think what would have happened to a veteran without those options.

We are filing many claims for post traumatic stress disorder (PTSD). Usually when we file a claim, we have a veteran who has

a diagnosis for a condition, but PTSD is different. Most veterans can get into the VA to see a social worker and can get assigned to group counseling fairly quickly. Most can see a psychiatrist within 3 to 4 months for an initial exam, but within the 12 to 18 months that a service-connected claim takes to adjudicate, the veteran is still left without a diagnosis for PTSD because the wait times prohibit the doctor from seeing the patient often enough to provide a definitive diagnosis of any mental health issue. Because no diagnosis exists, the Veterans Benefits Administration must deny the claim for service connection. Seeing private psychologists and psychiatrists is beyond the financial reach of most veterans.

My most memorable experience is a World War II veteran who was in receipt of a nonservice-connected pension. He was diagnosed with prostate cancer through a prostate-specific antigen test done by his primary care. Treatment was scheduled, but the wait time was several months. In the meantime, this very gentle man clearly understood that he would not survive due to the fact that his cancer had spread and was continuing to spread during this wait. The treatment would have only prolonged his life and would not have saved his life, but this would have been an excellent opportunity to send a positive message of support from our government to this World War II vet. That opportunity was missed. He died before his appointment with an oncologist.

This has been an honor for me to have this opportunity to bring examples of the difficulties experienced by the veterans who I serve caused by the long wait times to be seen at clinics. I did not come to criticize the VA, because the care given by our outpatient clinic is excellent, but at this time that care comes at a price, and that price is patience.

Thank you, Mr. Chairman. This concludes my testimony.

[The prepared statement of Ms. Jones appears on p. 31.]

Mr. MICHAUD. Thank you, Ms. Jones.

Mr. McCarthy.

STATEMENT OF KEVIN P. MCCARTHY

Mr. MCCARTHY. Thank you, Mr. Chairman and Members of the Subcommittee. I would like to thank you for the opportunity to testify before you. My name is Kevin McCarthy. I am the President of Unum. I have submitted written testimony, which has been made available to you, but I will briefly present an overview.

Unum's involvement was generated by our company's wanting to explore how we could assist with sharing best practices that might be useful in caring for our veterans. Recently, Representative Michaud visited Unum and viewed firsthand how the combination of our people and technology are integrated together in a way that reduces delays in every aspect of claims processing and case management, including appointment scheduling.

As a result of this visit and our meetings this summer and fall with House and Senate Congressional staff, with the Department of Veterans Affairs and with the U.S. Department of Defense (DoD) on the sharing of best practices between the private and public sectors, I am here today to discuss how we use these smart systems and our people not only to reduce waiting times in setting up independent medical examinations, but also to discuss how these are

aspects of a larger, integrated case management and claim management approach that include everything from regular contact with our insureds so they know what is happening in real-time on their claims to assisting them with vocational rehabilitation. This integrated approach actually speeds not only wait times on individual specific issues, but on the entire case management process.

With regard to the specific issue before you of outpatient wait times, we work closely with our insureds, and with their physicians, to make sure that they are receiving appropriate and regular care, and we follow up shortly after scheduled visits. As a function of our followup and prompting system, we track our insureds' medical visits and revisits, and we record new medical information.

As one of the world's leading employee benefits providers, Unum helps to protect more than 21 million working Americans and their families in the event of illness or injury. In 2006, we responded to more than 420,000 newly filed claims and replaced $4 billion of lost income to help provide support to our insureds and to their families. These benefits are paid directly to our insureds.

Obviously, the management of disability claims differs from health insurance, but when circumstances warrant, we do follow up in person with our customers and with their providers to determine if they have kept medical appointments. Also, we typically follow up shortly after appointments to determine if their medical status has changed.

Our ability to pay our customers billions of dollars annually with these high levels of satisfaction is due to our highly trained people supported by the right technologies. Specifically, we deploy experienced people and technologies with a comprehensive claims management process that applies the most accurate and appropriate resources to each claim and decision making supported by expert systems and resources with an emphasis on consistent quality and regular tracking.

While a person's disability can be a complex, ongoing and ever-changing life event, our goal is to make the claims process simple and transparent for our customers during what is a trying time in their lives, so we make it easy to submit a claim. It can be done by Internet, telephone, fax or mail. At any time after a claim has been submitted, our customers can speak regularly with a skilled specialist. We handle more than 4.5 million calls a year.

While our goal is to make it easy for customers to reach us, we also understand that many need our help. Thus, we regularly reach out to our insureds and to their healthcare teams. We view it as critically important to speak with our insureds and their physicians, and we frequently help our patients follow up with their doctors. We are able to do this because we have invested in an innovative technological process which sorts claims by complexity and severity, and it allows all case and claim management activities to be conducted real-time in one place. This technology is supported by hundreds of highly trained benefits specialists, physicians, nurses, and vocational rehabilitation specialists. Our technology allows our people, for example, to make appointments, to schedule exams and follow-up calls, to manage workloads, to review claim documents, and to provide real-time management access and ro-

bust quality assurance and continuous improvement. Each one of the activities the benefits specialist does is scheduled and tracked to ensure that the right resources are applied to the right claims at the right time.

The claim status is viewable on the Web so our customers can access their claim status. Privacy safeguards are in place. For the more complex claims, each customer is called, and we set individual followup action plans in place with the insured based on the dynamics of their specific medical condition.

Our contribution here today is to provide you with insight into our best practices, and we welcome the opportunity to continue to be a resource for public- and private-sector sharing as you continue to evaluate claim processes.

Thank you very much for the opportunity to testify before your Subcommittees.

[The prepared statement of Mr. McCarthy appears on p. 32.]

Mr. MICHAUD. Thank you very much, Mr. McCarthy.

As you mentioned, I have seen your system and your facility in Portland, and I am very impressed with your system. Patients see specialists very quickly.

What is the average time that it actually takes them to see a specialist or to see a doctor?

Mr. MCCARTHY. Typically we handle all claim inquiries within 3 to 5 days. The scheduling process, of course, depends on the availability of physicians and their responsiveness to the claimants, but we resolve all short-term disability claims within 3 to 5 days and all long-term disability claims typically within 45 days.

Mr. MICHAUD. As you mentioned, patients can view their cases online. They can see their care plan, their next appointment, future appointments, et cetera, and you follow up with the patients, as you mentioned, to make sure that they understand what they need and to make sure that they are getting it.

Can you go into a little more detail on how Information Technology (IT) manages your cases and how that could be implemented within the VA system?

Mr. MCCARTHY. Our systems are designed to assist our claimants and the specialists who manage and work with those claimants to make sure that care is delivered in a high-quality and consistent fashion.

So, for example, in the case of a patient's requiring an independent medical examination, our disability specialist will contact that claimant, will record the conversation, will log the requirement for an independent medical examination. Simultaneously, that information is available to one of our in-house physicians also online. We are able to then work with an outside physician to schedule that appointment. That information is then logged in the system. The disability benefits specialist then can see the activity. He knows when to follow up with the claimant to ensure that the appointment was kept and that care was delivered. All through the process, this information is available real-time to anyone managing and supporting our claimants.

Mr. MICHAUD. You also mentioned that you receive 4.5 million calls a year. How many staff handle those calls? Is there a waiting list? Is it an automated list, or can they get a live person?

Mr. MCCARTHY. They get a live person. Every call is answered within 20 seconds. We have 300 people answering these calls.

Mr. MICHAUD. Twenty seconds?

Mr. MCCARTHY. Twenty seconds.

Mr. MICHAUD. Three hundred people?

Mr. MCCARTHY. Three hundred.

Mr. MICHAUD. What is the availability if someone calls in? Can they call in during the evening, or is it during the daytime?

Mr. MCCARTHY. Twenty-four/seven.

Mr. MICHAUD. Twenty-four/seven. Thank you.

Mr. MCCARTHY. Thank you.

Mr. MICHAUD. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman.

Ms. Jones, I am very familiar with the great work the veterans service organization officers do, and my hat is off to you.

You mentioned in your testimony the difficulty in getting veterans appointments for specialty care, including dental, gynecological and oncology services. Is this a problem with the scheduling of appointments, or is it a specific problem with staffing in these specialties in the Ohio area where you are?

Ms. JONES. I have to think it is within the staffing. There is just not enough staff available.

Ms. BROWN-WAITE. Okay. So there are not enough of the specialty care physicians available. Am I understanding your response correctly?

Ms. JONES. Yes, ma'am.

Ms. BROWN-WAITE. Okay. How about primary care? What is the length of time with a veteran getting primary care?

Ms. JONES. An initial call is usually 2 to 3 months still.

Ms. BROWN-WAITE. So it is 2 to 3 months?

Ms. JONES. Yes, ma'am.

Ms. BROWN-WAITE. I mentioned in my opening statement the bill that I have that basically says if veterans cannot get medical care within 30 days, if they cannot get the appointments from the time that they ask for the appointments, that they would be able to seek care in the private sector, because the issue, really, is the timeliness of care.

Could you give me your view of whether this is a good idea or a bad idea or how you think your veterans would react?

Ms. JONES. That is a tough question.

I have to say that it is encouraging for me to think that we are looking outside of the box. I know that a lot of the veterans organizations are not pleased with that, so I have to make it clear that I do not speak for them.

For me, to see the possibility of our being able to use outside physicians might be a good idea. What I like about that is that maybe outside physicians who are already treating our veterans anyway would then get some kind of training about dealing with veterans issues. Right now most doctors do not even ask, "Are you a veteran," let alone, "Are you a combat veteran?" That is critical to their care that they are getting outside of the VA because they cannot get into the VA.

Ms. BROWN-WAITE. I appreciate your candid response to that.

Ms. JONES. Thank you.

Ms. BROWN-WAITE. I think that it is a mixed blessing. People want to receive the services in the VA because, when they do get the services, overall they are happy. I see you are shaking your head in agreement.

Ms. JONES. Yes, ma'am.

Ms. BROWN-WAITE. If there is a long delay in getting those services, you certainly do not want someone who has an ongoing problem, such as the one that you pointed out with the fellow with the prostate cancer—you do not want that going on without receiving the proper medical care. I know some veterans groups are adamantly opposed to this. If our goal here is to provide quality care, then care not rendered in an expeditious manner is not quality care, so we do have to, I think, think outside the box. If we cannot provide that in the VA, then I think that we need to throw that gauntlet down to the VA and say, if you cannot do it in 30 days, then the veteran would have the option to go elsewhere. That is why I put the bill in. It is not that I do not believe in the VA system; I do believe in the VA system, but we also want to make sure that there is a timeliness of that care.

I have just one other question, and that relates to—you mentioned the difficulty of the veterans that you are trying to assist getting their PTSD claims adjudicated in a timely manner——

Ms. JONES. Yes, ma'am.

Ms. BROWN-WAITE [continuing]. Because of the problem in obtaining an appointment with a psychiatrist, which, obviously, then delays the diagnosis needed to adjudicate the claim.

Do you feel that a joint VA/DoD/Benefits Delivery at Discharge physical may reduce the amount of time that it would take to obtain a diagnosis for PTSD and would allow a claim to be processed more rapidly?

Ms. JONES. If the veteran is going to start talking about what the issues are at that time.

What bothers me is that if they are still involved in DoD, they may not be open to discussing mental health issues.

Ms. BROWN-WAITE. Thank you.

I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you very much.

Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman.

My first question, really, is for both of the panelists. The VA has reported that 95 percent of outpatient appointments are scheduled within 30 days of the desired date. My question is: Based upon your experience, is that consistent with your own observations and experiences?

Ms. JONES. Absolutely not.

Mr. MCCARTHY. I would not have any experience, actually, directly with respect to veterans appointments, but in general in the private sector, that would be quite a common occurrence to be within that timeframe.

Mr. SPACE. Okay. Well, I want to follow up a little bit on what Congresswoman Brown-Waite referenced.

By the way, Mary, I want to commend you for the diplomatic fashion in which you responded to her inquiries.

Given that you have been involved in the system yourself as well as in your extensive experience with helping others navigate the system, is there any means—let us take the example of the gentleman whom you referenced in your testimony who suffered from prostate cancer. Is there any means by which a veterans service officer can intervene to expedite an outpatient scheduled appointment in the event that there are exigent or compelling circumstances?

Ms. JONES. We absolutely call in all the chips that we can when there is a circumstance where we have someone. Sometimes the VA can be responsive, but sometimes there simply just is not an available appointment. I have had experiences similar to what we are talking about where the VA is able to contract services out. It is what we saw when we had a large number of troops coming into our community from a maintenance company that was coming back from Iraq and was scheduled for dental care. They contracted out dental care for a period of time, and they did it locally rather than having them all try to fight their way into the VA clinic in Columbus. So I have seen them do some contracting when we call and say, "Look, we have a large number of people who are needing the same treatment," but that is not across the board, and that is not always available.

Mr. SPACE. So those are instances in which you have seen or have observed the active contracting out because of, for example, a large influx at a given moment in time.

Has that been a productive exercise? Has it been helpful to engage in that contracting out?

Ms. JONES. Absolutely. It has gotten the guys the care that they needed in a timely manner.

Absolutely. It has gotten them good care with local physicians, with people who they are probably familiar with anyway in some cases.

I have seen more and more contracting out with radiation services because of our Vietnam vets and the exposure issues and prostate cancer. So we see more and more radiation treatment for prostate cancer contracted out locally, and that has been very productive. Otherwise, our guys have to drive 2.5 hours daily for 5 to 6 weeks for that treatment to the nearest VA that can provide it. That is a long drive.

Mr. SPACE. Okay. Thank you, Mary. I have no further questions. I yield back.

Mr. MICHAUD. Thank you very much.

Once again, I would like to thank you both for your enlightening testimony, and I look forward to working with you as we move forward on this very important issue of making sure that veterans get timely access to healthcare.

So, once again, thank you both.

Ms. BROWN-WAITE. Mr. Chairman, if I may ask Ms. Jones just one additional question?

Mr. MICHAUD. Yes.

Ms. BROWN-WAITE. Because there are so many snowbirds who come from your State down to Florida, have any of them compared appointment times that they are able to get in, let us say, Southern States, not necessarily Florida, when they spend six months in an-

other State as opposed to when they are in your State? Have any of them mentioned that?

Ms. JONES. I have had several talk to me about that. Quite frankly, when they come to Ohio, they are a little upset. They say, "We are getting good care. I am calling in," you know, "and I am able to be seen very quickly in the Florida area." They then come back to Ohio, and it is hard to transfer from one VISN to another. I mean, that is not something that is easy to do to begin with. Then to try to get them in is just like trying to get a new patient in sometimes. Even though he is very involved in the VA in Florida, when he comes back to the State of Ohio, he is being seen as a new patient.

So there is a 2- to 3-month delay. What these guys who are regulars at doing this have learned is to try to get your medication filled before you leave Florida before you come back to Ohio for the summer. Yes, ma'am.

Mr. MICHAUD. I guess that raised another question for Representative Space.

Mr. SPACE. Thank you, Mr. Chairman, for indulging me. It will be brief.

Based upon your experience, Mary, do you see, perhaps, a difference in terms of the scheduling times that apply to those who have access to rural versus urban areas? In other words, is this a problem that afflicts rural America more so than urban America?

Ms. JONES. Very much so. I have talked to guys who have moved into our area, a more rural area, from, say, the Dayton, Cincinnati, Cleveland area where there is a hospital. A lot of them are ready to move back to their areas just because they cannot get the treatment that they need in our area.

Mr. SPACE. Thank you.

I yield back.

Ms. BROWN-WAITE. Mr. Chairman, I was just handed a question from another Member of the Oversight Subcommittee for Mr. McCarthy, Kevin McCarthy, the representative from Unum.

Mr. MCCARTHY. Yes.

Ms. BROWN-WAITE. His question is, "How might the system that Unum deploys in its intake and management of disability claims have any relevance to the VA healthcare system?"

The followup question that he has is, "Are there any lessons to be learned?"

Mr. MCCARTHY. Although we are not directly in the provision of care, we are in the business of tracking the responsiveness of our company within a care system, and so all of our disability benefits specialists use a common system.

So, for example, in the example that Ms. Jones just was using, a patient's moving—geography—would be tracked within the system, and he would be provided the same availability of information in real-time with the same amount of vocational, clinical and rehabilitation support or medical support regardless of where he would be located. For example, all of our tracking systems would follow the claimant. They would not be separated by jurisdiction, for example.

Ms. BROWN-WAITE. So, if I understand you correctly—and this question was directed at you. It was not from Mr. McCarthy. That is your name. I apologize.

So what you are saying is that your system would prevent the problems that Ms. Jones has brought to light where they go from one VISN to another?

Mr. MCCARTHY. I think, within our system, we have a number of quality standards built in. We do quality assurance evaluations based on those standards of all of our disability benefits management specialists. We track the constant availability of the information and the transferability of that information, so I would think that type of system would be beneficial to any administrative process involving the delivery of care.

Ms. BROWN-WAITE. Okay. Ms. Jones, let me just tell you that I used to hear from veterans who would go back North in the summer. They would have trouble, and they would be considered a new patient, but somehow I do not hear those complaints anymore, and I am not sure that they are getting their medications, if that is how they are solving it, or if in some areas the VA may be better at sharing the patient information. I do not know which of those two scenarios explains why it is happening. I have not heard in 2 years from a snowbird that they have had problems.

Ms. JONES. I have more recently, yes.

Ms. BROWN-WAITE. But it is on your end, not on the Florida end?

Ms. JONES. It is on our end.

Ms. BROWN-WAITE. Okay. Thank you.

I really do yield back this time.

Mr. MICHAUD. No problem.

Once again, I would like to thank our first two panelists for your testimony today. We look forward to working with you. Thank you.

Mr. MICHAUD. On our second panel is Belinda Finn, who is Assistant Inspector General for Auditing. Belinda is accompanied by Larry Reinkemeyer, who also works in the Office of Inspector General.

So I want to welcome you both here today, and we look forward to your testimony, Belinda.

STATEMENT OF BELINDA J. FINN, ASSISTANT INSPECTOR GENERAL FOR AUDITING, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LARRY REINKEMEYER, DIRECTOR, KANSAS CITY AUDIT OPERATIONS DIVISION, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. FINN. Thank you, Chairman Michaud, Chairman Mitchell and Members of the Subcommittee.

I am pleased to be here today to discuss our findings and conclusions on outpatient waiting times. With me is Mr. Larry Reinkemeyer, Director of our Kansas City Audit Office, who directed the work on our two audits.

The VHA calculates waiting time for each appointment from the desired date of care, which is defined as the earliest date that either the patient or the medical provider requests care. The VHA has established a performance goal of scheduling appointments

within 30 days. Veterans who cannot be scheduled within this timeframe should be placed on an electronic waiting list.

In 2005, we reported that the VHA did not follow established procedures when scheduling appointments, resulting in inaccurate waiting times and waiting lists. Because schedulers did not follow procedures, only 65 percent of the 1,100 appointments we reviewed had been scheduled within 30 days. Nationwide, the electronic waiting list could have been understated by as many as 10,000 veterans.

The VHA also lacked a standardized training program for schedulers, and it did not provide sufficient oversight of the process. Almost half of the 15,000 schedulers who talked to us about their training and scheduling practices said they had not been formally trained on the scheduling system; 81 percent had received no training on the use of the electronic waiting list. At the conclusion of our audit, the VHA agreed with our findings and accepted our recommendations.

In 2007, we conducted a followup audit to determine whether the VHA had addressed the findings and recommendations in our report. We concluded again that the data in the scheduling system remains inaccurate, in part because the VHA had not implemented five of the eight earlier recommendations. We reviewed 700 medical care appointments that the VHA had reported as being completed within 30 days. We found that only 75 percent of those appointments had actually met the 30-day timeframe. Our review of 300 consult referrals found that more than 180 veterans were not included on the waiting list, but should have been. The VHA disagreed with our findings and said that patient preference had caused the unexplained differences. Although policy requires schedulers to document patient preferences, the VHA felt this was an unrealistic expectation. They conceded, however, that the system lacked the documentation to support their position.

We contend that, without this basic annotation, the VHA cannot support its assumption that patient preference caused our findings. We find it contradictory that the VHA agreed with our 2005 report but disagreed with our followup audit. We used the same methodology and found a continuation of the same problems, problems that could have been resolved had VHA implemented our recommendations.

In 2006 and 2007, the VA reported high performance affecting appointments within 30 days. They reported this high level of performance even after we had twice reported the scheduling system contains inaccurate, incomplete and unreliable data.

In closing, I would like to say the issues today before us go beyond reported waiting times. Debating whose numbers are more correct only overshadows the primary point of both of our audit reports, which is that the information in the VHA's scheduling system is incomplete. The VA and Congress must have reliable information for budgeting, assessing and managing the demand for care. More importantly, they need accurate information to ensure that every veteran receives timely medical care.

Thank you for having us here today, and we would be happy to answer any questions.

[The prepared statement of Ms. Finn appears on p. 35.]

Mr. MICHAUD. Thank you very much, Ms. Finn.

What does the VHA need to do to improve their data reliability? Have you communicated that with them? What was their response, if they had one?

Ms. FINN. Yes, sir. We made recommendations in both of our reports that the VHA should provide the oversight of the schedulers, should monitor what the schedulers do, and should provide quality assurance over the data in the scheduling system. They agreed with the recommendation in 2005, but we did not find their actions had really resolved the problem, and therefore, we reinstituted the recommendation in our later report. They do have procedures to monitor the number of veterans who are taking more than 30 days to get an appointment. We found procedures in place to monitor this, but not procedures to monitor the quality and the accuracy of the data in the system.

Mr. MICHAUD. You had mentioned that they have not implemented five out of the eight recommendations. Did they tell you why they have not implemented those five?

Mr. Reinkemeyer.

Mr. REINKEMEYER. It would be better for them to explain that, but they have taken some actions. From 2005 to 2007, they created a pretty detailed directive in 2006–055 as part of the response to our first audit that lays out step by step procedures for the schedulers to follow, and it is pretty clear. Those, in fact, are the guides that we used when we did this last audit.

There was one recommendation that dealt with IT that they are working, and I think they are close to having that implemented now. I know that they want to close a couple of the recommendations but we just have not had a chance to evaluate them yet, and we will take a look at their actions for those to see if we agree with those or not. However, it would be best to ask them, I think, on exactly why some of them have not been implemented.

Mr. MICHAUD. Great.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you.

Have you all taken the data actually down and reviewed each of the VISNs to track the performances that the individual VISNs are experiencing?

Mr. REINKEMEYER. No. You could do that. The VHA has plenty of data that will show you by VISN what performance is occurring in that VISN.

In our first audit in 2005, we went to eight different facilities. That was the extent of our work. In this last audit, we went to 10 facilities at 4 different VISNs. We did not really compare who was doing better and who was doing worse. We tried to focus on the actual appointments themselves to see how well the data that was in the system was supported by the medical records.

Ms. BROWN-WAITE. I actually asked for information on VISN 8, which is the VISN that Florida is in, tracking their performance. When I asked for it, I got information that seems to indicate that while outpatient wait times are going down in the medical centers, the wait times are actually increasing at the CBOC level.

Is there any way to account for this situation?

Mr. REINKEMEYER. Well, typically the CBOCs—I mean, not all CBOCs are the same, but a lot of the CBOCs are not going to be staffed with the same type of providers, so I do not know exactly if it is waiting time for specialists or for primary care, but that could be one reason.

Ms. BROWN-WAITE. I did have them break it down by primary care. This was primary care's average wait time new patients/average wait time established patients. So we did it both for hospitals and for CBOCs. Obviously, more and more people are using the community-based outpatient clinics. I mean, that is, overall, a good thing that they are using the clinics, but I am now starting to also hear that there is a wait time. Let me ask you a somewhat related question.

At what point in time does the scheduling request begin?

On page 2 of the VHA directive 2006–055, number 4, it says, "'Desired Date' is defined as," quote, "The desired appointment date is the earliest date on which the patient or clinician specifies the patient needs to be seen. This desired date may be the date the request is made by the patient or the date a request is made by a clinician. When available, the desired date may be a specific date to be seen submitted by the patient or by the requesting provider. In some cases, the desired date may need to be modified after an initial appropriate clinic visit. For example: a patient may request to be seen by a specialist, but a clinician reviewing the request may determine that before being seen in specialty care, the patient needs to be evaluated in primary care," end of quote.

Isn't that kind of a very confusing definition of that point in time that the actual appointment was requested? It is almost like you read this five or six times, and you say, "Huh?"

Ms. FINN. Yes. I think the ultimate point of the definition is that both the medical provider and the patient can request a date. The medical provider, of course, recommends a date of care, and the patients also have some latitude as to when they schedule their appointments. We recognize that patients may schedule their appointments a little later or, perhaps, earlier than when the doctor absolutely recommends it.

Ms. BROWN-WAITE. Mr. Chairman, just a quick followup question. I know my time is almost up, and I will yield back.

Is the problem of how to set that point in time when the request is made because of the somewhat convoluted description in the VA's own directive?

Ms. FINN. The problem is recording the correct desired date of care in the scheduling system to make sure that it really reflects what the doctor recommends or what the patient has requested. That is the date that we measure the waiting times from.

Ms. BROWN-WAITE. I yield back the balance of my time.

Mr. MICHAUD. Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman.

I think we can all agree that inaccurate waiting time data compromises the VHA's ability to assess and to manage the demand for medical care. That is, in fact, taken directly from your testimony today. Your testimony also includes the following sentence, and I will read it and then follow it with a question.

"VHA managers plan budget priorities, measure organizational and individual medical center directors' performances and determine whether strategic goals are met, in part by reviewing data on waiting times and lists."

The operative part of that sentence was measuring an individual medical center director's performance. Clearly that data is important to assess whether a particular medical center director is performing adequately. My question relates to the bonuses that all of us are familiar with that raised some controversy earlier this year.

If you know—and perhaps you are not prepared to answer this—is it possible that bonuses were at least, in part, calculated or based upon high-performance standards regarding waiting times that were not accurate?

Ms. FINN. We know that the waiting time is part of the performance standards for directors. It is one of many factors. We really do not have a great deal of information today about how that is actually factored into a particular bonus.

Mr. SPACE. Are you prepared to say today whether there is evidence that waiting time data was intentionally fabricated at any of the medical centers that you have surveyed?

Ms. FINN. We know that some of the practices used by schedulers and some that schedulers have told us about would serve to understate a specific wait time. As to whether that was a widespread manipulation, I cannot say right now, but we have seen a number of cases where we believe that practices serve to understate the time.

Mr. SPACE. I understand that from reading your testimony. The word "practices" can encompass a lot of things. Certainly it can include inefficient habits. It can include procedures that are not up to par, but it could also include the intentional manipulation of data.

Did your investigation determine that there has been any act, intentional overt act, to misrepresent the data?

Mr. REINKEMEYER. In this recent audit, which was a followup to the previous audit, we did not really explore that question, but in 2005, if you have seen that report, we did an extensive survey that over 15,000 schedulers responded to. One of the questions was, have you ever been directed to intentionally manipulate scheduling procedures in order to circumvent the system, which would result in reduced waiting times? That is not the exact question, but it was close. Seven percent said yes. So, in 2005, we did have some evidence that schedulers were directed to schedule in a particular way in order to effect the waiting times.

In 2007, we know that those procedures are still out there. The two most common procedures would be taking longer than allowed before they are put on an electronic waiting list, and you probably saw some of our references to consult referrals from a primary care to a specialist where the standard is 7 days. If you do not act on that appointment within 7 days, you are supposed to be put on the electronic waiting list and the VHA and their directors would take that information and use it to determine where to apply resources. By holding onto those referrals for more than 7 days and not putting them on the electronic waiting list, that serves to understate the waiting list.

The second procedure that tended to manipulate would be establishing the starting point for the waiting time. It is the desired date. We have seen both in 2005 and in 2007 that a common practice for a scheduler was to find out when the first available appointment was—January 15th—and then use that as the desired date of care, which effectively reduces the waiting time to zero.

So those are the two types of scheduling practices that tend to manipulate VHA's data.

Mr. SPACE. If I may just have time for one more question?

Mr. MICHAUD. If it is quick. We still have one more panel, and we have votes coming shortly.

Mr. SPACE. I will be very quick. Okay.

The 7 percent that were directed to intentionally misrepresent the data, that falls separate and apart from those two incidences which represent practices that you just recited, correct?

Mr. REINKEMEYER. Yes.

Mr. SPACE. Has any action been taken to determine who was intentionally directing people to manipulate the data? If so, what repercussions have resulted from it?

Mr. REINKEMEYER. In 2005, we did not ask who did it, and the survey was anonymous. I cannot tell you now, but we have some information that would say where they were. If I recall correctly, they were spread out.

Mr. SPACE. Thank you. I will assume that the answer to that is no.

With that, I thank the Chairman for indulging me with additional time.

Mr. MICHAUD. Thank you very much.

I would like to ask the third panel to come up. While they are coming up, there will be additional questions that we will provide in writing, and hopefully, you will be able to answer them as well.

Mr. KENNEDY. Mr. Chairman.

Mr. MICHAUD. On the third panel——

Mr. KENNEDY. Mr. Chairman.

Mr. MICHAUD. Yes.

Mr. KENNEDY. Briefly——

Mr. MICHAUD. If you can hold your question until the end, we still have one more panel. We have to give this room up at 4:30, and we have votes, so——

Mr. KENNEDY. We have 120 veterans committing suicide a week. Did you break out mental health appointments on your outpatient waiting lists?

Mr. REINKEMEYER. No, sir.

Mr. KENNEDY. You did not.

Was there a correlation between inpatient waiting time and outpatient waiting time in your audits?

Mr. REINKEMEYER. Again, we only looked at the outpatient waiting times.

Mr. MICHAUD. Okay. On the third panel, we have Dr. Gerald Cross, who is the Principal Deputy Under Secretary for Health; as well as Dr. Paul Tibbits, who is the Deputy Chief Information Officer (CIO).

So I want to welcome the last panel. If you could summarize your testimony, your full testimony will be submitted for the record. As you know, we do have votes coming shortly, and we will not be able to continue the hearing because we will have to give up this room at 4:30. Unfortunately, the full Committee went over by 45 minutes, so I apologize for that.

So, Dr. Cross, without further ado, would you begin?

STATEMENTS OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM F. FEELEY, MSW, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION; ODETTE LEVESQUE, CLINICAL/QA LIAISON, OFFICE OF THE DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION; AND KATHY FRISBEE, DEPUTY DIRECTOR, SUPPORT SERVICE CENTER, VETERANS HEALTH ADMINISTRATION; AND PAUL A. TIBBITS, M.D., DEPUTY CHIEF INFORMATION OFFICER, OFFICE OF ENTERPRISE DEVELOPMENT, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF GERALD M. CROSS, M.D., FAAFP

Dr. CROSS. Thank you. Thank you, Mr. Chairman. And since time is short, I have a written statement. I will submit that, and I will abbreviate my oral statement.

Mr. MICHAUD. Thank you.

Dr. CROSS. We are making good progress in meeting the needs of our veterans in terms of access, and we are committed to providing all necessary care, including preventive care. I want to be clear that we are talking about waiting times for general, routine outpatient appointments. Veteran appointments with urgent or emergent needs are seen immediately separately.

In a healthcare system as large as VA where we provide over 1 million patient encounters in our clinics each week, we understand there are opportunities for improvement. With national implementation of the Advanced Clinical Access Initiative, we have made significant progress of reducing wait times.

And you may see some of the graphs that are portrayed on the stands to our left. In the patient satisfaction survey for the third quarter year to date fiscal year 2007, 85 percent of veterans surveyed reported that they received primary care appointments when they wanted them, and 81 percent reported that they received their specialty care appointments and that they were made at a time that was acceptable to them. In fiscal year 2007, 96 percent of our 40 million appointments were seen within 30 days of the desired appointment date. This represents waits for outpatient primary and specialty care appointments.

We continue to improve access for new veterans. The percent of new primary care patients seen within 30 days of their desired date has improved from 75 percent in fiscal year 2005, to 83 percent in fiscal year 2007. And in September 2007, 90 percent of new

primary care patients were seen within 30 days of their desired date. Our statistics are even better for follow-up appointments.

Finally, we are focusing on mental health access by setting new standards that require all new mental health patients to be seen and their needs for care evaluated within 24 hours, and that these veterans have a follow-up evaluation within 14 days. With the assistance of Congress and the administration, we have increased, by 3,600, the number of mental health professionals with our system since 2005.

As you are aware, VA has several concerns about VA's Office of Inspector General's audit methodology used in the 2007 report. While differences in methodology exist, the overriding focus of both sets of measurements, and our overriding focus, is the veteran patient. VA has a driving interest to accurately monitor and to continually improve access for our veterans. There are an estimated 40 million appointments each year in the VA system. There are multiple variables involved in that measurement, and tracking that does include patient preferences and differences in the organization of individual facilities and clinics.

VA has identified ongoing training of our scheduling clerks as critical for success; however, we are still using antiquated software for this important task. VA is proactively taking steps to review this whole scheduling process, including the way VA measures waiting times.

We will continue to improve our processes, educate scheduling staff and strive to improve clinic access to further reduce waiting times, and to this end VA has contracted with an independent third party to conduct an evaluation of VA scheduling practices and waiting time metrics. The contractor is beginning the pilot program phase of its assessment, and we anticipate receiving the final report in the spring of 2008.

In conclusion, we are taking the following substantive actions to aggressively address the issues of veteran access and wait times. We ask the VA's Office of Information and Technology to develop a new scheduling software package, as well as developing shorter-term software solutions for our current scheduling package. We are continually improving our training programs, and we are contracting with an outside consulting firm for an independent review of our scheduling process and metrics.

Thank you, and I will be pleased to accept your questions.

[The prepared statement of Dr. Cross appears on p. 41.]

Mr. MICHAUD. Thank you very much.

And because of time, Dr. Tibbits, we do have your written testimony, you wouldn't mind if we go right directly to questions; there is no objection?

Dr. TIBBITS. No. Fine.

[The prepared statement of Dr. Tibbits appears on p. 42.]

Mr. MICHAUD. I have a couple questions—my first, actually, Dr. Cross, is you mentioned the methodology, but we heard just from the previous panel that the methodology was the same in 2005 as it was in 2007, and you didn't object to the methodology in 2005. So I guess my question is why you haven't implemented, well, five of the eight recommendations that they recommended.

Dr. CROSS. We are recommending the recommendations that the IG proposed, and we do track that. I want to point out that one of the most important things that we are doing is the new directive to comprehensively approach many of the recommendations that they made. There was a difference in our analysis. And on review of the OIG report from 2005 to 2007, there were significant differences in what we found, and that was the reason, based on that evaluation, as to our different response.

Mr. MICHAUD. I understand that the VHA said that this is a documentation issue, but I also know that on the first page of the fiscal 2007 performance report VA provided to Congress just a couple of weeks ago, VA said it made 96 percent of its outpatient appointments within 30 days. Do you really feel that VA should be reporting 96 percent when you only can document 75 percent to the IG? How is VA or Congress to make the right policy decisions without having reliable numbers to go by?

Dr. CROSS. Congressman, the report that we did in the prior does include an additional explanation related to the IG report. So we did acknowledge the IG report and the difference that they found as opposed to what we found. And so I don't want to obscure that. We understand that and put that in there.

Mr. MICHAUD. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

Dr. Tibbits, how long has the VA been trying to launch its VistA scheduling program?

Dr. TIBBITS. The VistA program in the scheduling module dates back to the 1970s. It is actually in operation. Over that period of time, it has had modifications to it to get the best performance out of that kind of architecture and that software approach that we could get in the system.

It has limitations. Those limitations finally, I guess I can say, came to a head and were recognized as being not addressable in total with that old architecture, VistA, and the environment and programming medium that it is in. And the replacement scheduling application, helped do that scheduling, in order to replace that scheduling module in toto, was launched in May of 2001, to turn off the 2001, and to bring us into a more modern software and architecture, and also much more robust functionality, much better metrics.

Ms. BROWN-WAITE. So it wasn't just a name change in 2001?

Dr. TIBBITS. Not a name change. It was a complete, and remains today—that initiative to help do that scheduling is a complete revision of the programming approach, the architecture, a much more robust functionality.

Ms. BROWN-WAITE. And the cost of this program?

Dr. TIBBITS. I think I should get back to you with an exact figure on that, if you don't mind.

Ms. BROWN-WAITE. Has it been $30 million, $50 million?

Dr. TIBBITS. Well, I would rather get back to you with the number. I don't know the number today. We have the numbers both for the anticipated numbers and the actuals. It will be easy for me to get that information for you.

[The information from the VA follows:]

(In Millions)						
	FY 2004 Actual*	**FY 2005 Actual***	**FY 2006 Actual**	**FY 2007 Actual**	**FY 2008 Current Estimate**	**FY 2009 President's Budget Request**
VistA Scheduling Replacement	31,216	12,888	10,553	18,419	28,300	29,909

*FY 2004 and 2005 reports VHA obligations prior to the OI&T centralization. OI&T cannot substantiate these obligations since Scheduling Replacement was not a specific budget line item in the VHA budget operating plan. Prior to FY 2004, funds expended for Scheduling project activities were not specifically identified or reported.

Ms. BROWN-WAITE. I understand that the scheduling module has been delayed again. Is this accurate?

Dr. TIBBITS. That is the new package. Yes, it is accurate, and unfortunately some of that has occurred on my watch. I will be the first to tell you that we need to strengthen program management discipline in the Department. We are attempting to do so, both with IT workforce improvement initiatives, training and education, real-time coaching and mentoring. We are also bringing in industry experts, and the Department of Defense has numerous industry experts attached to them which we are bringing in to do real-time coaching and mentoring to help us revise our finance and accounting and program management practices as well. And also IBM, by the way, is consulting with us to help us implement the 36 processes that were recommended to us as part of standing up and reorganizing the entire Office of Information and Technology. So we are trying our best to strengthen those practices to get this program delivered on schedule to the office site.

Ms. BROWN-WAITE. So do I understand correctly from your testimony that it won't be fully implementational until 2011.

Dr. TIBBITS. Yes, ma'am. The current schedule is January 2011 to have that new module deployed throughout the VA. The alpha site deployment date is this summer, and the beta site would be December of 2008.

Ms. BROWN-WAITE. So 10 years for determining wait times scheduling.

Dr. TIBBITS. Yes ma'am. There are significant issues in the Department. Many of them——

Ms. BROWN-WAITE. Sir, issues—I don't think is what the taxpayers want to hear. That there are issues in the Department.

Dr. TIBBITS. Yes, ma'am. And the Department is taking, I would say, quite a number of steps to try to deal with those issues, not the least of which was the IT reorganization itself. We have moved 6,000 people from their former alignments in the organization to a new, we are taking steps to professionalize the workforce, we have the most empowered CIO in Federal Government, we have now complete alignment of authority and responsibility with respect to the CIO, none of which the Department had before, just 1 year ago the Department did not have this. So while we are well positioned to address those issues, nonetheless addressing those issues is hard work, and much work remains to be done.

Dr. CROSS. May I add, Congresswoman, that we can't wait until 2011. We are doing things right now within our side of this equation to make sure that our veterans get the access that they need.

That is why we are adding the staff. That is why we are opening the new clinics. That is what really matters.

We are going to deal with the IT issue working in collaboration with my colleagues from IT, but in the meantime there is much that we can do, and we must do that, and that is particularly boots-on-the-ground people helping veterans, getting them their appointments, putting the staff in the clinics, and that is what we are doing right now. That includes 3,600 mental health workers.

Ms. BROWN-WAITE. After all of this period of time, after 12 years of implementation, and now it is going to be up to 2011. Will this program be able to calculate waiting times, yes or no?

Dr. TIBBITS. Yes.

Ms. BROWN-WAITE. And if we are here in 2011, will we be told it will be 2015, and the answer will still be yes?

Dr. TIBBITS. Well, we are certainly taking steps for that not to be the case.

Ms. BROWN-WAITE. I yield back the balance of my time.

Mr. MICHAUD. Yet earlier today we heard testimony that a lot of the issues with calculating patients' waiting times has to do with the schedulers. Specifically what have you done as far as to help solve that problem with the schedulers to make sure that we do have accurate information?

Dr. CROSS. Mr. Chairman, what we have done is training, and training is very important. I think the Congresswoman read from a part of our directive. It is quite complex. And people have to understand that that doesn't come immediately to them. They have to be trained to do that.

I am going to ask a couple of my colleagues here, Ms. Frisbee or Ms. Levesque, to comment on that and talk a little bit about our training program.

Ms. LEVESQUE. We issued a policy on scheduling and subsequent to that had union negotiations. And once we were cleared, we provided the training to all the schedulers. And to date, we have trained about 40,000 schedulers, which means anybody who has access to the scheduling package. Many physicians like to schedule their own patients, so they have had to take the training as well, and those who have not taken the training have had their permission to schedule removed from them.

We are in the process of relooking at our directive. Given that it has been out there for a year, there are issues that bubble up as any issue would with any directive, and we are in the process of revising that directive. And once that is revised, we will revise the training for the schedulers, and we will do that on an annual basis. They will have to take the training annually. We also asked all the networks to certify that their facilities have basically trained all of their schedulers, and we received those certifications.

Mr. MICHAUD. And you heard the previous testimony from Mr. McCarthy from Unum in that their timeframe that they deal with their patients or clients is 3 to 5 days on average, and that they handle over 4½ million calls a year within 20 seconds with very limited amount of staff 24/7. Have you looked at what the private sector, such as Unum, is doing that might improve on what the VA is doing?

Dr. CROSS. I mentioned in my opening testimony that one of the things we are doing is bringing in an independent reviewer. And we have established a contract with a well-known, famous contractor, to look at waiting times and how we measure it.

I will ask Dr. Tibbits if he wants to add anything to that. I think the answer is no.

Mr. KENNEDY. If I might.

Mr. MICHAUD. Is there unanimous consent that Mr. Kennedy be allowed to ask questions? Any objections?

Hearing none, Mr. Kennedy.

Mr. KENNEDY. In our community health centers in Rhode Island, we have same-day walk-ins, and they have never thought it could be possible where they could go without prescheduled appointments, and they have now done without them. And they have accommodated it, and it is, to everyone's surprise, not a problem. And so I would be happy to hook you up with them and figure out how they have managed to do it. But I understand they are doing it in the VA in Hartford. They don't have prescheduled appointments. They have it via you walk in, you get taken care of.

Now, a big problem that I have is we are not even seeing a fraction of the veterans we need to see. The big issue here that we are not touching is the numerator and the denominator. VA is only touching a fraction of the number of veterans that it should be touching.

Now, the real question is what happens when the VA actually goes out and does its job, and that is touch all the veterans that are supposed to be brought into the VA? Then what happens to this waiting period? That is the real issue. And what happens when it has to contract out, and will it contract out for partnership with the private sector in order to meet these needs?

You mentioned the mental health. It is great if you hire a bunch of mental health providers, but it is a lot easier if you co-opt the existing mental health providers and use them as leveraging resources so you can build a broader system to meet the need.

But I am interested to hear whether you have heard of this notion of, you know, same-day walk-in services.

Mr. FEELEY. Dr. Cross, might I comment? I would just want to mention it is Bill Feeley, class of 1969 and Providence College responding.

I wanted to share with you that we have the 724 community-based outpatient clinics that were mentioned. So we are out there with mental health providers in all those clinics. You can have same-day walk-in service at any VA hospital in the system, and you can get that at the community-based clinics as well.

Because of the serious nature of the disease entity that we are talking about, we have established a new standard of a response within 24 hours to a patient who presents. On a call, they can come in, but we are going to evaluate them within 24 hours. The standard to see a patient routinely—not in crisis, but routinely—is dropping from 30 to 14 days, which is the way we are going to use these mental health warriors that we are hiring out there, and 3,600 of those employees. In addition, we already contract for $3 billion worth of services in various community-based setups where there might be remote challenges. So we are doing it.

And I would like to get on the record that people come to us as the subject matter experts on access frequently and view us that way. We are not perfect. This is a work in progress that will keep me busy for many years. I set a goal as a professional mental health worker to wipe out mental illness by the time I was 28. I am now 60, and I still have work ahead of me.

Mr. KENNEDY. I would just like to follow up. I was just down in south Texas, and there is no real VA down in the McAllen area. They send them up to San Antonio. They tell me that, you know, it is a 4- or 5-hour drive. That is the only place they can get their appointments. It would be a lot easier for them if they were able to get it, obviously, down where they live in that area. The population is huge. And rather than—maybe they could get their appointments all, you know, kind of in an accumulated timeframe and do better scheduling that way than have them take that 4-hour drive. Maybe they could do teleconferencing and other things. Have you thought about these things?

Mr. FEELEY. Let me just share with you, so no one thinks that you sent me this question in advance. I did a ribbon-cutting ceremony in Harlingen last Friday at the CBOC there that has been expanded from 11,000 square feet to 34,000 square feet, visited the clinic 35 minutes away. The mental health service delivery system that you are describing is going to be in this new Harlingen expanded clinic. And we are going to be contracting for inpatient care whenever needed since it is an unreasonable commute to expect someone who is having a mental illness breakdown to ride in a van for 300 miles.

So we are really going to bolster up services in the Laredo, McAllen, Harlingen, Corpus Christi area by investing in those mental health providers and bringing them down there. But Mexican food did bring me down to the dedication.

Mr. MICHAUD. I want to thank you, Mr. Kennedy, too, for your interest not only in veteran issues, but also in mental health. You have been a true leader in Congress. I really appreciate your interest in these issues.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

You know, in thinking about the whole scheduling problem that VA has had for a very, very long time, have you looked at what major hospitals do, New York University, Mayo Clinic, M.D. Anderson, a little clinic maybe in rural Ohio? Scheduling of patients isn't new, it is not rocket science. Why has it taken so long, cost so much? And yet, I will tell you, I have been here just 5 years. Before I got sworn in, I got sworn at by the VA people in my Congressional district because I asked them for a list of wait times, because what I heard on the campaign trail was nowhere like what they initially provided me. And I challenged them. I said, I don't believe these numbers. You better go back. You better look. And I gave them names of people who had told me how long they had to wait. Well, then they finally 'fessed up.

I do not believe that they have ever had the audacity to fudge those numbers again because they know I will call them on it. They know I stand on those numbers. But why are we reinventing the scheduling wheel here?

Dr. CROSS. Congresswoman, we are a learning organization. And I listened to what Congressman Kennedy said and what you said. We will learn from anyone, and we often do reach out to many different organizations, universities that we are affiliated with and others. If someone has a better package that will fit within our system to do the vast job that we are asking it to do, we are quite open to that.

Now I will ask my IT colleague to add to mine. I am not an expert on IT.

Dr. TIBBITS. Well, right. I mean, just from the IT perspective, I would say exactly the same thing. We are not wedded to in-house development, we are certainly not wedded to the legacy system which has inadequate functionality, and we are happy to look at cost packages. And so far, we have not identified a cost package. We have, by the way, looked at DoD's experience with commercial off-the-shelf packages for scheduling, which was not a happy experience. And we have wound up with the conclusion we wound up, that the existing system needs replacement, it needs replacement badly, the current foundation is not adequate to build on, and we need a new module.

Ms. BROWN-WAITE. The current system needs replacement badly, and so we have been at this now for 10 years?

Dr. TIBBITS. We have been at the replacement system since May of 2001.

Ms. BROWN-WAITE. That doesn't equate to quickly, even May of 2001.

As I said, this isn't rocket science. And I appreciate your offer to reach out to the private sector, but you can take an off-the-shelf program that perhaps M.D. Anderson uses, and it can be modified. You can take those modules and you can modify them.

I don't understand. Tell me the uniqueness of the VA scheduling system unless it relates to that very convoluted description that I read earlier today that I don't want to bore everybody by reading again, because it is like, okay, when is it official that appointment was requested? Is that what makes it unique? Please help me to understand.

Dr. TIBBITS. Sure. Let me speak to some of that, and then I am going to defer to my colleagues who understand the scheduling business far better than I do and the policies. But from an IT perspective, when one starts modifying a commercial package, it is a disaster, because what happens is modification of a commercial package then creates frequently a separate production line, which then that industry cannot continue to market commercially, but we wind up being a unique customer for that commercial package. That winds up being a very expensive proposition, which has proven to be a failure in many implementations of commercial packages around the world—around the country.

Now, what specifically makes VA requirements unique? I am not the best person to answer that, but we have veterans categories and many of the things that you all are very familiar with that the private sector does not have to deal with.

Ms. BROWN-WAITE. You are talking about a couple of extra boxes there on the initial application for an appointment.

Mr. Feeley, one quick question, and I would like this in writing from the VA. The bill that I referred to that says you either provide the healthcare service within 30 days or—really 30 days, by the way—or the patient can seek care elsewhere, I would like an official position by the VA on this, a written position. I realize you can't do that now. And you also have a new Secretary coming in. But I would like that within—I think maybe the next 30 days would be an appropriate response time. I certainly would appreciate it. And I would, with the permission of the Chairman, certainly share it with everyone else. And if you would send it to Mr. Michaud with a copy to me, I would greatly appreciate that.

[Congresswoman Brown-Waite sent a letter to VA on December 13, 2007, requesting additional views for H.R. 92. The request letter and VA's responses dated July 31, 2008, appear on p. 45.]

Mr. FEELEY. If I could just comment. I think that we need to meet the standard, and we are working very aggressively to meet that standard, and my goal is certainly to hope that we do. So we are continuing to monitor and measure on a biweekly basis. And I think the bill has elements of reasonableness if we can't meet the standard. But we will get the written position of the Secretary.

Ms. BROWN-WAITE. I appreciate that. Thank you. And I yield back.

Mr. MICHAUD. Thank you.

Once again, I would like to thank you, Dr. Cross and Dr. Tibbits, for your testimony and for the accompanying panelists. I look forward to working with you as we move forward to deal with the wait time issue. And we can't emphasize enough that this is extremely important because there are individuals out there who serve this great Nation of ours that need the service. They need it in a timely manner, and unfortunately, as we heard from the full Committee this morning, if they do not get that service, unfortunately some do ultimately commit suicide.

So this is an extremely important issue. I look forward to working with each and every one of you as we move forward to improve on what the VA currently does. And once again, thank you very much, and the hearing is adjourned.

[Whereupon, at 4:30 p.m., the Subcommittees were adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

This Joint Hearing on VA Outpatient Waiting Times will come to order.

Good afternoon. I would like to thank everyone for coming to today's hearing.

The focus of this hearing is waiting times for outpatient appointments in the Veterans Health Administration. Outpatient waiting times are one aspect of a much broader focus of the Subcommittee on Health—access to high-quality healthcare.

Access to healthcare is defined as the ability to get medical care in a timely manner when needed.

We know that access to healthcare is important for veterans. It improves treatment outcomes and quality of life for those who have it.

Since the beginning of the 110th Congress, the Subcommittee on Health has taken broad action to increase veterans' access to healthcare.

In May 2007, the House passed H.R. 612 which extends the period of eligibility for VA healthcare for veterans of Operations Enduring and Iraqi Freedom from 2 to 5 years.

Also in May, the House passed H.R. 2199 which develops programs aimed to improve access to care for veterans with Traumatic Brain Injury.

And in July of this year, the House passed H.R. 2874 which among other things, provides therapeutic readjustment and rehabilitation services to veterans, provides improved transportation to rural veterans, and improves and enhances services to homeless veterans.

I am very proud of our accomplishments so far this year and I feel that we have come a long way in improving healthcare for veterans. But we still have more work to do.

Today, I hope that we will learn more about how the VA is doing in seeing patients in a timely manner for initial and necessary follow-up appointments, and how VA tracks this information.

I would also like to learn how VA is managing patient care to provide necessary preventative medicine.

In a system that handles 40 million outpatient appointments per year, it is clear that efficient and effective policy, training and follow-up is critical in achieving success.

I hope that we can use this time to work toward solutions so that we can all achieve our primary goal to improve access to healthcare for all veterans. I am confident that by working together, we will be successful.

Timely access to quality healthcare is something that those who have served our country have earned. We must work together to provide it for them.

Prepared Statement of Hon. Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations

Yet, our veterans can only take advantage of this healthcare if they can get the appointments they need to access it. Unfortunately, too many of our troops are returning home and encountering long waiting times.

When I was back in the district last weekend, I met with a group of Arizona veterans. Many of these veterans expressed concerns about the long waiting times they have encountered to get doctors appointments.

One local veteran, John Tymczyszyn, tried to make an appointment for treatment for a service-related injury he suffered. John requested this appointment in December 2006, and his appointment was scheduled in late May 2007—six months after his initial request. John told me that he continued to struggle to make appoint-

ments within the VHA and because of that difficulty he now relies on civilian providers for his healthcare.

This is unacceptable.

When we've tried to look into the problem and see what we can do to address it, we have been unable to secure verifiable documentation of waiting times.

According to a recent audit by the Department of Veterans' Affairs Inspector General, the wait times reported by the VHA are both understated and incomplete.

The VA reported in the *Department of Veteran Affairs Fiscal Year 2006 Performance and Accountability Report* in November 2006 that 95% of veterans seeking specialty medical care were scheduled for appointments within the required 30-day period.

However, the IG audit found sufficient evidence to support that only about 75% of veterans had been seen within 30 days of the requested appointment date.

Furthermore, the IG audit found that schedulers are "not following established procedures for making and recording medical appointments." This means that we don't even have a clear picture of how many veterans have requested appointments.

VHA schedulers are supposed to act on a veteran's request within seven days. If this appointment cannot be made within the required 30 days, the scheduler should place the veteran's request on an electronic waiting list.

However, the IG found that a majority of schedulers are not trained to use this system so they don't use the electronic waiting lists.

But perhaps most alarming are reports that schedulers have been instructed to reduce waiting times by not putting patients on the electronic waiting list. This attempt to reduce cases of long wait times could lead to "gaming" of the scheduling process.

The VA has discounted the IG's report because it disagrees with how wait times were calculated. This is unacceptable.

I'm not willing to walk away from this audit over a disagreement about methodology. This is a real problem that we must look into.

When our veterans encounter long waiting times, their conditions go undiagnosed and serious disease go untreated. This is no way to treat those who have honorably served our country.

Furthermore, until we have a clearer picture about waiting times, the VA can't improve the situation because we can't identify problem facilities or effectively allocate resources.

It is time for us to do the right thing for our veterans and stop hiding behind unsupported claims that these servicemen don't encounter long waits for doctors' appointments.

I look forward to hearing from our witnesses.

Prepared Statement of Hon. Ginny Brown-Waite, Ranking Republican Member, Subcommittee on Oversight and Investigations

Mr. Chairman,

I thank you and Ranking Member Miller, along with the rest of the Members of the Subcommittee on Health for joining us in this important hearing on outpatient waiting times at the Department of Veterans Affairs.

As of October 2007, there were 7.9 million veterans enrolled in the VA healthcare system.

And today there are 153 VA Medical Centers and 724 Community-Based Outpatient Clinics (CBOCs) available to serve the needs of these veterans.

When a veteran or physician calls to schedule an appointment in one of these clinics, they should be able to receive an appointment that is timely and appropriate to the medical needs of the veteran.

I am looking forward to hearing from our first panel of witnesses today on how they feel outpatient waiting times at the VA has affected them, as well as any possible solutions they can offer.

I am also interested in hearing from the VA Office of the Inspector General on their perspective on the waiting times issue.

Finally, I expect to hear from the VA as to how they monitor waiting times, and what steps they are taking to improve the timeliness of services provided to our veterans.

On January 4, 2007, I introduced H.R. 92, the Veterans Timely Access to Health Care Act, which would make the standard for a veteran seeking primary care from the Department of Veterans Affairs 30 days from the date the veteran contacts the Department.

Unfortunately, this bill is needed because current practices do not meet that goal.

I monitor data for VISN 8 from the Department of Veterans Affairs to determine the time new patients and existing patients wait to receive an appointment.

While established patients wait less than 15 days for an appointment, the numbers for new patients are much higher.

What I also found interesting in looking over the data is that there appeared to be a decrease in the waiting times at the major medical facilities; however, at the CBOC level, waiting times have increased.

In the 3rd quarter of FY 2007, new patients had to wait an average of 45–50 days to receive an appointment at a VA CBOC, while new patients waited an average of 22–25 days to receive an appointment at the VA Medical Centers.

This is simply not acceptable.

I am also curious as to the dramatic decrease in waiting times at the VA Medical Centers in VISN 8.

I question whether patients are being redirected to the CBOCs to reduce waiting times at the medical centers.

If veterans are having problems receiving care within 30 days, then Congress needs to allow them to look for an alternative.

My bill is NOT a scheme to move the VA toward privatization; it simply ensures veterans receive care in a timely manner.

VA can and does provide a high level of care to all the veterans that are enrolled in the system; however, if a veteran cannot be seen by a physician then what good does that do?

The Department of Veterans Affairs' Web site states that the goal of the VA is "*to provide excellence in patient care, veterans' benefits and customer satisfaction*."

This hearing today is to determine whether the VA is meeting that goal with timely access to care.

As everyone here knows, this issue is tremendously important to every American.

Our veterans did not wait to answer the call to duty.

They answered their Nation's call, and took up arms to protect our freedom.

They served and many returned to us injured and in need of care.

I talk with the veterans from my district on a daily basis about the issues they have with the VA, and getting in to see a doctor in a timely fashion is at the top of their list.

And the care of our Nation's veterans should not be a political issue.

Instead, Congress should work together to improve veterans healthcare so that it becomes the model of good governance.

Thank you again, Mr. Chairman, and I yield back the balance of my time.

Prepared Statement of Mary C. Jones, Licking County Veterans' Service Officer, Licking County Veterans' Service Commission, Newark, OH

Mr. Chairman and Members of the Subcommittee:

Thank you for providing me with the opportunity to testify regarding the important issue of outpatient waiting times.

I have worked as a County Veterans Service Officer for the past 12 years and in that capacity have had an opportunity to enjoy a great relationship with the staff at both the Columbus VA Outpatient Clinic and the Newark Community-Based Outpatient Clinic and feel privileged to be able to have this relationship. I use the VA Healthcare system as my primary provider of medical care for my service-connected conditions. My concern with outpatient waiting times is our inability to get veterans into an appointment in a timely manner. Their appointments are scheduled so far out (often two to three months) that their condition worsens and they are left angry and frustrated at a system that is supposed to be in place to care for those who have given so much to our great Nation.

As examples of the problems created by these wait times I offer to you some experiences from our office. We see many veterans shortly after their return home. They have been promised dental care within 90 days from their discharge. One veteran's first available appointment was scheduled for almost 90 days from the date of request. When he got to the dental clinic he was told that his appointment needed to be canceled and re-scheduled. They did not have any appointments available within the 90-day period that he was entitled to dental care and therefore he was not seen.

Female veterans have unique healthcare concerns and face difficult wait times to be seen by gynecologists—often as long as six to eight months. Please keep in mind that most of the women that we are working with do not have other viable options

for healthcare. Many are war time veterans on a nonservice-connected pension and are therefore very low income. They are unable to get Medicaid treatment for preventative or diagnostic medical care. Pap tests and mammograms are increasingly important as we get older and are often life-saving diagnostic tools, but waiting as long as six months for the initial exam and then often even longer to get the test scheduled can lead to greater problems if a cancer exists.

I mentioned earlier that I am a service-connected veteran and that I use the VA outpatient clinic myself. I was having health concerns and tried to schedule an appointment with my physician and was told the earliest appointment I could get was in six months. Because I am a county employee and have medical insurance through my employment, I was able to see a doctor outside of the VA system within three weeks and ended up needing major medication changes and a heart catheterization. I hate to think what would have happened to the veteran who had no other options.

We are now filing many claims for post traumatic stress disorder (PTSD). Usually when we file a claim we have a veteran who has a diagnosis for a condition, but PTSD is different. Most veterans can get into the VA to see a social worker and can get assigned to group counseling fairly quickly. Most can see a psychiatrist within three to four months for an initial exam, but within the 12 to 18 months that a service-connected claim takes to adjudicate, the veteran is still left without a diagnosis for PTSD because the wait times prohibit the doctor from seeing the patient often enough to provide a definitive diagnosis of any mental health issue. Because no diagnosis exists, the VBA must deny the claim for service connection. Seeing private psychologists and psychiatrists are beyond the financial reach of most veterans.

My most memorable experience is a WWII veteran who was in receipt of a nonservice-connected pension. He was diagnosed with prostate cancer through a PSA test done by his primary care physician. Treatment was scheduled, but the wait time was several months. In the meantime this gentle man very clearly understood that he would not survive due to the fact that his cancer had spread and was continuing to spread during this wait. The treatment would only have prolonged his life and probably not saved his life, but this would have been an excellent opportunity to send a positive message of support from the government to this WWII veteran, and that opportunity was missed. He died before his appointment with an oncologist.

This has been an honor for me to have an opportunity to bring examples of the difficulties experienced by the veterans that I serve caused by the long wait times to be seen at the clinics. I did not come to criticize the VA, because the care given by our outpatient clinic is excellent, but at this time that care comes at a price and that price is patience.

Mr. Chairman, this concludes my testimony.

Prepared Statement of Kevin P. McCarthy,
President and Chief Executive Officer, Unum US, Portland, ME

Mr. Chairman, Members of the Committee, I'd like to thank you for the opportunity to testify before you. My name is Kevin McCarthy and I am the President of Unum US. Unum is a subsidiary of Unum Corporation.

Unum's involvement was generated by our CEO (a graduate of Virginia Military Institute) wanting to explore how the company could assist with sharing its best practices that might be useful in a new world, "post-Walter Reed." Since that time, Representative Michaud has visited Unum and viewed firsthand how the combination of our people and technology are integrated together in a way that reduces delays in every aspect of claim processing/case management. As a result of this visit and our meetings this summer and fall with House and Senate Congressional staff, the Veterans Affairs Administration and the Department of Defense on sharing best practices between the private sector and the public sector, I am here today to discuss how we use these smart systems and people not only to reduce waiting times for setting up independent medical examinations or assisting a claimant's medical team in developing a treatment plan specific to that individual, but also how these are aspects of a larger integrated case management/claim management approach that includes everything from regular contact with our insureds so they know what is happening "real time" on their claim to assisting them with vocational rehabilitation. This integrated approach actually speeds up not only actions like wait times on individual, specific issues, but the entire claim/case management process. We would be pleased to continue to be a resource for the sharing of best practices be-

tween the public and private sectors as you continue to evaluate the disability adjudication/case management processes at the VA.

Corporate Overview

Unum is a company of people serving people. As one of the world's leading employee benefits providers, Unum helps protect more than 21 million working people and their families in the event of illness or injury.

We provide more than a benefit check to customers—we provide a wide range of benefits and services designed to help people during what is often the most trying time of their lives—loss of income due to illness or injury.

For 30 years Unum has been an industry leader in providing income protection and employee benefits. Unum is ranked #1 in long-term disability income protection, #1 in short-term disability income protection, #1 in individual income protection, and #1 in group long-term care insurance. We are also among the market leaders in group life insurance and supplemental benefits. We provide leave management administration services, health and productivity services and a work-life balance program with health risk assessments.

In 2006, we serviced more than 420,000 newly filed claims (disability products, long-term care, and voluntary benefits) and replaced $4 billion in lost income to help provide support to our insureds and their families. These benefits are paid directly to our insureds. To our knowledge, this is more than any other private income protection provider in the world.

Our customers expect that their claims will be paid promptly and accurately. In order to ensure we get it right the first time, we carefully measure customer satisfaction. In fact, 9 out of 10 are satisfied with the handling of their claim. In addition, 97% of the businesses we insure give us high marks.

Our ability to pay our customers billions of dollars annually with these high levels of satisfaction is due to our highly trained people, coupled with the right technology.

The substance of my testimony will be focused on how we track, manage and pay the more than 400,000 claims we receive each year with high levels of customer satisfaction.

Our people and tracking systems ensure we stay in close touch with our customers as we take the steps necessary to enable us to pay their claims. Our physicians and claims payers work closely with the insureds' medical providers to, for example, schedule medical examinations, set up calls so our doctors can speak directly with the insureds' doctors and establish that they are receiving regular care and treatment.

How do we keep our promises?

By employing:

- experienced people and leading technology;
- a claims management approach that applies the most accurate resources to each claim;
- best-in-class decision making supported by expert systems and resources with an emphasis on quality and tracking.

Customer Service and the Disability Management Process

While a person's disability can be a complex, ongoing and ever-changing life event, our goal is to make the claim payment process simple and transparent for our customers during this trying time in their lives.

We make it easy to submit a claim. It can be done by Internet, telephone, fax or mail.

At any time after the claim has been submitted, our customers can speak with a skilled person. We handle more than 4.5 million calls a year. Eighty percent of calls are answered within 20 seconds and 85 percent are managed without holding or transferring. It is a combination of selecting talent with the right skills, developing quality training programs, and employing the right technology that enables us to handle these high volumes with just 300 employees.

While our goal is to make it easy for customers to reach us, we also understand that many need our help.

Thus, we regularly reach out to our insureds and their healthcare teams. We view it as critically important to speak with our insureds and their physicians and we frequently help them follow up with their doctors.

We are able to do this because we have invested in an innovative technological process which sorts claims by complexity and severity—this technology is supported by hundreds of highly trained Benefits Specialists, physicians, nurses and vocational rehabilitation consultants. Again, it is this unique combination of people and technology that enables us to fully understand and respond to our customers' needs.

The Benefit Specialists help the claimants keep everything on track—the Benefits Specialists essentially "case manage" the claims. For example, they set up medical exams, help insureds with vocational rehabilitation, assist our customers in obtaining Social Security once we have determined that they may be eligible, and ensure that the relevant medical records have been received by Unum for a full, fair and thorough evaluation.

Our technology provides a single point of coordination which enables the team to efficiently:

- manage workloads;
- make appointments;
- review all claim documents;
- schedule follow-up appointments, calls, letters and medical exams; and
- provide real-time management access and quality assurance review.

This technology involves an imaging system so all the claims are paperless and can be viewed across multiple locations at the same time. This allows us to tap into expertise in other locations while also enabling easy communication between team members, even if they are not located in the same office. It also allows real-time claim assessment and processing. Finally, it ensures a consistent claim history, claim documentation, medical records and correspondence.

The technology also includes an automated scheduling system so claim management activities—such as calling doctors' offices and setting up independent medical exams—are done accurately and promptly.

Each one of the activities the Benefit Specialist does is scheduled and tracked to ensure that the right resources are applied to the right claims at the right time. In fact, the technology gives us the ability to determine whether appointments are being kept, calls are being made and whether there are delays in the claim processing.

The claim status is also viewable on the web so our customers can see their claim status "real-time." Privacy protections are in place.

Unum's goal is to make a determination within 3–5 days on 95% of short duration claims and within 45 days on longer term, more complex claims.

In regard to the specifics of the management process, when a claim is received it undergoes an initial claim review. During this phase the following steps occur:

- we verify eligibility;
- we evaluate the claimant's functional ability;
- we work in partnership with the insured's employer to assess the physical and cognitive occupational demands;
- we partner with the employer to determine any possible accommodations that could be made so the person can return to work; and
- the Benefit Specialist partners with in-house medical, vocational and management resources as needed.

The more complex claims are sent electronically to Benefits Specialists and medical professionals who specialize in certain types of claims—allowing efficient, high quality, customer focused handling. For these claims, each customer is called and we set up an individual follow-up action plan with the insured based on the dynamics of the specific medical condition. The claims process looks at the whole person, not just the diagnosis. We provide information and motivation to the claimant and the employer and work in collaboration to find the most appropriate resolution to the claim. The claimant's level of function is assessed, medical records and the treatment plan are obtained, and activities of daily living are determined. We then work with the insured on a return to work plan. A specific claim example may be a behavioral health claim that is based on ICD9 ("International Coding of Diagnostics 9"—a standardized Medical Diagnosis system where each diagnosis is assigned a code, i.e. The "ICD9 code") code and is sent to a Benefits Specialist with a specific skill set. That Benefit Specialist would review the claim on our image-based system. Based on the specific facts of the file, the Benefit Specialist could: call the claimant, obtain medical records, schedule an independent medical examination if necessary, call the claimant's doctor or set up a meeting between one of our doctors and the claimant's medical team to establish a treatment plan or gather outstanding information. The system could be set up to automatically remind our claims payer, nurse or doctor to call the claimant and see whether the appointment was kept or the agreed upon treatment plan was being followed. Based on the specific diagnosis, the system can automatically generate follow-up activities to ensure that our team is in regular contact with the insured and his or her medical team. As the insured's condition improves or otherwise changes, we can continuously adjust our actions to make sure that the insured is getting the treatment, care and

claim management that will enable us to assess the individual's condition "real-time."

During the assessment and review process, the Benefits Specialist partners with the insured's medical team as well as with our internal doctors, nurses and vocational rehabilitation staff to:

- assess the duration of the claim;
- provide rapid resolution to medical issues; and
- assist with helping the claimant return to work.

In addition to medical and vocational professionals, the Benefits Specialist has access to a wide variety of experts who can help with Social Security advocacy, wellness and disease management, an employee assistance program and return-to-work consulting.

Quality Assurance

The investment in the people and technology has given us the ability to easily measure and carry out all of the actions we schedule during the claim process.

From a Quality Assurance perspective, it gives us the ability to roll up the information in many ways. For example, we know whether appointments are being kept as we stay in close touch with the claimants and their doctors.

Behind the tracking systems, our robust quality assurance and continuous improvement programs also help:

- maintain a strong, customer-based focus;
- manage workloads for each of our claims specialists, nurses, doctors, and vocational rehabilitation specialists;
- facilitate an audit of claim decisions, both real-time and post-claim;
- support an appeal process with feedback; and
- allow for management review, involvement and reporting.

In conclusion, we would be more than happy to assist you in any way. You have an open invitation to visit Unum. We would welcome the opportunity to continue to share knowledge of our capabilities, systems and expertise. Thank you for the opportunity to testify before the Committee.

Prepared Statement of Belinda J. Finn, Assistant Inspector General for Auditing, Office of Inspector General, U.S. Department of Veterans Affairs

INTRODUCTION

Mr. Chairmen and Members of the Subcommittees, I am pleased to be here to address the Office of Inspector General's (OIG) findings related to the Veterans Health Administration's (VHA) reported waiting times for outpatient appointments. I am accompanied by Larry Reinkemeyer, Director of the Kansas City Audit Operations Division, who directed the teams responsible for the audits we performed. Our audit coverage on outpatient waiting times and waiting lists consists of two reports. I will discuss both reports today in order to provide a more complete assessment of the problems we identified and the current status of actions by VHA to improve outpatient waiting times.

In July 2005 we issued *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures* (Report No. 04–02887) and concluded that schedulers were not following outpatient scheduling procedures, resulting in inaccurate waiting times and incomplete waiting lists. As a followup to the 2005 report, we issued *Audit of the Veterans Health Administration's Outpatient Waiting Times* (Report No. 07–00616–199) in September 2007. We again concluded that schedulers were not following established procedures for making outpatient appointments, causing VHA's reported performance on waiting times and waiting lists to be unreliable for Congressional and VA decisionmaking.

OIG IDENTIFIES DATA INTEGRITY PROBLEMS IMPACTING THE RELIABILITY OF VHA'S WAITING TIMES INFORMATION

In FY 2005, at the request of the Secretary of Veterans Affairs, we audited VHA's compliance with outpatient scheduling procedures to determine the accuracy of the reported veterans' waiting times and facility waiting lists. Our objectives were to determine whether schedulers followed established procedures when selecting the type of appointment and entering the desired appointment date into the Veterans Health Information Systems and Technology Architecture (VistA) and to evaluate the effec-

tiveness of the procedures used at VHA medical facilities to ensure all veterans either had appointments or were identified on electronic waiting lists.

Our 2005 audit work analyzed a statistical sample of 1,104 appointments from a universe of 38,786 appointments at 8 medical centers. We reviewed scheduling data and medical records to determine when the appointments were scheduled, how the schedulers created the appointments, and whether the schedulers used the correct desired dates when creating the appointments. We also reviewed each appointment to determine whether the veteran qualified for the electronic waiting list and if service-connected veterans received appointments within 30 days. In addition, we gathered information from 15,750 (53 percent) of the 29,818 schedulers nationwide on their training, experience, adequacy of supervision, and scheduling practices through a national survey. We also interviewed 247 schedulers at the 8 medical facilities visited during the audit.

VHA calculates outpatient waiting time for each appointment from the desired date of care recorded in the VistA scheduling software to the actual appointment date. The desired date of care is defined as the earliest date that the patient or clinician specifies the patient needs to be seen. In addition, VHA policy establishes a goal of scheduling appointments within 30 days of the desired appointment but not more than 4 months beyond the desired appointment date. When a specific appointment date is not requested, VHA policy requires the scheduler to use the next available appointment. VHA policy requires that all appointment requests, including consult referrals to a specialist, must be acted on by the medical facility within 7 days. Acting on the request involves either scheduling the requested care or placing the patient on the electronic waiting list. The electronic waiting list is a standard tool that VHA implemented in December 2002 to capture and track information about veterans waiting for clinic appointments in VHA medical facilities.

Our 2005 results showed that outpatient scheduling procedures needed to be improved to ensure accurate and reliable reporting of veterans' waiting times and facility waiting lists. Because schedulers did not follow established procedures, medical facility directors were unaware that 18 percent of the service-connected veterans in our sample waited more than 30 days for their appointment. We projected that over 2,000 service-connected veterans waited longer than 30 days from their desired date to see a physician at these 8 medical facilities. Nationwide, as many as 24,463 service-connected veterans could have been similarly impacted. Inaccurate waiting time data and waiting lists can compromise VHA's ability to assess and manage demand for medical care. VHA managers plan budget priorities, measure organizational and individual medical center directors' performance, and determine whether strategic goals are met, in part, by reviewing data on waiting times and lists.

We found that schedulers created appointments using the wrong appointment type for 380 (34 percent) of the 1,104 appointments and the wrong desired date for 457 (41 percent) of the 1,104 appointments in our sample. When scheduling an outpatient appointment, schedulers are asked if the appointment should be considered as "next available." If the scheduler answers yes to this question, then the system enters that date as the desired date of care by default. If the scheduler answers no to the question, then the scheduler must input a desired date of care. In 2005, VHA strived to schedule at least 90 percent of all next available appointments for veterans within 30 days. Our results showed, however, that 65 percent of the next available appointments were scheduled within 30 days—well below the VHA goal of 90 percent and the medical facilities directors' reported accomplishment of 81 percent.

VHA medical facilities did not have effective procedures to ensure all veterans were identified on the electronic waiting lists. In fact, our testing showed that 5 medical facilities understated their waiting list by 856 veterans. Nationwide, the electronic waiting lists could be understated by as many as 10,301 veterans. We also identified clinics with substantial backlogs of consult referrals where veterans did not have appointments within 7 business days, and those veterans were not included on the electronic waiting lists. Further, 17 percent of the 247 schedulers interviewed told us they maintained informal waiting lists of veterans who needed appointments.

VHA did not have a standardized training program for schedulers so schedulers were receiving most of their training as on-the-job training. This led to inconsistencies implementing the scheduling procedures and directly contributed to the errors we identified. Forty-five percent of schedulers responding to our survey reported that they had received no formal training on the use of the VistA scheduling module, and 81 percent responded that they had received no training on the use of the electronic waiting list. Further, 2,246 (68 percent) of the 3,298 schedulers who identified themselves as trainers in our nationwide survey, did not know how to correctly create an appointment for a veteran who wanted an appointment as soon as

possible but who did not need urgent or emergency care. Seven percent of schedulers said that managers or supervisors directed or encouraged them to schedule appointments contrary to established procedures. Sixteen percent of the schedulers reported that they maintained informal waiting lists.

We recommended that the Under Secretary for Health take the following actions to improve outpatient scheduling procedures and the data integrity of waiting time information:

- Ensure that medical facility managers require schedulers to create appointments following established procedures.
- Monitor the schedulers' use of correct procedures when creating appointments.
- Monitor consult referrals to ensure that all veterans with referrals either have scheduled appointments within 7 business days or are included on electronic waiting lists.
- Establish an automated link from the Computerized Patient Record System consult package to the Vista scheduling module.
- Ensure medical facilities prohibit the use of informal waiting lists.
- Develop a standard training package for medical facilities to train schedulers on electronic waiting list and VistA scheduling modules.
- Ensure all schedulers view the video training titled "Vista Scheduling Software: Making a Difference."
- Require all schedulers to receive annual training on the electronic waiting list and VistA scheduling module.

The Under Secretary for Health agreed with the findings and recommendations to make the needed improvements in outpatient scheduling. According to the Under Secretary, VHA was vigorously addressing problems with waiting times and scheduling delays, and they had taken steps to accurately quantify the numbers of patients on waiting lists, lengths of waits, and the reasons for the scheduling delays. The Under Secretary also stated that VHA's Advanced Clinic Access (ACA) initiative, in conjunction with other planned and ongoing improvements, was expected to result in needed scheduling enhancements that are consistently applied to all VHA medical facilities. While we did not evaluate the implementation of the ACA initiative, our 2005 results showed that the schedulers' use of incorrect procedures distorted the reported measurement of veterans' waiting times and facility waiting lists, regardless of whether the clinic had implemented ACA.

In response to our 2005 report, VHA issued new policy, Directive 2006–055, on October 11, 2006, for implementing processes and procedures for the scheduling of outpatient appointments and for ensuring the competency of staff involved in any or all components of the scheduling process. VHA's directive also addressed the VA medical facilities' responsibilities relating to recall, reminder systems, and other forms of patient-driven scheduling, noting that facilities must ensure that the patient entitled to priority access is given an appointment in 30 days and all others within 120 days. The facility retains principal responsibility for providing the patient an appointment to be seen within the appropriate timeframes. VHA policy further extends the facility's responsibility to call and/or send a reminder letter and to make available a scheduled appointment for the patient to be seen within 30 days of the originally specified desired date for patients entitled to priority access or 120 days for all others.

OIG FOLLOWUP REVIEW SHOWS VHA'S OUTPATIENT WAITING TIMES INFORMATION STILL HAS DATA INTEGRITY PROBLEMS

In November 2006, we received a Congressional request to follow up on the patient waiting times issue to determine if VHA had improved their practices and procedures related to outpatient scheduling. The objectives of our review, completed in 2007, were essentially the same as our 2005 review, except that we also assessed whether the 2005 audit report recommendations were fully implemented.

During our followup review, we determined whether established scheduling procedures were followed, outpatient waiting times reported by VHA were accurate, and electronic waiting lists were complete. We visited 10 medical facilities, testing 700 appointments. A key point of our methodology was that we reviewed appointments that VHA had reported as being completed in 30 days. We also tested 300 consult referrals to assess the accuracy of the consult tracking report because medical facility personnel said that clinic personnel did not always update the report after action was taken. VHA includes and relies upon this same information in its performance and accountability reporting measure. At the time of our review, these 10 facilities listed over 70,000 consult referrals that were over 7 days old on the consult tracking reports.

The review showed that many of the data integrity weaknesses reported in 2005 were still impacting the reliability of patient waiting times and that schedulers were not following established procedures for making or recording medical appointments. We concluded that the accuracy of VHA's reported waiting times could not be relied on and the electronic waiting lists at the 10 medical facilities were not complete.

In reviewing each appointment, we researched the medical records to find out when the referring medical provider had recommended that the patient receive an appointment and compared the recommended date of care to the actual appointment. We found unexplained differences between the desired dates as shown in the scheduling system and used by VHA to calculate and report waiting times, as compared to the desired dates recommended by the medical provider and indicated in the patients' related medical records. In a few appointments, schedulers had annotated the appointment records to indicate when a patient requested a specific date and we used that date to calculate the waiting time. Our review also found instances where medical providers had suggested a range of time, such as 4 to 6 months, instead of a specific date for care. In those cases, we followed the guidance in VHA's scheduling directives and used the earliest point of the time range as the desired date of care.

Our review of 700 appointments provided us with reasonable assurance to conclude that schedulers were not recording either accurate, complete, or in some cases any information to support the desired date of care used to compute the reported waiting time. Overall, we found evidence to support that only 524 (75 percent) of the 700 appointments that VHA reported as having completed within 30 days actually were. The 700 appointments that had occurred within 30 days included 78 percent of the primary care appointments and 73 percent of specialty care appointments. As a result, VHA's reported waiting times are not based on accurate and complete information. For example, on December 20, 2005, a veteran who was 50 percent service-connected was seen in an Eye Clinic. The provider wrote in the progress note that the veteran should return to the clinic in 6 weeks (January 31, 2006). On September 6, the scheduler created an appointment for the veteran on October 17. The scheduler entered a desired date of October 2, which resulted in a reported waiting time of 15 days. However, based on the provider's desired date of January 31, the veteran actually waited 259 days for his appointment. The scheduling records did not contain any explanation for the delay. Medical facility personnel told us the reason this appointment took so long to schedule was because it "fell through the cracks."

In order to validate our results at each medical facility, we provided our case review findings to the local medical facility personnel responsible for scheduling. In response, our findings were validated as being accurate and supportable. Concern over our methodology did not become an issue until the draft report was presented to VHA senior management. VHA nonconcurred with this finding and told us that even though schedulers did not document it, the unexplained differences between the date recommended by the medical provider and the date shown in the scheduling system can be attributed to patient preferences for a specific appointment date. VHA directives require schedulers to annotate appointment records to indicate patient requests for specific appointment dates. VHA personnel told us that schedulers often do not document patient preferences due to high workload; and that this documentation only serves to support audit requirements. We contend that this basic annotation is critical to the integrity of reported waiting times information. To accept an assumption that every patient requested a desired date different than the documented desired date shown in the medical records would be irresponsible and contrary to VHA's own directives. We would agree that some of the date differences we identified in appointment information could possibly be due to patient preferences that were not documented by schedulers. However, in the absence of specific information, neither we nor VHA can be sure whether patient preference or the scheduler's use of inappropriate scheduling procedures contributed to the 25 percent error rate we found.

VHA'S ELECTRONIC WAITING LISTS CONTINUE TO BE INCOMPLETE

VHA's policy prohibits schedulers from making appointments for veterans that exceed the 30- or 120-day requirement and the policy requires that those veterans be placed on the electronic waiting list immediately. Our review identified 64 veterans (9 percent of the total appointments reviewed) who should have been on the 30-day electronic waiting list and were not.

Additionally, VHA's consult tracking report identified over 70,000 veterans with consult referrals over 7 days old that—in accordance with VHA policy—should have been on the waiting list of the 10 facilities we reviewed. Our review of 300 consult referrals found that 183 (61 percent) of the associated veterans should have been

on the waiting list and more than half of those had been waiting more than 30 days. The remaining referrals had already been acted on, but facility personnel had not updated the records to reflect the true status (for example, completed or discontinued). The lack of action on consults may lead to situations such as the following one highlighted in our 2007 report:

- On April 18, 2006, a veteran who was 80 percent service-connected, including service-connected for hearing impairment, was referred to the Audiology Clinic. Because this was a consult referral, the veteran should have received the next available appointment. On September 20 (155 days after the referral), the scheduler created an appointment for the veteran for October 20 and entered the desired date of September 20, which resulted in a reported waiting time of 30 days. However, based on the provider's desired date of April 18, the veteran actually waited 185 days for his appointment. The scheduling records did not contain any explanation for the delay. Medical facility personnel agreed with our recalculated waiting time.

At the time of our review, the 10 facilities had reported only 2,600 veterans on the waiting list. In 2007, we found that schedulers at some facilities interpreted guidance from their managers to reduce waiting times as instructions never to put patients on the electronic waiting list. This seems to have resulted in some "gaming" of the scheduling process. Medical center directors told us their guidance was intended to ensure patients received their appointments timely and did not need to be on the electronic waiting lists.

Low priority for training schedulers continues to affect the accuracy of waiting times and completeness of waiting lists. Schedulers and managers told us that, although training is readily available, they were short of staff and did not have time to take the training. In 2007, 47 percent of the schedulers we interviewed reported they had no training on consults within the last year, and 53 percent had no training on the electronic waiting list within the last year.

PRIOR OIG RECOMMENDATIONS REMAIN OPEN

Outpatient waiting times continue to be inaccurate and waiting lists continue to be incomplete because management has not yet effectively implemented our recommendations. Almost 3 years later, five of the eight recommendations remain open, which included one recommendation that was reopened based on the findings in our 2007 report. Specifically, actions taken by VHA with respect to one of the previously closed recommendations proved ineffective in monitoring schedulers' use of correct procedures when making appointments.

We believe that the most important recommendations from our two reports concern the need for VHA management to monitor how schedulers perform and routinely test the accuracy of reported waiting times and completeness of electronic waiting lists. In our opinion, these are critical quality assurance steps that are necessary to ensure that the VistA system contains complete and accurate information on waiting times.

In addition to monitoring the accuracy of information, management needs to take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and those documented in the VistA scheduling package. To date, VHA has not implemented an effective process to routinely test the accuracy of reported waiting times and the completeness of electronic waiting lists.

The findings in our 2005 and 2007 reports demonstrate that the data recorded in VistA and used to calculate veteran outpatient waiting times is not reliable. It is our position that until VHA establishes procedures to ensure that schedulers comply with policy and document the correct desired dates of care, whether recommended by medical providers or requested by veterans, that calculations of waiting times using VHA's current system will remain inaccurate.

2007 FOLLOW-UP REVIEW LEADS TO FIVE OIG RECOMMENDATIONS

Based upon our follow-up work, we recommended that the Under Secretary implement the following recommendations:

- Establish procedures to routinely test the accuracy of reported waiting times and completeness of electronic waiting lists, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and documented in the VistA scheduling package.
- Ensure schedulers comply with the policy to create appointments within 7 days or revert back to calculating the waiting times of new patients based on the desired date of care.

- Amend VHA Directive 2006–055 to clarify specialty clinic procedures and requirements for receiving and processing pending and active consults to ensure they are acted on in a timely manner and, if not, are placed on the electronic waiting lists.
- Ensure all schedulers receive required annual training.
- Identify and assess the alternatives to the current process of scheduling appointments and recording and reporting waiting times, and develop a plan to implement changes to the current process.

VHA RESPONSE TO LATEST OIG REPORT AND OIG REBUTTAL

The Under Secretary for Health agreed that our report correctly identifies areas VHA needs to address to improve outpatient waiting times accuracy. The Under Secretary acknowledged that our report highlights many of the roadblocks VHA faces making improvements in wait times. However, VHA took exception to the findings on the wait times because of their perceived limitations of our review methodology.

The Under Secretary stated that one of the most valid measurements VHA has relating to access efficiency is generated directly from a patient satisfaction survey of the veterans seeking healthcare services and noted that 85 percent of the veterans who completed the survey reported that they had access to primary care appointments when they needed them, and 81 percent of these same veterans also reported satisfaction with timely access to specialty care.

We see no valid basis for comparison between the results of the patient satisfaction survey and the results of our audit. Further, there is no basis for comparing overall patient satisfaction and VA's compliance with specific policy requirements, or the accuracy of waiting time information reported by VHA. We also noted that waiting time information reported by VHA was obtained by the same data system that the OIG used to conduct the audit, not from the patient satisfaction survey. To support any level of comparison, the patient satisfaction survey would have to ask veterans whether they were seen in the 30-day requirement.

In addition, the patient satisfaction results do not support the results VHA reported to Congress in November 2006. VHA reported that 96 percent of all veterans seeking primary care and 95 percent seeking specialty care were seen within the 30-day standard. Only 85 percent of the veterans who responded to the survey reported satisfaction with access to primary care and only 81 percent were satisfied with timely access to specialty care. These percentages are closer to the results in our audit, which were 78 percent and 73 percent, respectively. Our results are accurate, well-documented, and based on all available VA information.

We also disagree with the Under Secretary's statement that during our review we did not consider a patient's preference for a specific date other than what the medical provider requested. We accepted schedulers' comments on specific date requests as evidence of patient preference, but we cannot accept a blanket statement that all differences are due to patient preference. Although the Under Secretary stated that it is unrealistic to expect schedulers to document patient requests due to workload demands, we noted that scheduling directives contain numerous requirements for documentation of patient requests and actions.

While we recognize that ensuring scheduling information nationwide has its challenges, both the 2005 and 2007 OIG reviews showed that schedulers were not following VHA's policies and procedures to record the correct desired date of care. Further, the findings in our reports do support the fact that data recorded in VistA and used to calculate veteran outpatient waiting times is not reliable. Until VHA establishes procedures to ensure that schedulers comply with policy and document the correct desired dates of care, whether recommended by medical providers or requested by veterans, calculations of waiting times from the current system will remain inaccurate.

Our follow-up review results showed that VHA has not taken timely action to implement five of the eight recommendations in our 2005 report, and the Under Secretary for Health, by his own admission said the system information is inaccurate in that it does not always document patient preference for a specific date. We find it contrary for VHA to state their agreement with the findings and recommendations in our 2005 report and then to disagree with our follow-up report that found a continuation of the same problems—problems that could have been resolved had VHA implemented the recommendations in our 2005 report. In fact, VHA's response to our 2007 report concedes the failure of scheduling clerks to adequately document patient preferences in appointment dates. Both reports demonstrated and supported the fact that the system is not accurate and therefore should not be relied on as an accurate source for reporting waiting times to Congress.

PERFORMANCE AND ACCOUNTABILITY REPORTING

VA's FY 2006 Performance and Accountability Report prominently reported that 96 percent of primary care outpatient appointments and 95 percent of specialty care outpatient appointments were scheduled within 30 days. We cannot compare this performance measure to the results of our latest audit because we selected appointments from a different timeframe. In FY 2007, VA reported that 97.2 percent of primary care appointments and 95 percent of specialty care appointments were scheduled within 30 days. We took great exception to VA's reporting of this performance measure because our audit clearly showed significant issues with the integrity of data being used to formulate these performance measures. Although VA has continued to report these measures, they added a footnote acknowledging our reports.

CLOSING

Long-term fixes and changes to the scheduling system may take years to implement; however, in the meantime VHA needs to address the data integrity issues associated with its scheduling system and ensure accuracy in its current system. In addition, VHA needs to ensure scheduling procedures are followed and implemented consistent with its own policies. It is problematic when VHA continues to report waiting time information to Congress that was knowingly derived from a system that contains inaccurate and incomplete data. Debating the differences between our reported error rate and VHA's reported waiting times would only serve to overshadow the primary point of both audit reports, which is that the data in VHA's scheduling system is inaccurate. Our concern is that VA and Congress not only have accurate and reliable information for budgeting, assessing, and managing the demand for care but, more importantly, for ensuring no veteran falls through the cracks and fails to receive timely medical care.

Mr. Chairmen, that concludes my remarks and thank you once again for the opportunity to discuss this important issue. Mr. Reinkemeyer and I would be pleased to answer any questions.

Prepared Statement of Gerald M. Cross, M.D., FAAFP,
Principal Deputy Under Secretary for Health,
Veterans Health Administration, U.S. Department of Veterans Affairs

Good afternoon Chairman Michaud and Chairman Mitchell and Members of the Subcommittees. Thank you for inviting me here today to discuss the issue of outpatient waiting times. Accompanying me today are Mr. William Feeley, Deputy Under Secretary for Health for Operations and Management; Ms. Kathy Frisbee, Deputy Director of the VHA Support Service Center; and Ms. Odette Levesque, Clinical/QA Liaison for the Office of the Deputy Under Secretary for Health for Operations and Management.

I am pleased to have this opportunity to share with you the current actions the Department of Veterans Affairs (VA) is taking to guarantee that our veteran patients have access to timely medical care at our VA facilities. We are making good progress in meeting the needs of our veterans and we are committed to providing all necessary care, including preventive care, in a timely manner. I just want to be clear that we are talking about waiting times for general routine outpatient appointments; veteran patients with urgent or emergent needs are seen immediately. In a healthcare system as large as VA, where we provide over one million patient encounters in our clinics each week, we understand there would be opportunities for improvement. VA is actively seeking solutions to further reduce wait times as we are committed to ensuring the care we provide our veterans is timely as well as high quality.

VA has identified timely access to outpatient care as a top priority. With national implementation of the Advanced Clinical Access initiative, we have made significant progress in reducing waiting times, but challenges continue. In the patient satisfaction survey for the third quarter year to date for FY 2007, which is administered by the National Research Corporation (NRC), 85 percent of veterans surveyed reported they received primary care appointments when they wanted them, and 81 percent reported that their specialty care appointments were made at a time that was acceptable to them.

In FY 2007, 96 percent of our 40 million appointments were seen within 30 days of the desired appointment date. This percentage represents waits for outpatient primary and specialty care appointments. It does not, however, reflect waits for outpatient or inpatient procedures such as colonoscopies or joint replacements. VHA is also building upon existing measures by actively moving forward with enhance-

ments to the current scheduling package. For example, an enhancement to the current surgery case scheduler is expected to be released nationally during the middle of this fiscal year and will better enable us to manage and measure wait times for outpatient and inpatient procedures.

We are improving access for new veterans as well as improving waiting times for mental health services and medical procedures. The percent of *new primary care patients* who were seen within 30 days of their desired date has improved from 75 percent in FY 2005 to 83 percent in FY 2007—and the percent of new primary care patients seen within 30 days of their desired date for the month of September 2007, was 90 percent. Our statistics are even better for patients seen for follow-up appointments. Finally, we are focusing on mental health access by setting a new standard this fiscal year that requires all new mental health patients be seen and their needs for care evaluated within 24 hours and that these veterans have a follow-up evaluation within 14 days. With the assistance of Congress, we have increased by 3,600, the number of mental health professionals within our system since 2005. This includes physicians, psychologists and social workers.

The conclusions made by VA's Office of the Inspector General (OIG) in the recent September 10, 2007 report on outpatient waiting times differs from the 85 percent patient satisfaction score with respect to access and VA's metric on the 96 percent of appointments seen within 30 days of the desired date. VA has several concerns about the OIG's audit methodology that was used in this particular audit. VA takes OIG reports seriously. Non-concurrences are infrequent with the last major non-concurrence occurring in the early 1990's. For this report on wait times, specifically, the methodology used by OIG and VHA to calculate waiting times do not match. VA's waiting times data reflects a "real time" approach to measure patient access using an old scheduling system not designed for this purpose. While differences in methodology exist, the overriding focus for both sets of measurements is the veteran patient. VA has a driving interest to accurately monitor and continually improve access for our veterans.

VA has worked diligently to develop an objective, reliable process to measure waiting times. I am not aware of any other large system in the public or private sector that has attempted to duplicate the efforts of VA to measure the waiting times for each appointment. There are an estimated 40 million appointments each year in the VA system. There are multiple variables involved in this measurement tracking, which includes patient preferences and differences in the organization of individual facility services and clinics, including scheduling practices. VA has identified that ongoing training of our scheduling clerks is critical for success. For this reason, we require our scheduling clerks to be trained using our scheduling education modules and to pass a competency exam for certification. We also began requiring annual refresher training.

VA is proactively taking steps to review the total scheduling process, including the way VA measures waiting times. We will continue to improve our processes, educate scheduling staff, and strive to improve clinic access to further reduce waiting times. To this end, VA has contracted with an independent third party to conduct an evaluation of VA's scheduling practices and waiting time metrics. The contractor is beginning the pilot program phase of its assessment, and VA anticipates receiving the final report in Spring of 2008.

In conclusion, we are taking the following substantive actions to aggressively address the issues of veteran access and wait times—we are developing a new scheduling software package as well as developing shorter term software solutions for our current scheduling package; we are continually improving our training programs, and we are contracting with an outside consulting firm for an independent review of our scheduling process and metrics.

Thank you, again, for having me here today. I would be pleased to answer any questions you or any of the Members of the Committee may have.

Prepared Statement of Paul A. Tibbits, M.D.,
Deputy Chief Information Officer, Office of Enterprise Development,
Office of Information and Technology, U.S. Department of Veterans Affairs

Good afternoon Chairman Michaud, Chairman Mitchell, Ranking Member Brown-Waite, Ranking Member Miller and Members of the Subcommittees, thank you for the opportunity to report on the progress made by the Department of Veterans Affairs (VA) on providing the information technology needed to ensure that veterans are afforded timely access to health care. We are committed to serving veterans and meeting the wait time policies of the VA.

VHA has been using a scheduling system that was designed in the 1970's and is out-of-date, negatively impacting patient scheduling and patient access. The Health*e*Vet Scheduling Project (Replacement Scheduling Application) was initiated in May 2001 to address this deficiency. The RSA software offers a number of advantages over the current scheduling system and I will highlight just a few:

- Improved support and flexibility for site management of resources (people, rooms, equipment).
- Greater efficiency in scheduling appointments.
- Improved continuity of care for referral management and veterans who travel to other VA medical centers.

RSA waiting time metrics will be similar in construct to the metrics now used by VHA but will have a higher degree of specificity because they will be provider based rather than clinic based.

As you know the RSA project has experienced significant delays from the original plan to release the software in mid-2005. These delays have resulted from both vendor and VA related issues. My office is actively addressing the causes of these delays by taking the following actions:

- Bringing in industry experts to strengthen program management discipline;
- Establishing standard IT processes for system development, based on industry best practices, with mentoring for the VA staff by industry experts;
- IT staff professional development focused on implementation of the high priority industry best practices needed to assure software delivery on schedule and at cost.
- Re-organizing the IT development organization to better focus on high priority software projects and to identify and develop common services once for use in all projects.

However, much work remains to be done.

The current schedule for RSA is to release the alpha version to Muskogee VAMC in early summer 2008. This release will support basic functionality followed by a test release with full functionality at the Dallas VAMC in December 2008. I anticipate that RSA will be installed at all VAMC's by January 2011.

Recognizing the difficulty that these delays impose upon VHA, the VA Office of Information and Technology is making limited enhancements to the current scheduling system as well as formalize the process for converting locally developed "Class III" software adapted to become national "Class I" software. Class III software is developed locally to meet a business need and historically sites have shared this software to some extent. This sharing has produced variations in the base VistA system which if we allow to continue will impede our ability to convert to a national Health*e*Vet architecture, while providing less than uniform IT support for scheduling across VA medical centers. In the interest of leveraging the ingenuity and innovation that resides locally we have created a path for converting Class III software to national Class I software so that the Class III software will be standardized before it is shared across VA facilities, and it will be implemented in all VA facilities. As of October 2007, the VHA Informatics and Data Management Committee prioritized the first three Class III products for national release: Shift Hand-off Tool, Medication Reconciliation, and Surgery Case Manager. The Shift Hand-off Tool is projected for release in January 2008. This will provide, when the veteran's primary care physician is not available, a synopsis of the hospital care, pertinent medical history, alerts and special instructions relative to a patient's care during a particular shift. Medication Reconciliation is projected for release in January 2008. This will provide a complete and accurate medication list that would be given to every patient upon discharge from the VA facility or upon departure from every clinic visit. Last, Surgery Case Manager is projected for release in May 2008. This will track and report the length of time veterans must wait for surgical procedures. Tracing this will give VA the ability to improve efficiency and improve access to inpatient surgical care by allowing facilities to identify delays and access issues.

To assure that we are addressing all the high priority requirements, VA has commissioned an independent study which will be completed in Spring 2008. This study will look at patient scheduling, scheduling staff, business rules, patient preferences, data accuracy, and a review of the redesigned scheduling software, as well as comparisons to health industry practices.

Thank you for the opportunity to appear before you and provide you the status of our ongoing efforts. My colleagues and I are happy to answer any questions you or other Members of the Subcommittee might have.

Statement of Hon. Jeff Miller,
Ranking Republican Member, Subcommittee on Health

Thank you Chairman Mitchell and Chairman Michaud.

Timely access to healthcare services is a critical aspect of providing high quality care to our Nation's veterans.

Since 2004, the VA has continued to report substantial improvements in meeting the performance standard VA itself established to schedule appointments within 30 days of a patient's requested date of an appointment.

However, while we have been receiving reports showing that VA was meeting its goal in about 96% of the cases, I am extremely disturbed by a recent audit of VA's outpatient waiting times by the VA Office of Inspector General (IG).

The IG found that previous problems with outpatient scheduling procedures uncovered in their 2005 audit still exist and the accuracy of the data recorded to calculate outpatient waiting times is not reliable.

The IG report states: "While waiting time inaccuracies and omissions from electronic waiting lists can be caused by a lack of training and data entry errors, we also found that schedulers at some facilities were interpreting the guidance from their managers to reduce waiting times as instruction to never put patients on the electronic waiting list. This seems to have resulted in some "gaming" of the scheduling process."

I take great interest in monitoring how long veterans must wait for care and it is unacceptable for the VA to provide incomplete and erroneous waiting time data.

I expect as an outcome of our hearing today that VA immediately employ corrective actions to record and report waiting times accurately. It is my top priority to ensure that veterans are able to access the care they need from VA.

Further, as a cosponsor of my colleague, Ginny Brown-Waite's legislation, H.R. 92, the Veterans Timely Access to Health Care Act, I believe if VA cannot meet its own established access standard for any veteran, that patient should be given the choice to receive care in a non-VA facility.

Thank you, Mr. Chairman. I look forward to the testimony and I yield back the balance of my time.

Statement of Hon. Cliff Stearns,
a Representative in Congress from the State of Florida

Thank you Mr. Chairman for holding this important hearing.

If there is one issue that we hear about more often than any other, it is the issue of access to healthcare for our veterans. From my veterans, I am pleased to hear that veterans are happy with the quality of care they receive at our medical centers and hospitals, however often the wait time for appointments, in particular specialty appointments, can be incredibly long—months after they request to be seen. This is unacceptable. The Veterans Health Administration (VHA) reports to Congress on the number of patients seen within 30 days of requesting an appointment, and there is also an electronic waiting list at the VA to ensure that no veteran falls through the cracks. However, these systems are not being used correctly.

In 2007, Inspector General (IG) auditors assessed whether VA schedulers followed procedures correctly when selecting appointments and veterans' desired dates of care. The auditors also looked at how medical facilities ensured that all veterans seeking care either had appointments or were identified on electronic waiting lists. The IG determined that scheduling procedures were *not followed* and that electronic waiting lists were *not complete*. Often schedulers did not enter the correct desired dates of care. In 2007, the error rate of schedulers' entries was 72%! The IG also found that the VA's performance measures were overstated. VHA reported that 96% of all veterans seeking primary medical care and 95% seeking specialty care were seen within 30 days of their desired date. IG's analysis showed instead that 78% of veterans seeking primary care and 73% of the specialty care were seen within 30 days.

I understand that we will hear today more about the issue of whether the statistics are correct or not, and the issues involved in getting these numbers right. The issue of VA outpatient waiting times comes down to whether or not the desired date of care recorded in the scheduling system is the correct date to use. However, the main issue, the key problem that we are here to deal with today, is how are we going to work together to ensure our veterans are receiving timely access to healthcare? I look forward to hearing the testimony from our witnesses regarding their plans.

Thank you.

POST–HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
December 13, 2007

The Honorable Gordon Mansfield
Acting Secretary
Department of Veterans Affairs
820 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Mansfield,

On December 12, 2007, the Subcommittee on Health and the Subcommittee on Oversight and Investigations held a joint hearing on Outpatient Waiting Times at the Department of Veterans Affairs.

During this hearing, I discussed legislation I introduced to help reduce outpatient waiting times at VA Medical Centers and Community-Based Outpatient Clinics, H.R. 92. At the end of the hearing, I asked Dr. Cross to provide within 30 days the official administration views on this legislation, which he agreed to do.

In order to assist you, I am enclosing a copy of H.R. 92 for your review. Please provide in writing the official administration views on this legislation by January 11, 2008. I would also greatly appreciate you sharing your response with Chairman Filner, Ranking Member Buyer, Chairman Michaud and Ranking Member Miller of the Subcommittee on Health, and Chairman Mitchell, who I have the honor of serving with on the Subcommittee on Oversight and Investigations.

I look forward to receiving your response shortly.

Sincerely,

Ginny Brown-Waite
Ranking Republican Member

Enclosure (H.R. 92)

110th CONGRESS
1st Session

H.R. 92

To amend title 38, United States Code, to establish standards of access to care for veterans seeking healthcare from the Department of Veterans Affairs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

January 4, 2007

Ms. Ginny Brown-Waite of Florida introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to establish standards of access to care for veterans seeking healthcare from the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. Short title.

This Act may be cited as the "Veterans Timely Access to Health Care Act".

SEC. 2. Standards for access to care.

(a) Required Standards for Access to Care.—Section 1703 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(e)(1) For a veteran seeking primary care from the Department, the standard for access to care, determined from the date on which the veteran contacts the Department seeking an appointment until the date on which a visit with a primary-care provider is completed, is 30 days.

"(2)(A) The Secretary shall prescribe an appropriate standard for access to care applicable to waiting times at Department healthcare facilities, determined from the time at which a veteran's visit is scheduled until the time at which the veteran is seen by the provider with whom the visit is scheduled.

"(B) The Secretary shall periodically review the performance of Department healthcare facilities compared to the standard prescribed under subparagraph (A). The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report providing an assessment of the Department's performance in meeting that standard.

"(3) Effective on the first day of the first fiscal year beginning after the date of the enactment of this section, but subject to paragraph (4), in a case in which the Secretary is unable to meet the standard for access to care applicable under paragraph (1) or (2), the Secretary shall, or with respect to a veteran described in section 1705(a)(8) of this title may, use the authority of subsection (a) to furnish healthcare and services for that veteran in a non-Department facility. In any such case—

"(A) payments by the Secretary may not exceed the reimbursement rate for similar outpatient services paid by the Secretary of Health and Human Services under part B of the Medicare Program (as defined in section 1781(d)(4)(A) of this title); and

"(B) the non-Department facility may not bill the veteran for any difference between the facility's billed charges and the amount paid by the Secretary under subparagraph (A).

"(4) Paragraph (3) shall not apply to a veteran enrolled or seeking care at a Department facility within a Department geographic service area that has a compliance rate, determined over the first quarter of the first calendar-year beginning after the date of the enactment of this Act, for the standards for access to care under paragraphs (1) and (2) of 90 percent or more. The Secretary shall make the determination of the compliance rate for each Department geographic service area for purposes of the preceding sentence not later than July 1 of the first calendar-year beginning after the date of the enactment of this Act.

"(5)(A) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives for each calendar-year quarter, not later than 60 days after the end of the quarter, a comprehensive report on the experience of the Department during the quarter covered by the report with respect to waiting times for veterans seeking appointments with a Department healthcare provider.

"(B) Each report under subparagraph (A) shall include the total number of veterans waiting, shown for each geographic service area by the following categories:

"(i) Those waiting under 30 days for scheduled appointments.

"(ii) Those waiting over 30 days but less than 60 days.

"(iii) Those waiting over 60 days but less than 4 months.

"(iv) Those waiting over 4 months but who cannot be scheduled within 6 months.

"(v) Those waiting over 6 months but who cannot be scheduled within 9 months of seeking care.

"(vi) Those who cannot be scheduled within one year of seeking care.

"(vii) Any remaining veterans who cannot be scheduled, with the reasons therefore.

"(C) For each category set forth in subparagraph (B), the report shall distinguish between—

"(i) waiting times for primary care and specialty care; and

"(ii) waiting times for veterans who are newly enrolled versus those who were enrolled before October 1, 2001.

"(D) Each such report shall also set forth the number of veterans who have enrolled in the Department's healthcare system but have not since such enrollment sought care at a Department healthcare facility.

"(E) The final report under this paragraph shall be for the quarter ending on December 31, 2010.".

(b) Effective Date.—Subsection (e) of section 1703 of title 38, United States Code, as added by subsection (a), shall take effect on the first day of the first month beginning more than six months after the date of the enactment of this Act. The first report under paragraph (5) of that subsection shall be submitted for the quarter ending on December 31 of the first calendar year beginning after the date of the enactment of this Act.

U.S. Department of Veterans Affairs
Washington, DC.
July 31, 2008

The Honorable Ginny Brown-Waite
Ranking Republican Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Brown-Waite:

On December 12, 2007, we appeared before the Subcommittee on Health and the Subcommittee on Oversight and Investigations, to testify on waiting times at VA medical facilities. At the hearing and again by letter dated December 13, 2007, you requested the Department's views on H.R. 92. Please find enclosed a copy of the Department's testimony sent to the House Committee on Veterans' Affairs, Subcommittee on Health, for the legislative hearing held on April 26, 2007. H.R. 92 is the first bill discussed in our written statement.

We would also like to take this opportunity to expand upon two technical issues. First, as we stated in our original testimony, VA has no significant objection to H.R. 92 with respect to setting a 30-day standard for the scheduling of patients. We would, however, like to request that the bill language be clarified under section (2)(a), regarding the starting date from which the 30-day standard would be computed. The current language would begin this computation on the date that the "veteran contacts the Department." There are many patients who contact the Department to schedule appointments that are needed more than 30 days in the future. The more appropriate start point would be the desired date specified by the veteran. This could be reflected by changing the relevant language to read: "For a veteran seeking primary care from the Department, the standard for access to care, determined from the *desired appointment date specified by the veteran seeking an appointment* until the date on which a visit with a primary-care provider is completed, is 30 days." In addition, VA is almost always able to provide access to primary care within 30 days of the desired date at its Medical Centers, but may have more difficulty meeting the access standard at some of the smaller Community-Based Outpatient Clinics. VA's policy is to offer care to a veteran within the specified 30-day access standard at a location that is proximal to the veteran, but it should be understood that this may or may not be at the specific location requested by the veteran.

Second, there is no requirement in the bill that contractors, even if they are Medicare providers, agree to accept the Medicare rate from VA. Regarding the provision to restrict VA to pay the Medicare rate, VA is developing regulations that would support the requirement that providers accept a Medicare rate payment. However,

these regulations will allow VA flexibility in those circumstances where services cannot be obtained based upon use of Medicare reimbursement rates. VA wishes to avoid a situation where the Medicare reimbursement rate requirement would limit the services that the VA could provide to veterans if the services cannot be purchased in the community at this rate.

We estimate the cost of H.R. 92 to be as follows: For veterans enrolled in priority groups 1–7, we estimate the cost of meeting the bill's 30-day standard to be $205,850,000 for FY 2009 and for veterans currently enrolled in Priority Group 8, we estimate that cost to be $61,123,000 for FY 2009, which is part of the FY 2009 President's Budget. With respect to the 20-minute standard we discussed in our testimony, we estimate the costs to be $1,278,850,000 for FY 2009, and $14,817,870,000 over a 10-year period. This requirement was not envisioned in the FY 2009 President's Budget request and would involve significant new resource demands in future years that could create the need for offsets in other medical requirements.

The Office of Management and Budget advises that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely yours,

James B. Peake, M.D.
Secretary

Enclosure

[The enclosed testimony of Dr. Gerald M. Cross, M.D., FAAFP, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs, which was enclosed, has been previously printed in Committee on Veterans' Affairs, Subcommittee on Health "Legislative Hearing on H.R. 92, H.R. 315, H.R. 339, H.R. 463, H.R. 538, H.R. 542, H.R. 1426, H.R. 1470, H.R. 1471, H.R. 1527, 1944 and Discussion Draft Rural Health Care Bill," April 26, 2007, Serial No. 110–17, and will not be reprinted. You can download a copy of Dr. Cross' testimony from the Committee's Website at *http://www.house.gov/sites/comms/veterans__dem/hearings/schedule110/apr07/04–26–07/print__versions/4–26–07cross.htm*.]

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
January 16, 2008

The Honorable James B. Peake, M.D.
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake,

As part of my Subcommittee's oversight over patient waiting times at the Department of Veterans Affairs, I am writing to request information relating to outpatient waiting times at VA medical facilities.

I am requesting a breakdown by VISN and facility of the outpatient and specialty care waiting times for the Department's major medical centers and the community-based outpatient clinics. I am also interested in the percentage of waiting times which fall within the 30-day timeframe for outpatient appointments, and whether documentation exists as to why those that fell outside the 30-day timeframe took longer to obtain an appointment.

I would like a response to this request no later than February 15, 2008. Thank you for your kind consideration.

Sincerely,

Ginny Brown-Waite
Ranking Republican Member

U.S. Department of Veterans Affairs
Washington, DC.
February 15, 2008

The Honorable Ginny Brown-Waite
Ranking Republican Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Brown-Waite:

In response to your request, the Department of Veterans Affairs (VA) is providing information on outpatient wait times at VA medical centers. I, too, share your concerns regarding our veterans receiving timely medical appointments and quality healthcare.

The Veterans Health Administration's (VHA) 30-day timeliness standard does not apply to the wait time for a veteran to "obtain an appointment" (i.e. the act of scheduling an appointment with the clerk), but rather to the wait time between the desired date for the appointment to occur and the actual date the scheduled appointment is completed. Attached is a breakdown for primary and specialty care waiting times from VA operated clinics using VA's scheduling software during the month of December 2007 (fiscal year 2008). This is the most recent data available on completed appointments.

Nationally, during the month of December 2007, 97.6 percent of all scheduled appointments were completed within 30 days or less of the desired date for that appointment as specified by the provider or patient.

VHA frequently collects documentation of the reasons these times exceed 30 days. Examples of why some patients wait greater than 30 days from the desired appointment date are as follows:

- Patient Preference. Schedulers are instructed to talk to the patient during the scheduling process to ensure that the date and time of the appointment offered is acceptable to the patient. In many instances, staff found these patients were scheduled more than 30 days from desired date because patients had specifically requested an appointment beyond the specified 30 days. So while they appear as waiting on the Access List, in fact they are scheduled to be seen at times and on dates of their own choosing.
- Cancelations and No-Shows. Staff reported that many veterans waiting more than 30 days according to the Access List had failed to appear for their scheduled appointment or had canceled a previously scheduled appointment. VHA monitors Missed Opportunities monthly and provides data to the facilities. Cancelations and No-Shows make up the Missed Opportunities Report. For example, during the month of December 2007, the missed opportunities rate nationally for Cardiology was 13.7 percent and Mental Health was 18.3 percent (see enclosures).
- Scheduler Errors. In some instances, staff found patients waiting more than 30 days from the desired appointment date due to errors made by schedulers. Those errors were typically errors in entry of the "desired date" and were subsequently corrected.
- Capacity Constraints. In other instances, staff determined patients were waiting beyond 30 days from the desired appointment date due to capacity constraints that would not allow them to offer appointments sooner. In those instances, facilities may have purchased non-VA care, or added VHA resources through recruitment to fill vacancies, added additional space, opened additional clinics, or expanded clinic hours.

Thank you for your interest and support of the efforts of our dedicated VHA staff to provide timely and quality care to our Nation's veterans.

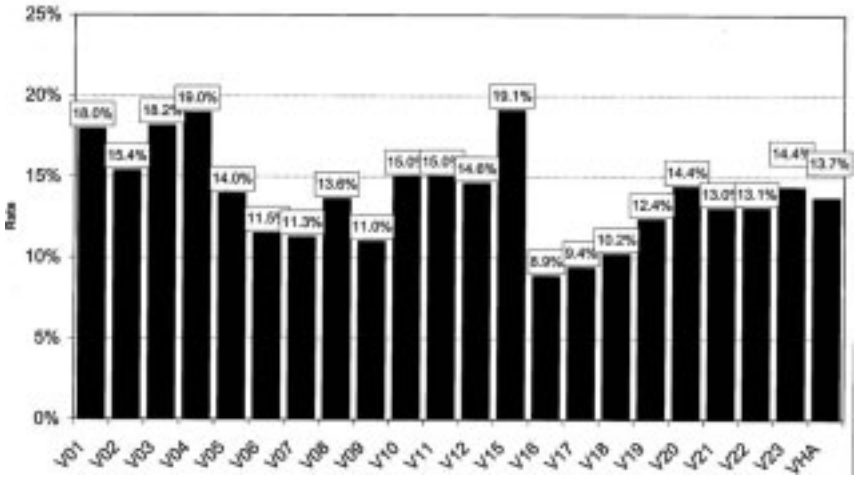
Sincerely yours,

James B. Peake, M.D.
Secretary

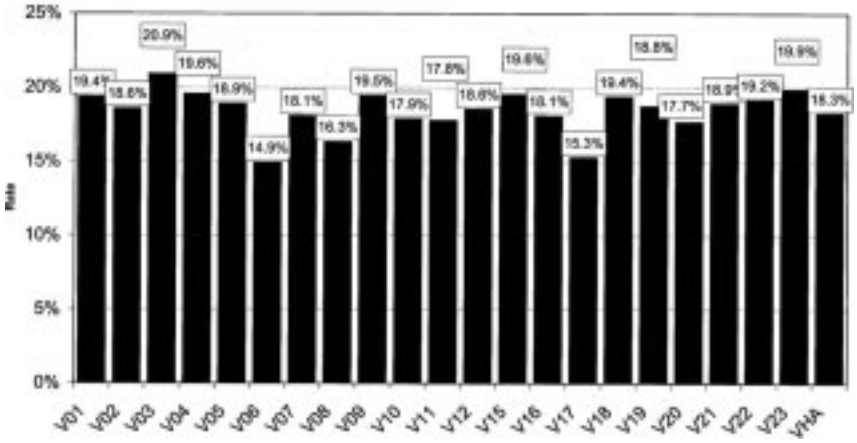
Enclosures

[The attachment, "a breakdown for primary and specialty care waiting times from VA operated clinics using VA's scheduling software during the month of December 2007 (fiscal year 2008)," will be retained in the Committee files.]

Report: Cardiology Missed Opportunity Rates
Contains: Missed Opportunities as percent of all Completed Appointments
Date: Month of December 2007



Report: Combined Mental Health Missed Opportunity Rates
Contains: Mental Health Missed Opportunities as Percent of Completed Appointments
Date: Month of December 2007



Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
February 14, 2008

Honorable George J. Opfer
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Opfer:

On Wednesday, December 12, 2007, the Subcommittee on Health and the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs held a joint hearing on outpatient waiting times.

During the hearing, the Subcommittees heard testimony from Ms. Belinda Finn, the Assistant Inspector General for Auditing. She was accompanied by Mr. Larry Reinkemeyer, Director of the Kansas City Audit Operations Division. As a follow-up to that hearing, the Subcommittee is requesting that the following questions be answered for the record:

1. VHA states in their response to your 2007 report that it is unrealistic to expect schedulers to maintain such a high level of documentation. What level of documentation is minimally required to provide auditable analysis?
2. Overshadowed by the discussion on accurate waiting times is the high number of veterans waiting for specialty consults. How significant is this issue, and what are industry acceptable standards?
3. Should VHA have VAMC directors certify waiting times' lists and would this certification improve the waiting times numbers?

We request you provide responses to the Subcommittee no later than close of business, Wednesday, March 12, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman
Subcommittee on Health

JEFF MILLER
Ranking Republican Member
Subcommittee on Health

HARRY E. MITCHELL
Chairman
Subcommittee on Oversight and Investigations

GINNY BROWN-WAITE
Ranking Republican Member
Subcommittee on Oversight and Investigations

U.S. Department of Veterans Affairs
Washington, DC.
March 17, 2008

The Honorable Michael H. Michaud
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are the responses to the questions from the December 12, 2007, joint hearing before your Subcommittee and the Subcommittee on Oversight and Investigations on outpatient waiting times. A similar letter is being sent to Congressman Jeff Miller, Ranking Republican Member, Congressman Harry Mitchell, Chairman, Subcommittee on Oversight and Investigations, and Congresswoman Ginny Brown-Waite, Ranking Republican Member, Subcommittee on Oversight and Investigations.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

GEORGE J. OPFER
Inspector General

Enclosure

Responses from the Office of Inspector General to Post Hearing Questions on Outpatient Waiting Times

1. VHA states in their response to your 2007 report that it is unrealistic to expect schedulers to maintain such high level of documentation. What level of documentation is minimally required to provide auditable analysis?

In our 2007 report, the Under Secretary concedes that the failure of scheduling clerks to adequately document patient preferences in appointment dates contributed to the OIG findings and states that it is unrealistic to expect schedulers to maintain such a high level of documentation. While the OIG recognizes the workload associated with millions of appointments made every year, documenting changes in veteran desired dates is required by VHA's policy. The Under Secretary also comments that this documentation is solely to support audit requirements and does little, if anything, to support the actual scheduling of the appointment. Contrary to this position, the OIG maintains that full compliance with established scheduling procedures is critical to ensuring patients are seen in a timely manner. Compliance is also critical to ensure data integrity. In the absence of specific information, neither we nor VHA can be sure whether the desired date differences were due to patient preference or the scheduler's use of inappropriate scheduling procedures. To accept VHA's assumption that our reported error rate in waiting times is somehow flawed because we failed to consider that the veterans may be cancelling and changing their appointments for which there is no supporting documentation would be irresponsible.

At a minimum, we expect schedulers to maintain the documentation prescribed by VHA Directive 2006–055. This requires that for every patient who requests a specific appointment date that is different than the date specified by the provider in the medical records, the scheduler should annotate why the date was used in the "Other Info" section in the Veterans Health Information Systems and Technology Architecture (VistA) scheduling package. For example, "patient requested appointment for 3/2/08." The "Other Info" section is included with a series of questions and prompts that each scheduler answers when creating most appointments. During our review, we generally found no information in the "Other Info" section.

2. Overshadowed by the discussion on accurate waiting times is the high number of veterans waiting for specialty consults. How significant is this issue, and what are industry acceptable standards?

We believe this issue is significant for several reasons. The high number of veterans waiting for specialty consults means that veterans with serious medical conditions could be experiencing significant delays in receiving treatment from medical specialists. We also believe that a sizable number of veterans may be affected. In our 2005 review, we reported that electronic waiting lists could be understated by as many as 10,301 veterans nationwide. At the 10 facilities we reviewed in 2007, VHA's consult tracking report identified over 70,000 veterans with consult referrals over 7 days old that—in accordance with VHA policy—should have been on the waiting list of the 10 facilities we reviewed. At the time of our review, the 10 facilities had reported only 2,600 veterans on the waiting list. We believe that this problem could potentially be much larger since the VHA medical system consists of 153 medical centers.

While having a large number of veterans on waiting lists is an indication that VA may not be capable or funded to handle its patient workload within prescribed timeframes, we believe there is an even more significant issue—the large numbers of veterans waiting for specialty consults who are intentionally or inappropriately not placed on waiting lists who fall through the cracks and do not receive needed critical care.

We were unable to identify a firm industry standard on acceptable waiting time for specialty care, although we noted an international study on access to care that measured the percentage of patients who waited 4 weeks or longer for specialty care.

3. Should VHA have VAMC directors certify waiting times' lists and would this certification improve the waiting times numbers?

Requiring VAMC Directors to certify waiting times and waiting lists would help establish accountability. However, the most important action VHA needs to take is to establish procedures to routinely test the accuracy of reported waiting times and completeness of electronic waiting lists, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and documented in the VistA scheduling package.

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
February 29, 2008

The Honorable James B. Peake
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

On Wednesday, December 12, 2007, the Subcommittee on Health and the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs held a joint hearing on outpatient waiting times.

During the hearing, the Subcommittees heard testimony from Dr. Gerald M. Cross, Principal Deputy Under Secretary for Health; and Dr. Paul Tibbits, Deputy Chief Information Officer, Office of Information and Technology; Mr. William F. Feeley, Deputy Under Secretary for Health for Operations and Management; Ms. Odette Levesque, Clinical/QA Liaison; and Ms. Kathy Frisbee, Deputy Director of the Veterans Service Support Center. As a follow-up to that hearing, the Subcommittee is requesting that the following questions be answered for the record:

1. What specific actions will VHA implement to improve the accuracy and completeness of the scheduling information? Please provide an implementation schedule with milestones and exit criteria.
2. Are there any issues that would affect your ability to ensure improvements are made in a timely manner?
3. In 2005, the OIG made specific recommendations—with which VA agreed—to ensure and then monitor schedulers' use of correct procedures when creating appointments. In its 2007 report, the OIG once again reported concerns with the reliability of VA's waiting time data. If required documentation, without which it is not possible to tell whether an appointment was made within 30 days, did not exist, is not the proper conclusion for auditing purposes that the appointment was not made in 30 days? Suppose that VA claims 95 percent of appointments are made within 30 days, but documentation required by VA policy does not exist to support 20 percent of those appointments. Does VA believe that it would be justified in claiming the 95 percent number in those circumstances?
4. How do you determine if training is effective if you have no process in place to test and monitor schedulers' compliance with scheduling procedures?
5. Other than monitoring appointments with waiting times of more than 30 days, what specific actions do you take to test the reliability of the waiting times performance that you include in your annual Performance and Accountability Report?
6. How will you ensure the accuracy of the current scheduling system until a new system comes online?
7. If you propose eliminating your current measurement of waiting times and rely entirely on patient satisfaction surveys, how would you ensure the survey provides you sufficient, meaningful information necessary to place resources in the most appropriate places to positively impact timely patient care?
8. How are directors for each facility held accountable for veterans' waiting times in their facilities? What measurement did you hold them to in 2007, and are those same standards in place for 2008?
9. Would it be in the veterans' best interests if you knew exactly how many veterans were waiting for an appointment and then how long veterans were waiting for appointments? How do you know where to apply resources if facilities do not capture accurate waiting time performance data?
10. The OIG found that there were a number of veterans that should have been on the electronic waiting list but were not. In 2007, in a review of 10 facilities, it appears that a significant number of veterans were waiting an extended period of time for action on their request for a consult with a specialist. Electronic waiting lists were created as a mechanism to ensure visibility over all veterans without appointments. Why are your facilities not using them appropriately?

11. Do you think having VHA bring back the policy of having VAMC directors certifying the waiting times list would improve the accuracy of the waiting times numbers?
12. Why was the certifying procedure the medical facility directors had to comply with eliminated?
13. Do you think there is a conflict of interest between the VA's goal of minimizing veteran-patients waiting times and the temptations for directors to game the numbers to make this specific performance measure look good for their annual reviews?
14. Since the disbandment of the Medical Administration Service, supervisory oversight controls of the scheduling clerks may have been compromised. In addition, their career development needs might not be properly addressed. How is VA addressing career needs of the scheduling clerks with a national work group? Can you give us an update of what this work group is planning to accomplish?
15. Can you please tell us how VHA defines "waiting times?" And is your definition standardized across every VISN?
16. Please provide documentation of waiting times in the Central Ohio region. Specifically, the Subcommittees are interested in what is happening with primary and specialty care around the Newark area. Do veterans in Licking County have access to more than the Newark Community-Based Outpatient Clinic? What are the procedures for arranging treatment at and transportation to the Chalmers P. Wylie Independent Outpatient Clinic in Columbus, Ohio?
17. What is the status of the feasibility study conducted by the VA for southeastern Ohio? When is it expected to be completed and released?
18. The OIG report documents a number of instances where wait time statistics were artificially improved. It is the understanding of the Subcommittees that the average wait time is one of the indicators that helps determine bonuses for administrators. Is there a correlation between incorrectly improved wait time statistics and the bonus amount specific administrators received for FY2007?
19. Has there been any evidence (anecdotal or otherwise) to indicate that schedulers were encouraged to falsify records specifically for the purpose of increasing bonuses?
20. When determining Medical Center Director bonus amounts, is there a specific formula equating wait times to a bonus dollar amount?

We request you provide responses to the Subcommittee no later than close of business on April 4, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman
Subcommittee on Health

JEFF MILLER
Ranking Republican Member
Subcommittee on Health

HARRY E. MITCHELL
Chairman
Subcommittee on Oversight and Investigations

GINNY BROWN-WAITE
Ranking Republican Member
Subcommittee on Oversight and Investigations

Responses to Questions from Hon. Michael H. Michaud, Chairman, and Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health, and Hon. Harry E. Mitchell, Chairman, and Hon. Ginny Brown-Waite, Ranking Republican Member, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, to Hon. James B. Peake, M.D., Secretary, U.S. Department of Veterans Affairs

Outpatient Waiting Times

Question 1: What specific actions will VHA implement to improve the accuracy and completeness of the scheduling information? Please provide an implementation schedule with milestones and exit criteria.

Response: The Veterans Health Administration (VHA) has implemented several specific actions to improve the accuracy and completeness of the scheduling information. VHA has revised the scheduling directive for schedulers. Schedulers will find

the scheduling directive to be more user friendly and simpler to follow. The revised scheduling directive will be released within the next 60 days.

VHA has also identified and addressed several software deficiencies that contributed to scheduling errors. For example, information entered into VistA to explain changes to desired date is being obscured or erased by existing software. To resolve this deficiency, VHA is working with the Office of Information and Technology (OIT) to correct this information loss.

Additional improvements implemented by VHA include new software that now enables schedulers to link an appointment to a specific consult request. VHA released a first version of its report on wait times from the actual consult request date to the dates of appointment in February 2008. Refinements are being made to the report format and will be made available nationally on VHA's Web site.

In July 2008, OIT will release a software patch that creates a new field within the consult request software where requesting providers will be required to specify the desired date for the service requested. VHA has submitted a request for an additional software modification which would display the provider's desired date on the scheduler's screen as an appointment is scheduled, link that to the scheduled appointment and then transmit the information to the Veterans Service Support Center (VSSC) wait time database. This information would be used to measure the wait time from that desired date until the date of the scheduled appointment.

Finally, a *scheduling process* workgroup has been proposed to be jointly chartered by OIT and the Systems Redesign Office. This group will be charged with standardizing scripts, processes and tasks for the major types of scheduling issues. The Department of Veterans Affairs (VA) would use the products of the workgroup to make improvements in the existing software, training, and tools.

Question 2: Are there any issues that would affect your ability to ensure improvements are made in a timely manner?

Response: Yes, there are some issues which could affect our ability to ensure improvements are made in a timely manner. Revisions to the Scheduling Directive must be negotiated with the union. The negotiation process could take up to several months to complete.

VHA lacks national data tracking and direct measurement systems specific to consultation requests. While information is now being captured on request dates of consults and it is linked to scheduled appointments, there is no provision for automatically reporting of information contained in the computerized patient record system (CPRS). This information includes the types and dates of consult requests, and dates of clinical or administrative closure. This deficiency cannot be corrected until new software routines are developed to automatically transmit information, and new resources (including equipment and staffing) are available to manage and analyze the large volume of data that would be involved. VHA is working with OIT to resolve this issue.

Question 3(a): In 2005, the OIG made specific recommendations—with which VA agreed—to ensure and then monitor schedulers' use of correct procedures when creating appointments. In its 2007 report, the OIG once again reported concerns with the reliability of VA's waiting time data. If required documentation, without which it is not possible to tell whether an appointment was made within 30 days, did not exist, is the proper conclusion for auditing purposes that the appointment was not made in 30 days?

Response: No, that would not be the correct conclusion. The data exist, but not necessarily in the proper form or format. To resolve this problem, scheduler's use of correct procedures when creating appointments is being monitored using a comprehensive audit tool, which is supplemented with feedback and regular training. The unions are reviewing these procedures currently.

Question 3(b): Suppose that VA claims 95% of appointments are made within 30 days, but documentation required by VA policy does not exist to support 20% of those appointments. Does VA believe that it would be justified in claiming the 95 percent number in those circumstances?

Response: Yes, VA believes that it would be justified in making the claim of 95 percent of appointments made within 30 days. The Office of Inspector General (OIG) does not consider a desired date real unless documentation of the date exists in the record. The documentation exists, but not necessarily in the form or format accepted by the OIG. VA is developing software that will resolve this problem.

Question 4: How do you determine if training is effective if you have no process in place to test and monitor schedulers' compliance with scheduling procedures?

Response: VA uses several ways to determine if training is effective. For example, supervisors provide training to schedulers, when needed, and monitor schedulers' compliance and performance, and this is part of the scheduler's annual performance appraisal. VHA is standardizing the way supervisors monitor scheduler's compliance and is providing tools to assist in monitoring schedulers' performance. OIT is converting software which will be used by facilities to randomly pull appointments created by each scheduler for review by supervisors.

VHA is negotiating with union representatives on instructions supervisors will follow to review appointments to ensure desired date was correctly entered. Follow-up will be required in instances in which a scheduler fails to correctly schedule a specified percentage of the appointments reviewed. Facility directors are required to monitor supervisors' reviews of scheduler performance.

Question 5: Other than monitoring appointments with waiting times more than 30 days, what specific actions do you take to test the reliability of the waiting times performance that you include in your annual Performance and Accountability Report?

Response: To test the reliability of the waiting times performance, VHA, on a regular basis, sends wait time data to the facilities to review for accuracy. During the review process, outliers are identified and explanations are provided relative to the reasons for the outlier status. This is a process of sorting out the differences in outlier numbers associated with real wait time problems versus scheduler errors, either in entry of desired date, or in selection of an appointment date. Patients with extended wait times are called and provided earlier appointments as appropriate consistent with their preferences and clinical necessity.

VHA also test reliability of the waiting times performance by asking patients on its Survey of healthcare experience of patients (SHEP) to respond whether they received an appointment when they wanted to be seen. Steady improvement has been noted in patient satisfaction on this issue. VHA tracks patient complaints received and has noted improvements in numbers of complaints received in spite of increased numbers of veterans being scheduled.

In fiscal year (FY) 2004, VHA distributed nationally an electronic tool for use by facilities in continuous auditing of the accuracy of appointments scheduled more than 30 days from desired date. VHA Directive 2006–055 published October 2006 required continuous auditing by supervisors of performance of employees in scheduling using locally developed or veterans integrated service network (VISN) approved tools. VHA is now finalizing actions to distribute new tools nationally to optimize this auditing process.

Question 6: How will you ensure the accuracy of the current scheduling system until a new system comes on line?

Response: Among the actions VA has taken to ensure the accuracy of its current scheduling system are developing and implementing a revised directive on scheduling for schedulers to follow; modifying our existing scheduling software package; developing a standardized method to monitor scheduler accuracy; and negotiating with unions on enhanced training and supervision for schedulers.

It is important to note, however, that even once the new replacement scheduling application comes online there will still be some scheduling errors. The office responsible for the application is actively working on a transition plan which would ensure those errors are kept to a minimum.

Question 7: If you propose eliminating your current measurement of waiting times and rely entirely on patient satisfaction surveys, how would you ensure the survey provides you sufficient, meaningful information necessary to place resources in the most appropriate places to positively impact timely patient care?

Response: VA is not proposing to eliminate current measurement of waiting times completely. We would not eliminate measurement of waiting times in clinics entirely but would use these metrics as internal measures. We would retain some method of monitoring the clinic backlog such as a measure of "future open capacity" and/or "third next available," which are capacity measures. These are the most common methods used in non-VA healthcare.

SHEP data capture meaningful patient information. Currently, we provide SHEP data on a quarterly basis. VHA is considering various means of obtaining more comprehensive data, in addition to SHEP data, such as asking patients or random sam-

ple of patients some key question immediately upon seeing their provider. The cost involved is yet to be determined.

Question 8(a): How are directors for each facility held accountable for veterans' waiting times in their facilities?

Response: VHA continues to place increased focus and accountability for improving performance relative to wait times through national teleconference calls, meetings, and sending data to the facilities on a regular basis. Directors remain accountable for health system indicators which include new patient wait times, missed opportunities and wait times to see a provider. These contribute to the overall director's performance evaluation.

Question 8(b): What measurement did you hold them to in 2007, and are those same standards in place in 2008?

Response: During FY 2007, 60 percent of the directors' overall score was dependent on results of 22 performance measures. As a result, during FY 2007, 2.7 percent of a director's performance depended on veteran's waiting times. Measures included outpatient wait times for new and established patients, missed opportunity rates and wait times to see a provider.

During FY 2008, 60 percent of the directors' overall score is dependent on results of 15 mission critical measures. As a result, during FY 2008, 4 percent of a director's performance depends on veteran's waiting times. The measure for FY 2008 is a percent of appointments completed within 30 days for Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) veterans.

Question 9(a): Would it be in the veterans' best interests if you knew exactly how many veterans were waiting for an appointment and then how long veterans were waiting for appointments?

Response: Some measure of patient wait time is needed. During FY 2007, VHA refined its approach to measurement of all patients waiting for outpatient appointments. The consult-scheduling software linkage was distributed and implemented to enhance tracking wait times for consult processing. Reporting strategies are now being refined. A new access list was developed to provide a snapshot in time of all patients waiting beyond their desired date for a scheduled appointment or on the electronic wait list. A new pending report was created to enable facilities to drill down to view all pending appointments. In addition, for FY 2008, the VHA consult completion monitor has been refined to measure numbers of consults clinically completed with results within 30 days of request and within 60 days of request. VHA will continue to measure wait times for new and established patient appointments and missed opportunity rates.

Question 9(b): How do you know where to apply resources if facilities do not capture accurate waiting time performance data?

Response: VHA acknowledges that there is a level of imprecision in the data; however, experience has shown that it is adequate for resource decision making purposes. In order to make resource decisions, information beyond single waiting time measurements are needed. Clinics need to consider information such as the changes in patient demand, changes in clinic supply, changes in no-show rates, the quality of consults sent to specialty care, continuity scores, re-visit rates, and panel size or case load. In general, if waiting times are stable, the problem is more likely a backlog problem than a resource problem.

Question 10: The OIG found that there were a number of veterans that should have been on the electronic waiting list but were not. In 2007, in a review of 10 facilities, it appears that a significant number of veterans were waiting an extended period of time for action on their request for a consult with a specialist. Electronic waiting lists were created as a mechanism to ensure visibility over all veterans without appointments. Why are your facilities not using them appropriately?

Response: The CPRS consultation software is used not only to request specialty consultation but also to order tests and procedures that are not specialty consultation. On reviewing the lists of consults the OIG asserted should have been placed on the electronic wait list, VHA determined that OIG had erred in large measure by reviewing a few consults and then projecting numbers that should have been on the electronic wait list based on existing, pending, and active consults at the facilities without actually reviewing those lists of pending and active consults.

On closer review, VHA found many if not most of these unscheduled active and pending consults not listed on the electronic wait list were procedures, and not medical consultations. Examples: consult requests for fee basis and other types of non-VA care, consult requests for electrocardiograms (EKG) performed on patients in pre-procedural beds, consult requests for medical and surgical procedures scheduled to be done in an operating or procedure room. VHA is working to distinguish the "formal consults" (requests to qualified healthcare providers for management and treatment of problems requiring clinical input, direction in treatment, or review of the record) from the use of the consultation software for other purposes.

Experience has shown that electronic wait lists, in the fashion previously implemented was overly prescriptive and effectively resulted in low priority veterans being served sooner than high priority veterans. The new access directive will correct this problem and make the use of the electronic wait list easier for facilities. As indicated above, VHA has created an access list which provides a snapshot of patients waiting past their desired date for a scheduled appointment or on the electronic wait list. This provides the universe of patients waiting 30 days past their desired date and is a more precise metric.

Question 11: Do you think having VHA bring back the policy of VAMC Directors certifying the waiting time's list would improve the accuracy of the waiting times numbers?

Response: The policy of certification was updated, but not eliminated by VHA. Prior to publication of VHA Directive 2006–028 in May 2006, VHA required each facility and network director to certify full compliance with the requirements of VHA Directive 2002–059 and VHA Directive 2003–068 that provided business rules for scheduling. When published, VHA Directive 2006–028 and VHA Directive 2006–055 (Oct. 2006) provided new, updated business rules for scheduling. In May 2007, every facility and network director was required to certify compliance with VHA Directive 2006–055.

We believe that we have focused facility and network leadership on access issues through numerous teleconferences and meetings and will continue to highlight during the coming year. In addition to the mission critical wait time measures, the directors remain accountable for health system indicators which include new patient wait times, missed opportunities and wait times to see a provider and contribute to the overall director's performance evaluation.

Question 12: Why was the certifying procedure the medical facility directors had to comply with eliminated?

Response: The certifying procedure was not eliminated. The last certifications of compliance with requirements of VHA Directive 2006–055 were collected in May 2007, less than 9 months ago. However, we do believe that there are more effective ways of focusing attention on access than having leadership certify compliance with numerous elements identified in a directive. We will continue to focus attention on access in the coming year.

Question 13: Do you think there is a conflict of interest between the VA's goal of minimizing veteran-patients waiting times and the temptations for directors to game the numbers to make this specific performance measure look good for their annual reviews?

Response: No, VA does not think there is a conflict of interest. We believe that having a variety of performance measures and patient satisfaction data will ensure the integrity of the process. During the past several years, we have had teams visit facilities to do consultative reviews, numerous communities of practice that discuss access issues faced locally, shared best practices; regional collaborative meetings, and paired sites who are struggling with those who have demonstrated success. Wide spread discussion, learning, and focus contributes to a "learning organization" atmosphere rather than gaming.

Question 14(a): Since the disbandment of the Medical Administration Service, supervisory oversight controls of the scheduling clerks may have been compromised. In addition, their career development needs might not be properly addressed. How is VA addressing career needs of the scheduling clerks with a national work group?

Response: Turnover of scheduling clerks is a problem that may be more related to grade and pay issues than service organization. During FY 2007, a small work group was tasked with creating a viable career ladder for schedulers, to enable pro-

gression from nationally standardized GS 3 to GS 7 positions, while still responsible for scheduling.

Question 14(b): Can you give us an update of what this work group is planning to accomplish?

Response: VHA has initiated action to standardize the monitoring of scheduler compliance and has provided tools to facilitate supervisory actions in monitoring the performance of schedulers. The work of this group continues.

Question 15: Can you please tell us how VHA defined "waiting times?" And is your definition standardized across every VISN?

Response: Wait times are measured for two different groups of patients. "New patients" are those patients not seen within the facility within a clinic group within the last 24 months. For these new patients, wait times are defined as the days from the date an appointment is created until the date the appointment is completed. Time the patient spent waiting on the electronic wait list prior to the scheduling of the appointment and time added by clinic cancelation of the original appointment created are included in the total wait time reported.

All other patients are designated as "established patients." Wait times for established patients are defined as the days from the "desired date" entered by the scheduler until the date the appointment is completed. Time the patient spent waiting on the electronic wait list prior to the scheduling of the appointment and time added by clinic cancelation of the original appointment created are included in the total wait time reported.

Question 16: Please provide documentation of waiting times in the Central Ohio region. Specifically, the Subcommittees are interested in what is happening with primary and specialty care around the Newark area. Do veterans in Licking County have access to more than the Newark Community-Based Outpatient Clinic? What are the procedures for arranging treatment at and transportation to the Chalmers P. Wylie Independent Outpatient Clinic in Columbus, Ohio?

Response: Veterans in Licking County have access to the Columbus Independent Outpatient Clinic which is 35 miles west of Newark and the Zanesville Community Outpatient Clinic which is 33 miles east of Newark. Patients may opt to come to the Columbus Clinic on their own or they may be referred by primary care providers for specialty services that are offered in Columbus. If patients do not have means of transportation, this can be arranged through the Disabled American Veterans (DAV). DAV, a veterans service organization, transport patients from different counties around Central Ohio to the Columbus clinic.

The chart below contains the most recent wait times for all clinics in Newark. A psychiatrist goes to Newark 2 days a week. A social worker was recently hired and should be able to screen and see new patients more timely until tele-mental health can be implemented or additional providers hired.

Clinic	Wait in Days (Established Patient)	Wait in Days (New Patient)
Newark/P Care/Physican 1	12	20
Newark/P Care/Provider 3	26	26
Newark/Nemali	42	49
Newark/Social Work	5	5
Newark/PTSD	16	16
Newark/Renal	19	19
Newark/Podiatry	1	1
Newark/Nutrition	12	12

The following wait time data are provided. Major enhancements to primary and specialty care services took place at the Newark Community-Based Outpatient Clinic (CBOC) in Central Ohio between July 2007 and January 2008. During January 2008, a total of 671 patients were seen in 14 different clinics at the Newark CBOC.

By contrast, during January 2007, 10 patients were seen under the two mental health clinics at the Newark CBOC. During July 2007 a total of 22 unique patients were served by this CBOC in mental health. Primary care and other specialty care services were not available at the Newark CBOC.

Patient Type	DSS Clinic Stop	Performance Measure Clinic Group July, 2007	Total Patient Appts.
New	502	Mental Health—Ind	3
Estab	502	Mental Health—Ind	8
Estab	566	Mh Risk Fac Red Edu Grp	11
Patient Type	**DSS Clinic Stop**	**Performance Measure Clinic Group January, 2008**	**Total Patient Appts.**
Estab	102	Admit/Screening	6
New	124	Nutr/Diet—Grp	1
Estab	171	Hbpc Nursing (Rn/Lp)	33
New	172	Hbpc Physic Extnd (Np,cns,pa)	3
Estab	172	Hbpc Physic Extnd (Np,cns,pa)	7
Estab	173	Hbpc—Social Work	4
Estab	175	Hbpc—Dietician	2
Estab	301	General Int Med	83
New	323	Primary Care/Med	17
Estab	323	Primary Care/Med	265
New	408	Optometry	35
Estab	408	Optometry	90
New	411	Podiatry	4
Estab	411	Podiatry	6
New	502	Mental Health—Ind	2
Estab	502	Mental Health—Ind	76
Estab	540	Ptsd Clinical Team Pts Ind	10
Estab	561	Pct Ptsd—Grp	20
New	566	Mh Risk Fac Red Edu Grp	1
Estab	566	Mh Risk Fac Red Edu Grp	6

Question 17: What is the status of the feasibility study conducted by the VA for southeastern Ohio? When is it expected to be completed and released?

Response: The healthcare needs of veterans residing in Southeastern Ohio was discussed at a Joint House and Senate Veterans' Affairs Committee field hearing that was held in Ohio on May 29, 2007. VHA committed to evaluating the healthcare needs of veterans residing in southeastern Ohio in response to the assertion that there needs to be a VA medical center (VAMC) in this region.

VHA conducted an analysis, which demonstrated a projected decline in veteran population and enrollment by 2025. In addition, the projected bed demand of 29 inpatient medicine beds by 2025 is of concern. Small hospitals (30 beds or less), whether VA or non-VA, face significant challenges in providing a full range of services and in maintaining high-quality healthcare across multiple subspecialties. The market share (ratio of the number of veterans enrolled in the system to the total veteran population) of just those counties that fall within District 18 is 35 percent, which is higher than both VISN 10 and national levels. The higher than average market share in District 18 indicates that veterans in the area do not perceive a

significant access barrier to obtaining care, that is indicative of areas with low market share rates.

While VHA is not meeting access standards for acute hospital care (see table below) in one of the three Ohio markets (i.e., the Central market) there is sufficient capacity in other VISN 10 and nearby facilities to meet inpatient needs. As a result of this analysis, VA has concluded that there is an insufficient veteran population combined with declining demand to support a VA-owned and operated hospital.

Type of Care	Travel Time Standard	Guideline for Percent Enrollees Living Within Travel Time	VISN 10 FY06 Market Performance		
			Western	Central	Eastern
Primary Care	30 Min.—Urban 30 Min.—Rural 60 Min.—Highly Rural	70%	81%	72%	89%
Acute Care	60 Min.—Urban 90 Min.—Rural 120 Min.—Highly Rural	65%	94%	36%	63%
Tertiary Care	240 Min.—Urban 240 Min.—Rural Community Standard—Highly Rural	65%	65%	100%	100%

Question 18: The OIG report documents a number of instances where wait time statistics were artificially improved. It is the understanding of the Subcommittees that the average wait time is one of the indicators that helps determine bonuses for administrators. Is there a correlation between incorrectly improved wait time statistics and the bonus amount specific administrators received for FY2007?

Response: No, VA does not believe that there is a direct correlation between incorrectly improved wait time statistics and the bonus amount specific administrators received for FY 2007. Because waiting times is but one indicator among many that facility directors are evaluated on to determine a bonus, a correlation between incorrectly improved wait time statistics and a bonus is difficult to characterize. Similarly, instances in the IG report cited as wait time errors may be based on different characterization of the data.

VHA has identified errors associated with projections and surveys conducted by the OIG. For example, the OIG reviewed only completed appointments, so documentation that had been created by schedulers would have been obscured by the software glitch VHA has identified that truncates text entries under "other info" once an appointment is completed (and erased for appointments rescheduled after a cancelation).

The OIG's methodology was to review a sample of cases to determine the percent with what would appear to be incorrect desired appointment dates based on differences between provider instructions and scheduler entered desired dates, and an absence of documentation to explain the use of these desired dates. OIG then projects this rate of differences between the desired dates entered by providers, and the desired dates entered by schedulers (and used by VHA to calculate waiting times) on the entire population of scheduled appointments. Example: In reviewing desired dates entered for 750 established patient appointments in VISN 3, OIG identified differences between the desired dates specified by providers versus those entered by schedulers in 394 of these appointments (53 percent). When they applied this discrepancy rate to all established patient appointments, they concluded 98,454 established patient appointments would be subject to the same discrepancy.

The OIG measures new patient wait times differently than VHA. VHA measures new patient wait times from the date an appointment is created until the date of the appointment. Relative to appointments created in response to consults or new patient requests, because there is a lag time between these requests and creation of an appointment (VHA has allowed a 7 day lag time). OIG states VHA understates wait times in its reports. On the other hand, we believe it is equally possible that actual waiting times for new patients are overstated because when schedulers contact a patient to create an appointment, the patient is offered the opportunity to say when they want to be seen—their desired date. Their desired date may be a future date. Because VHA does not measure new patient wait time from desired date, but rather from appointment creation date, each time the patient expresses

a preference for a future appointment date, wait times are understated. It appears the new patient is waiting longer when using the creation date to measure new patient wait time, rather than the desired date specified by a patient when that date is some time in the future.

Question 19: Has there been any evidence (anecdotal or otherwise) to indicate that schedulers were encouraged to falsify records specifically for the purpose of increasing bonuses?

Response: We have no evidence to substantiate this claim. In its 2005 *Report of Audit of Scheduling*, the OIG reported that 10 percent of the schedulers who responded to its survey said that their leadership had pressured them to keep wait lists short, causing them to circumvent established procedures for scheduling. In its 2007 *Report of Audit of Scheduling* at 10 facilities, there was no mention of findings that schedulers were pressured by leadership to keep wait lists short by circumventing established procedures for scheduling. In its 2008 *Report of Audit of Scheduling* at 5 facilities within VISN 3, the OIG reported it found no evidence of leaders or managers threatening staff in a manner that encouraged a willful manipulation of scheduling procedures.

Question 20: When determining Medical Center Director bonus amounts, is there a specific formula equating wait times to a bonus dollar amount?

Response: There is no specific formula. Medical Center Directors are evaluated on the entire executive career field performance contract as well as additional measures/monitors identified by their respective network director.

