A CONTINUED ASSESSMENT OF DELAYS IN VETERANS' ACCESS TO HEALTH CARE

HEARING

BEFORE THE

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

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

TUESDAY, APRIL 19, 2016

Serial No. 114–65

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE
25–154 WASHINGTON : 2017

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

Tuesday, April 19, 2016

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Tuesday, April 19, 2016

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Bost, Brown, Takano, Brownley, Ruiz, O'Rourke, Walz, and McNerney.

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. The hearing will come to order. I would like to welcome everyone to today's hearing entitled "A Continued Assessment of Delays in Veterans' Access to Health Care." This hearing marks two years since this Committee exposed the wait time scandal that has gripped the Department since 2014.

I am proud of the work that we have done in those two years, particularly digging into the actions of bureaucrats whose self-interest was put ahead of the veterans that they were charged with assisting. The purpose of this hearing is to examine the efforts that VA has taken to improve access to care for veterans and to identify where serious issues still exist.

Based on the bipartisan work of this Committee, GAO has undertaken an audit of new patient primary care wait times at six facilities across the Veteran Health Administration. GAO's review found that veterans at those facilities waited between 22 and 71 days, which is significantly more than the 5-day average that Secretary McDonald has declared to this Committee earlier this month. Now, this discrepancy can probably be easily explained.

First, VA only tracks and monitors a portion, a portion, of a veteran's actual wait time when tracking access data. Instead of considering a veteran's wait time to be from the date when the veteran first contacts VA to request an appointment to when the appointment takes place, VA actually considers a veteran's wait time to be from the date when the veteran wants an appointment and the date when the appointment actually occurs.

This is problematic because it doesn't take into account the following. Doesn't take into account the time it takes the VA scheduler to contact the veteran to schedule the appointment; the fact that it is a regular practice for schedulers to negotiate a desired

date with a veteran; or the fact that outright manipulation of desired dates to zero out wait times is still one of the most prevalent types of data manipulation that occurs within the Department today.

In effect, VA continues to ignore the main forms of data manipulation while it continues to come to Congress, to this Committee, saying there is no data manipulation. To this point, you will not find what you do not seek. The obvious result of VA reporting only a portion of a veteran's actual wait time is artificially low results.

I still don't understand how a culture could persist in presenting inaccurate data to this Committee, or more importantly to the veterans of this country. A true picture of wait times, or more importantly, the veteran experience the Secretary speaks about quite frequently, can help us ensure an adequate allocation of the resources that we are asked to provide. But when this Committee only hears requests for more manpower, more space, and more flexibility, it is hard to reconcile the additional resources with a reported wait time of only five days.

This discrepancy between reality and VA claims was captured by GAO in its report where VA data shows that wait times were, at best, underestimated by two-and-a-half times, and, at worst, 11 times the full wait time that the veteran experienced.

Another tactic that VA uses to make its wait time appear lower is to combine shorter wait times for the large pool of established patients with the longer wait times of the smaller pool of new patients. This dilutes the wait time data, making new patients waits appear shorter since they have been co-mingled with data from the other cohort.

For years VA has blamed incorrect appointment scheduling and long wait times on training issues, largely because it was warned about those issues as far back as 2005 when the Inspector General's office published a report highlighting the improper scheduling practices and poor training process.

Many OIG and GAO reports since that time have found that the same scheduling problems continue to exist. Yet, in the 11 years since VA continues to blame wait time manipulation on the very same cause, a control over which a VA has complete control. Secretary McDonald has repeatedly asked that we allow him to run VA like a business. But I can assure you that if an executive running a company used the same excuse to explain away 11 years of problems in a row with no change to show for it, that individual would be out of a job. But not at VA.

Despite years of reports of confirming systemic issues, the Department has successfully fired just four people for wait time manipulation while letting the bulk of those behind its nationwide delays in care scandal off with no discipline or very weak slaps on the wrist. Another issue regarding accountability is how VA continues to ignore retaliation against the whistleblowers that we have relied on for some of the information that our Committee has acted on.

The Committee has asked VA for all adverse actions where an employee was disciplined for retaliation against a whistleblower. VA provided our Committee a list showing that as of March 15th, 2016, only six individuals were disciplined for whistleblower retal-

iation. However, looking deeper at the report, one of the listed employees is Sharon Helman, who the Committee has already shown was not successfully disciplined for whistleblower retaliation, was, in fact, successfully disciplined for failing to report accepting gifts.

Two of the other disciplined employees were listed as housekeeping aide supervisors who are clearly not high-level supervisors. That leaves three employees. Two received reprimands and one received a less than 14-day suspension. To be clear, according to VA-provided documentation no employee has been removed for whistleblower retaliation. This is representative of the fact that, contrary to public statements by VA senior officials, whistleblower retaliation appears to most certainly be tolerated within the Department.

So now, two years after what was and is a systemic crisis in care being brought to light, it is time for VA to stop using misleading data to tout wait time successes that simply do not show the real wait time experienced by our veterans.

I want to hear what concrete actions have been taken, what fundamental changes have been made, and what tangible cultural shifts are occurring within the Department. Advertising artificially lowered numbers does nothing to stimulate the change that is needed to improve veterans' access to care.

And with that, I yield to the Ranking Member, Ms. Brown, for any opening remarks that she may have.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF CORRINE BROWN, RANKING MEMBER

Ms. BROWN. Thank you, Mr. Chairman, for calling this hearing today. Following the wait time scandal of Phoenix, Congress passed, and President Obama signed, the Veterans Access, Choice and Accountability Act of 2014. In it, we mandated that there be an Independent Assessment of veterans' health care.

The Assessment Highlighted many of the things we hear from our veterans. We hear that VA provides excellent health care, especially health care related to the special needs of our veterans. We also hear that in certain areas, VA is at the forefront of health care in this country. We also hear from our veterans that VA care is often fragmented, and that it can be difficult to navigate and arrange non-VA care. We hear of long wait times and limited access.

Following the assessment in the Surface Transportation in Veterans Health Care Choice Improvement Act of 2015, we mandated a report by the VA regarding a plan for how VA could consolidate all purchased care programs into one New Veterans Choice Program. We received that report last year and this Committee is currently working with the VA on the best way to implement the legislative request.

The VA is on track to see 6,277,360 unique patients, and 9,247,803 unique enrollees. In Fiscal Year 2015, VA completed 56.7 million appointments, nearly 2 million more than Fiscal Year 2014. That is roughly 226 appointments per day. Let me repeat that. That's 226,000 appointments per day.

The number of patients that the VA sees would put any other health care system to shame.

I am pleased the GAO study newly enrolled veterans and their access to primary care. In my conversations with veterans, time and time again they say that once you get into the VA system, the care is the best in the world. Let me repeat that. Once you get into the system, the care is the best in the world. It is this initial appointment that is so hard to get. I am troubled by the GAO finding that nearly half was unable to access primary care because VA medical center staff did not schedule appointments for these veterans in a quick timeframe.

The GAO report goes on to say that veterans' access to primary care is hindered in part by data weaknesses and by the lack of a comprehensive scheduling policy.

We are at a tipping point right now as to what the VA would look like and the services it would provide for veterans in the coming decades. I look forward to hearing from witnesses today as to what this aspect of the VA would look like in the future.

With that, Mr. Chairman, I yield back the balance of my time.

[THE PREPARED STATEMENT OF CORRINE BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Ms. Brown.

As a custom with this Committee, I would ask that all Members waive their opening statement to allow me the opportunity to introduce the witnesses at the table today.

From VA, we are going to hear from Dr. David Shulkin, the Under Secretary for Health in the Department of Veterans Affairs, and he is accompanied by Dr. Lynch, Assistant Deputy Under Secretary for Health and Clinical Operations. From the office of Inspector General we have Mr. Larry Reinkemeyer, Director of OIG's Kansas City office of Audits and Evaluation, he is accompanied by Mr. Gary Abe, Acting Assistant Inspector. Finally, we will hear from Ms. Debra Draper, Director of the Health Care Team at the Government Accountability Office.

And I would ask if all the witnesses would please stand so we can swear you in.

[Witnesses sworn.]

The CHAIRMAN. Thank you. Please be seated.

Let the record reflect that all witnesses did answer in the affirmative.

Dr. Shulkin, you are recognized for your opening statement of five minutes.

STATEMENT OF DAVID SHULKIN

Dr. SHULKIN. Good morning, Chairman Miller, Ranking Member Brown, Members of the Committee. As the Chairman said, I'm accompanied by my right here by Dr. Thomas Lynch, who is the Assistant Deputy Under Secretary for Clinical Operations, and seated behind me, Dr. Poonam Alaigh, who is the Senior Advisor to the Under Secretary.

I arrived at VA approximately nine months ago, and I understood when I came here that this access crisis was a national priority and the status quo simply wasn't acceptable. It's not my ob-

jective today to tell you that we fixed all the problems or that we don't have issues, rather it's my objective today to tell you that we are focused on this, this is my number one priority, that this is VHA's number one priority, and we're going to stick at this 'til we get this problem resolved.

The first thing I did when I arrived as the Under Secretary was to assess all the data on wait times. There were literally file cabinets full of reports and bookshelves filled with data. And I have to tell you, I made it through medical school okay, but I had a really hard time understanding all this data; very, very confusing.

What I didn't see was the ability to clinically prioritize which veterans needed care first, and I didn't know how to run a health care system unless I understood that you needed to see the patients that were sickest the first.

So that's the first thing we did, we changed it so we could clinically prioritize the veterans. And that led to two national standdowns where we opened up every VA medical center across the country and saw those veterans who needed the care that day on the day of the stand-down. And that led to real significant sustainable improvements.

We had 57,000 urgent consults in what we call Level 1 at the first stand-down, today it's a 77 percent reduction, there were 12,000 urgent Level 1 consults. On our second stand-down, we addressed 81,000 urgent appointments and we got 93 percent of those gone through and resolved.

This month, we're launching what we call our Declaration of Independence, which is called the Declaration of Access, which are nine core principles that are going to fundamentally redesign the way that we provide access to veterans. They include some pretty bold moves like same-day access in primary care, and same-day access in mental health.

Now I will tell you these are aspirational goals to be done by the end of 2016, but I've never been part of a change effort that started with low expectations. And I'm confident we can get these bold goals done because today we have 34 medical centers in the VA system that are currently doing same-day access in primary care. So we can do this, we have to spread these best practices throughout the system.

We also have to make the wait times more understandable. Mr. Chairman, as you said, it is very, very difficult to understand. And I will tell you that I am—my academic studies are in patient safety. I teach my students that there are bad systems, not bad people. And so I've already said we have to change our systems, but when we do identify bad people in the VA, and people who have lost their ways not following out values, we will hold them accountable.

We have held 29 individuals so far accountable with disciplinary actions on the VA wait crisis. As the Chairman said, four of them have been fired. We've trained 32,067 schedulers. We've done 11,500 individual visits auditing these schedulers. The Joint Commission has been invited and visited every single one of our medical facilities. We have a new training program for schedules to launch this spring, beginning in May. But our measurement system's too complex. And where I want to move this to is the veteran experience: asking veterans are they satisfied with access.

And, in fact, in every medical center today, we have a system called VetLink. When you come in, you go to a kiosk, you actually are asked whether you're satisfied with the access to care. Eighty-nine percent of veterans today are satisfied with the access to care throughout VAs. And I have all of your individual data by the way.

But we have to do better. We hired 17,000 new employees in the last fiscal year, that's a net number. A ten percent increase in productivity through RVVs user over the last two years. Two point two million square feet we've added of clinical space. We have a new scheduling system being rolled out now called VSE, a new veterans application that they can schedule themselves.

We've allowed direct scheduling in audiology and optometry. We have group practice managers now over all of our medical centers. We're sharing best practices and access across the entire system. And, of course, as you know, we're working much closer than ever with our community partners to provide care.

Fifty-seven million appointments last year, as the Ranking Member said, 1.6 million more visits last year than the year before, 96 percent scheduled within 30 days. We're processing claims faster than ever before, 25 percent increase in claims processed last month. We're looking forward to the comments by the GAO and the IG. I have to tell you, we're not afraid of criticism, we welcome it, we want this type of transparency.

In conclusion, I just want to tell you, the VA is making sweeping changes, we are making progress, but there's significant work that lies ahead. That's what I'm here to do. But recall, as the Ranking Member said, the VA provides excellent care everyday, in fact, this year alone four peer-reviewed studies showing our care is equal or superior to what's happening in the private sector.

We appreciate the support of all of you on this Committee and look forward to answering any questions. Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF DAVID SHULKIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Dr. Shulkin.

Mr. Reinkemeyer, you are now recognized for five minutes.

STATEMENT OF LARRY REINKEMEYER

Mr. REINKEMEYER. Mr. Chairman and Members of the Committee, thank you for this opportunity to discuss the recent reports we have issued that have addressed various obstacles to veterans receiving timely access to health care. As you mentioned, I am accompanied by Mr. Gary Abe, the Deputy Assistant Inspector General Of Audits and Evaluations.

Two years ago, VHA's ability to provide veterans timely access to care became an even larger national focus. In 2014, we published two reports detailing the serious conditions that existed at the Phoenix health care system and provided VA leadership with recommendations for immediate implementation. These reports brought much needed accountability over serious access issues.

Since our August 2014 reports, we have initiated a series of audits and reviews evaluating the extent to which veterans receive timely care. We have published several comprehensive reports de-

tailing veterans' experiences during their initial application and their enrollment for health care, VHA's effectiveness in its efforts to improve veterans' access to psychiatrists, and VHA's consult management.

In addition, a number of more recent reviews are still in progress, including work which Members of Congress requested at the Phoenix health care system to evaluate hiring practices of medical support assistants, or the schedulers, and continued concerns about timely access to care.

The national attention sparked by our reporting on the Phoenix health care system resulted in a dramatic increase in the number of contacts to the OIG hotline and the number of inquiries and requests sent to us by Members of Congress. A number of these hotline contacts continue to allege inappropriate practices by VHA staff that undermine the integrity and reliability of wait time metrics, as well as allege that VHA's initiatives to provide veterans care in the community are not working.

Our audits, reviews, and health care inspections have reported challenges VA faces in administering all aspects of purchased care programs, authorizing, scheduling care, documenting the care in the veterans' VA medical records, and timely and accurate payments for care.

Two reports we issued in February 2016 highlight some of the problems we see. In our review of alleged untimely care at the Colorado Springs community based outpatient clinic, we substantiated the allegation that some eligible Colorado Springs veterans did not receive timely care and non-VA care staff did not add veterans to the Veterans Choice list, or the VCL, in a timely manner, or in some cases not at all.

Generally, this occurred because scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days, which resulted in the veteran's exclusion from the VCL.

In our review of alleged patient scheduling issues at the VA medical Center in Tampa, we again substantiated that the facility did not add all eligible veterans to the VCL when their scheduled appointment was greater than 30 days. But we also found that staff inappropriately removed veterans from the VCL, and the facility staff did not cancel veterans' existing VA appointments when they did receive an appointment in the community through the Veterans Choice Program, which blocked other veterans from taking that VA appointment.

My office recently initiated a pilot project to audit one VISN and its facilities to evaluate three key components of access: data reliability of wait time metrics, access through the Veterans Choice Program, and consult management.

Our objective for this pilot is to provide comprehensive and timely oversight at all facilities within a VISN in order to provide the facility directors within that VISN a report detailing their current data and scheduling practices. We hope that by focusing our resources on this issue, we can audit each VISN and its facilities every three years as we currently do with our VBA regional offices.

We feel this work is important and will help provide a veteran centric view of what actions VISN management is taking to ensure situations like Phoenix do not occur in the future.

In conclusion, our work has shown that VA faces challenges in providing adequate access to health care. We have a number of active projects involving VHA practices and procedures that ultimately affect veterans' access to the Veterans Choice Program. We will continue to work with VA to provide the independent oversight and objective recommendations to help move these programs and initiatives forward.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or Members of the Committee may have.

[THE PREPARED STATEMENT OF LARRY REINKEMEYER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Reinkemeyer.

Ms. Draper, you are recognized for five minutes.

STATEMENT OF DEBRA DRAPER

Ms. DRAPER. Chairman Miller, Ranking Member Brown, and Members of the Committee, thank you for the opportunity to be here today to discuss veterans' access to VA health care. My testimony today is based on GAO's ongoing body of work in this area, including most recently a report publically released yesterday, "A Newly Enrolled Veteran's Access to Primary Care."

I wish that I was here today to discuss better news, but, unfortunately, that's not the case. Since 2000, and in particular over the past five years, we have consistently reported on VA's failure to ensure veterans' timely access to health care. In 2012, we found that outpatient medical appointment wait time data were unreliable, implementation of the scheduling policy was inconsistent across medical facilities, telephone access was problematic, and scheduling resources were not effectively allocated.

In 2014, we found that access to outpatient specialty care was problematic due to mismanagement of the consult process, including poor oversight and the lack of clear policies. In 2015, we looked at veterans' access to mental health care and found that the way VA calculates wait times does not always reflect the overall time a veteran is waiting for care, the lack of clear policies precludes effective oversight, and access data may not be comparable over time or between medical facilities.

Our most recent work focused on newly enrolled veterans' access to primary care, which is typically the entry point to VA's health care system, and critical to ensuring veterans obtain needed medical care, including specialty care. For this work, we found many of the same problems as we had previously reported.

We reviewed a sample of 180 newly enrolled veterans' medical records across six VA medical centers and found, for example, for the 60 veterans in our review who requested VA contact them to schedule appointments, but had not been seen by primary care providers, 17 were not contacted at all because these veterans did not appear on the new enrollee appointment list, which is intended to help track newly enrolled veterans needing appointments. Medical center officials were not aware that this problem was occurring and could not tell us why these veterans did not appear on the list.

Further, for 12 of these 60 newly enrolled veterans, medical centers did not follow VA policy for making contact to schedule an appointment, which states that there should be three documented attempts by phone, and if unsuccessful, a letter sent. For the 120 veterans who requested care and were seen by primary care providers, we found the average number of days between the initial request that they be contacted to schedule appointments and the dates they were actually seen ranged from 22 to 71 days. About half were seen in less than 30 days.

However, veterans' experiences varied widely with 12 veterans, for example, waiting more than 90 days. Delays in care were due to issues such as appointments not being available when veterans wanted to be seen and medical centers' failure to follow VA scheduling policy.

In this most recent work, we also continue to see data weaknesses due to errors such as schedulers incorrectly changing dates, as well as the lack of a comprehensive scheduling policy, which has created confusion and contributed to the errors seen.

In 2015, veterans' health care was added to GAO's high risk list due to VA's problems providing timely access to care, among other reasons. This list identifies government operations that are vulnerable to fraud, waste, abuse and mismanagement, or need a major organizational transformation.

In designating VA health care as high risk, we identified a number of concerns, all of which affect veterans' access to timely health care and includes, for example, ambiguous policies, and inconsistent processes, inadequate oversight and accountability, and poor training.

It has now been over a year since the addition of VA Health Care to the high risk list, and to date, we have seen at best, little progress by VA in addressing the issues. We are very concerned about the lack of meaningful progress and our concern is heightened further because the window of opportunity for making progress under the current administration is rapidly closing, if not already closed.

VA health care's access problems are significant, persistent, and not only a disservice to our Nation's veterans, but places them at risk for harm. The status quo is not appropriate, nor should it be accepted.

Mr. Chairman, this concludes my opening remarks, I would be happy to answer any questions.

[THE PREPARED STATEMENT OF DEBRA DRAPER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Dr. Shulkin, I know that you have been hard at it for nine months. And a simple question, does it irritate you that even after your nine months—and we are talking about two years from the exposure of the wait time problem—that there still is serious problems in manipulation of wait times?

Dr. SHULKIN. I am very, very impatient to get this problem resolved. I am concerned that we have data out there that is not necessarily understandable by people. I am concerned when I hear

about mistakes being made. Wherever we do find that there is manipulation of data, that is unacceptable and we're taking action.

So we're doing everything that we can, but am I impatient? Am I upset about it? Absolutely. We are—this is why it's our number one priority, Mr. Chairman.

The CHAIRMAN. Expound on the action that you are taking, because it appears, you know, that folks have said for almost a decade that it has been lack of training or improper training. That is 10 years that this has been going on, or more. Give me some concrete steps as to what you are doing, and have you really analyzed what the root cause—

Dr. SHULKIN. Yep.

The CHAIRMAN [continued]. —of this issue is?

Dr. SHULKIN. Well, let me first start. It's an excellent question, and very fair question. First of all, I want everybody to be clear, we do not have access or wait times in our performance measures. In other words, nobody's getting bonuses, there is no incentive whatsoever to be manipulating this financially as there was in the past. So, I think, thanks to your Committee's work, we make sure that that isn't existing.

So I'm going to go back to the fact that, in general, we mostly, of our 340,000 employees, have very, very good, dedicated employees; we have bad systems in place. One of the things that we've talked to you about is this is our current scheduling system to the right. It is DOS black screen. To think that this is how we're having our 32,000 schedulers have to schedule appointments invites confusion; it invites the inability to do this accurately.

So we are putting in now, currently being rolled out, the one to the left, which looks like a Microsoft Outlook calendar. That's important that we give our people the right tools. We're also evaluating a commercial system called MASS, which offers greater capabilities.

Number three, we are insisting that our leadership do visits to the schedulers personally, and where they find that people aren't scheduling appropriately, they're pulling their scheduling keys, and we're doing that on a regular basis.

We are talking about this and trying to do better training. We are taking disciplinary actions where we find that people have deviated. So we're just going to have to stick at this. I don't know any other faster magical way to make this happen, and I'm frustrated by it.

The CHAIRMAN. I think it would surprise many of the Members to know, or maybe it wouldn't, you know, we just saw an example of the scheduling software that is being used $127 million later, and we are just now looking at something that could be purchased off the shelf.

Quick question. GAO found that almost one-third of the veterans that it reviewed, 17 out of 60 did not get contacted for an appointment because they did not appear on the NEAR list, and one would assume that directors at these facilities neither knew this was occurring, nor they didn't know why a veteran would not appear on the NEAR list. And so the question is why would a hospital director not know?

Dr. SHULKIN. Yep. Well, when you read the GAO report, I think it's pretty clear that we didn't do the best that we could for veterans. So that's why we appreciate the spirit and the information 'cause it's going to help us do this better. So we are sunsetting the NEAR report, we are moving it towards an automatic system called Welcome My VA where we're contacting, reaching out to every veteran.

Part of the problem that was in the GAO report they said is we had the wrong phone numbers for some of these veterans, we couldn't reach them. When we reached some veterans, they didn't want appointments, they wanted C&P exams, so we got them there. Other veterans said, no thank you, I know I originally said I wanted an appointment, but I no longer want an appointment.

So we have to do a better job, but it wasn't that every veteran that Ms. Draper just mentioned we failed. We failed too many, but a lot of them, frankly, those facilities just weren't able to get in touch with or when they did, they didn't want the appointments.

The CHAIRMAN. Okay. And my time is expired, but I got one more question that I want to ask you because a lot of folks have talked about accountability at the table and wanting to hold people accountable for things that they had done, but, you know, in the media, there have been examples including an employee who participated in an armed robbery, a chief of staff that was improperly prescribing drugs to a VISN director's wife, a nurse who is being charged with manslaughter in the death of a veteran patient, they are all still on the payroll.

Similarly, according to the weekly list that VA provides to the Committee in the wake of the nationwide wait time manipulation scandal, VA has successfully fired only four people for wait time manipulation. How is any of this possible, especially those on the front end who have been—some of them have been convicted of crimes?

Dr. SHULKIN. Yep. Seems hard to believe, Mr. Chairman, so let me try to step through my understanding, and if I make any mistakes, I will commit to you that I will get back to you with that.

You mentioned the VISN director, he is not on our payroll; he's retired from Federal service. It is my understanding that the person who—who was found with some of the criminal allegations, no longer at the VA. The person—one of them actually is going through a court hearing and we're following the court's procedures on that.

But, look, somebody who does either violate the law or violate our principles does not belong at the VA, and we clearly take that seriously. We go through a very extensive process of, you know, due process to get them there, sometimes it takes a long time, but we do not want people that shouldn't be treating veterans treating veterans, and I take that very seriously. So if there are some of those cases that you've talked about that we haven't acted fast enough, we will go back and take a look at them.

The CHAIRMAN. You talked about the VISN director having retired, it wasn't the VISN director, it was his wife that was receiving prescription drugs by the chief of staff of that particular hospital.

And one other thing, something that hit the press a couple weeks ago and that was the doctor at Tomah that had his medical license suspended for emergency reasons by the state. I believe you took action, fired that individual, now a court or a—has been adjudicated that his license should not have been suspended on an emergency basis. So you have to, I assume, put that person back on the payroll—

Dr. SHULKIN. No.

The CHAIRMAN. Not on the payroll?

Dr. SHULKIN. Not the payroll.

The CHAIRMAN. Okay.

Dr. SHULKIN. No. No, you're correct about the court action, but that does not change our administrative action.

The CHAIRMAN. Okay. Is that person appealing at this point, your firing of them?

Dr. SHULKIN. My understanding is they're looking at their options in that regard, yes, sir.

The CHAIRMAN. Okay. Because my question would be, if that person is brought back on the payroll and subsequently the medical board goes through the normal process of suspending that person's license, how do you get that money back from that individual that comes back on your payroll?

Dr. SHULKIN. Well, you know, I think we have to let people have their due process, but right now we've made the decision, an administrative decision, not to have him on the payroll, and we are not planning on changing that decision unless there's new information that comes up that we would have to consider.

The CHAIRMAN. Okay. Thank you, thank you very much.

Ms. Brown?

Ms. BROWN. Thank you, Mr. Chairman. Mr. Secretary, it just seems like you have been here longer than nine months. This problem that we are having with the VA goes back more than ten years. I have been on this Committee for 23 years, and we have had problems with the VA over a long period of time, and it would be a misnomer to act like these things just occurred.

I would like to ask, and I am very concerned about, is that the GAO report have once again, just a couple of days ago, put VA on the high risk list. Explain that to me, and what we are doing to take care of this problem? I want to address the stand-down, what you all have done, and all the positive things that you have done? I am real concerned.

Dr. SHULKIN. Yes. Well, I believe that VA was placed on the high risk list probably well over a year ago because it was prior to my confirmation, but the GAO has been very clear about the reasons they put the VA on the high risk list.

We have inconsistent policies and procedures; we have not systematized best practices, or the best processes across the VA the way that a health care system should; and we have 102 outstanding recommendations, or at least that was when we went on the GAO report, I think we've gotten some of them down, but there's still many outstanding recommendations.

We work with the GAO now on a regular basis to show them how we're working to fix that, and in consultation with them. But look, the GAO was right in this regard. We have policies and procedures

that were conflicting, and we're working to fix that 'cause you can't have that.

The best practices across the system, that's what health care system should be doing, it's why it's one of my five priorities, and we are focused on learning from the best and putting it throughout the system.

This is going to make VA a better system, and I thank GAO for that. I'm anxious to get off this list fast. I don't agree with Mr. Draper's assessment that we're not making progress. I know we're making progress. It may not be as fast as she wants us to, or as fast as I want us to, but we're heading in the right direction and we're addressing the right issues.

Ms. BROWN. The stand-downs?

Dr. SHULKIN. The stand-down—the stand-downs are part of it, but the stand-downs aren't a way that you sustain improvements; they are the declarations of emergencies. When you have urgent patients that aren't being seen, they are emergencies, and we have to act like that. But they've led to sustainable improvements, our nine core principles of how we're going to redesign accessing the system. So ten years from now, a year from now, we're not going to be talking about this in the same way.

Ms. BROWN. When you all had the stand-downs, how many people showed up in the various areas?

Dr. SHULKIN. One hundred percent of our medical centers were open on those Saturdays. No exceptions. People asked for exceptions; I denied them. So we acted as a system in the country. Thousands of people—Dr. Lynch, do you have a number of how many?

Dr. LYNCH. I think we had 5,000 employees that were actually involved in the stand-down. There were 10,000 patients or so that were actually seeing on the day of the stand-down. But make no mistake, the stand-down was only a symbol. Everything was going on prior to that stand-down. So we were actually evaluating open consults, evaluating pending appointments, scheduling appointments, and assessing patients prior to that.

The stand-down was actually a way to really bring together the five points that are in Dr. Shulkin's priorities. We focused on access, we engaged our employees, we looked to the community for help where we needed it, we engaged best practices from across the networks, and we're working to basically restore trust with our veterans.

Ms. BROWN. I just want to say the next time that you all schedule a stand-down, it would be good to let the Members of this Committee know because we would like to attend, I know I would like to be at my center on a Saturday when this occurs.

Dr. SHULKIN. I know at the last stand-down, Congresswoman, I was in Orlando, Florida, and there were Members of the Congressional staff there. So we welcome your involvement.

Ms. BROWN. My last question. What policies, directives, have resulted from the stand-downs?

Dr. SHULKIN. What we've done as a result of the stand-down, we sequestered a team of people from the field, not from the central office, who have told us what needs to be done to redesign the system so we don't ever get long wait lists again of veterans who need care urgently.

And that led to this Declaration of Access, the nine core principles that every VA medical center is now signing their name to, committing to these principles to fix access in calendar year 2016 with same-day access in primary care and mental health, eliminating our recall system, which we've been using for veterans for a long time, and in making sure that we're using telehealth and expanded opportunities to improve access.

Ms. BROWN. Thank you. And thank you, Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Thank you very much.

I heard something I was unaware of just a second ago. You testified, I think, at a Subcommittee hearing on Thursday about the commercial scheduling software MASS that you just talked about, and I think your testimony was that it is on a strategic hold at this point. A hundred and fifty-two million dollars is what it would cost to do that? And the question is, how in the world could a pilot cost $152 million?

Dr. SHULKIN. Yep. So, again, the VSE, the VistA scheduling enhancement solution that's being rolled out now, total cost of the project, $6.4 million. MASS, which we do have a contract for—it's an IDIQ contract so we can implement this—the next step would be to do a pilot at three sites. It would be a ten-month pilot where you have to build the interchanges between VistA and MASS, and the cost of it is $152 million. The total cost of the national rollout is $600 and something million.

The CHAIRMAN. Okay. With that, Mr. Lamborn, you are recognized.

Mr. LAMBORN. Mr. Secretary, you paint a much too rosy picture. The system is broken. For those of us on the this side of the dais, we talk to the people, and we listen to the people, and the people in my district are very frustrated and angry that we have all of this dysfunction here in Washington, and more specifically with the bureaucracy that continues to fail our veterans.

People want real reform, real change, and not just talking points about how everything is about to be fixed. And I have even been told to my face, well, the problems were already fixed at the beginning of the study and what the GAO documented was—or, the Office of Inspector General documented was after the beginning of the study and everything is okay. We can't have a real conversation if you won't even admit that there is a problem in places like Colorado Springs.

I want to share with you a brief excerpt from a letter I recently received from a constituent who found it impossible to navigate the VA system to get health care. His case is important as an individual, but I think there are thousands like him. He wrote a respectful letter, but he is simply beyond being fed up. Here is an excerpt.

"Sir, I speak for myself and thousands of veterans when I tell you enough is enough." He says, "Stop the tough talk and for once act on the corruption and deceit going on at the clinics." And he is talking about the CBOC in Colorado Springs. He ends up with his letter describing a 14-month runaround with the clinic and says, "When will it stop?"

So when will it stop, Mr. Secretary? Veterans take way too much time to get their care, and they are not being able to really have access to the Veterans Choice Program, which is especially frustrating because that was implemented by Congress to try to stem the tide of some of this dysfunction.

So the first question, Mr. Secretary, according to the OIG, in places like Colorado Springs, VA staff did not add some veterans to the Choice list or did not add others in a timely manner. What we see clearly is that besides the VA altering the times for VA care, like Phoenix and other places all over the country, it now does the same thing by acting as a gatekeeper for veterans who should have access to Choice. Why aren't veterans really being given the opportunity to use the Choice Program?

Dr. SHULKIN. Okay. Congressman, if you think I've painted a rosy picture, I've failed because I'm telling you right now I am acknowledging that we still have significant issues, and we have a lot of work to do. That's why it's my top priority, and I'm not going to rest until we do get this fixed. It's why I came here, and I am focused on it, and you and I sound similar when I'm with my staff because I'm hearing directly from the veterans just like you. So I'm with you.

What I am saying, and maybe this is where you thought I was painting a rosy picture, I know we're headed in the right direction. Where we had 57,000 urgent veterans waiting more than 30 days for care, today that's 12,000. Our electronic wait list for our Level 1, our most important clinics, down 32 percent in the past couple months. Our veterans themselves are telling us on these kiosks—we can't manipulate this data, it's our veterans—that 89 percent are satisfied with their care.

The Choice Program isn't working for veterans, there's no question. We've told you that, and we need to make this system work better, and that's why we have legislation before you to try to simplify and streamline the care in the community to make this work better. So we have significant problems. I'm hearing the same things you are. We're headed in the right direction, but we are a long way from declaring that we've got this problem solved.

Mr. LAMBORN. Mr. Secretary, your own metrics from February of this year showed that 29 percent of veterans received appointments in excess of 30 days, 5 percent of those waited longer than 120 days, worst of all, over 2,400 veterans are still waiting on a wait list to receive an appointment, and 708 of those have been waiting longer than 120 days.

These metrics made the clinic in my district the eighth worst in the United States. So, and I know of at least three people who have died, and it could have been because of this waiting problem. It could have been directly a result of these delays.

So I do not see the VA fixing it. I don't really see them being held accountable. And I just have to agree with the man who wrote the letter to my office, enough is enough. Thank you, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Lamborn.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman. Dr. Shulkin, I am very concerned that the VHA has been placed on the GAO's high risk

list and that veterans are still struggling to get timely access to care. The VA has undergone significant change in the past year, and it will take continued commitment from those in this room and Members on the Committee to work together to make sure the VA is functioning the best it can to care for our veterans. But I want to move on to some other questions I have, Dr. Shulkin.

In your testimony you mentioned that one of the VA's top priorities remains legislation to streamline the process for VA to work with outside providers. Now I am concerned that the provider agreement legislation this Committee considered throws out crucial workplace protections in the name of expediency.

I offered an amendment when we marked up the provider agreement bill to ensure that the Office of Federal Contract Compliance Programs retained the authority to enforce workplace nondiscrimination protections. The OFCCP is the only Federal office that protects LGBT employees from discrimination in the workplace, and notably protects veterans from being discriminated against for their veteran status.

Your testimony seemed to imply that we can improve provider agreements without undermining workplace protections. Do you agree?

Dr. SHULKIN. What I agree with is, is that I know that we desperately need provider agreements to make this program work better for veterans. It's not working well and we need them desperately to be able to do that. I certainly don't know if there's an unintended consequence that you're talking about, and so I haven't looked at your legislation, but we have no intent of wanting to impose discrimination or to take away protections from people in putting in place provider agreements.

What provider agreements do is, too many small providers, the doctors and the small practices that are today caring for veterans, can't deal with the Federal contracting process. It's way too complex. They simply drop out, especially our nursing homes and our skilled nursing facilities. So we need provider agreements to be able to do a easy to do contract with our providers to care for our veterans. We certainly have no intent to discriminate against our employees.

Mr. TAKANO. I realize there is a need to get these providers on board as quickly as possible, I am concerned that in the spirit of quickly as possible that on two counts, the possibility of the LGBT people could be discriminated against, and our own veterans could be discriminated against, that we need to make sure we balance—

Dr. SHULKIN. Yeah.

Mr. TAKANO [continued]. —the desire to bring the providers on, but make sure those provider agreements are not discriminatory.

Dr. SHULKIN. Yeah. Yeah, Congressman, I have to tell you, I don't understand the linkage between what a provider agreement does and how it could potentially discriminate, but I will get back to you and have our legislative people help me understand that, because that's not our intent.

Mr. TAKANO. Well, thank you. Part of providing timely access to care requires having a sufficient workforce. Leveraging community providers can benefit veterans, but we must be mindful of the fact

there are many areas across the country that face health workforce shortages in the private market as well.

And that is why I was supportive of increasing the number of graduate medical school education residencies in the Choice Act. Can you keep—give us a brief update on how that rollout is going?

Dr. SHULKIN. Well, I think it is one of the most important things that you authorized as part of the Choice Act; we need to train more health care professionals. There are actually more medical students now than residency spots, and so the VA expanding these spots is important. You authorized 5,000, to date we've only—we've only implemented more than about 380 of those spots.

So we're continuing to work with your academic partners in your districts to look to expand these. There are a couple issues, one is the funding, as you know, goes away with the end of the Choice Program. So when an academic center—'cause we do this in partnership with academic centers, VA doesn't, with the exception of Puerto Rico, run its own GME programs.

So we say to our academic partners in California, would you like to expand your psychiatry program, and they say of course we would, but the funding's going to be eliminated when Choice is sunset. Then they say, well, what happens then? So that's one of the problems we'd like to work with you on.

Mr. TAKANO. I think there are Members on both sides of the aisle that are working with you on that—

Dr. SHULKIN. Yes, actually.

Mr. TAKANO [continued]. —as well as the Medicare cap issue.

Dr. SHULKIN. Yes. That's an important issue too, the Medicare cap issue. But we believe this is part of the solution: training more health care professionals in areas of need. I know, for example, in El Paso we're just working, thanks to the Congressman, to work with tech—with Texas Tech on the new agreement.

Mr. TAKANO. Well, I certainly appreciate my colleagues Mr. O'Rourke and Ms. Titus, and my colleagues on the other side of the aisle, for working together in a bipartisan way to deal with this germane issue.

Dr. SHULKIN. Yes, thank you.

The CHAIRMAN. Dr. Shulkin, there were two pots of money in the Choice, the 10 billion and then there was 5 billion. So the 5 billion doesn't sunset, the Choice Program sunsets, but the 5 billion is there until the 5 billion goes away.

Dr. SHULKIN. Yeah. My understanding is on the GME program, it has a five-year—it has a five-year length of time that you can use the funding for. If I have a correct understanding of that, that would be good news. So I'll look at that.

The CHAIRMAN. So it is your testimony today that the part of the reason you cannot get more slots is because of the sunset, and that needs to change?

Dr. SHULKIN. The reason we're not going faster, and we want to desperately go faster, is our academic partners need to agree to do this with us. They're telling us that there are two things in general that are preventing them from going faster. One is the Medicare cap issue. The Medicare cap says that if you go above your number, you can't get additional Medicare reimbursement, direct and indi-

rect graduate medical education funding. Many hospitals, every hospital I've worked for, has been at their cap or above.

The second is the length of time that it takes to start a program. When you start a program from ground zero to starting it, it often takes two years or so. If your money's going to expire before you graduate your first group of residents, the administrators at those hospitals say I'm not so sure this is a great deal for us.

So those are the two issues I'm hearing. If I have it incorrect about the money running out after five years, that would be good news and I will look into that.

The CHAIRMAN. Well, if we are just now talking about setting up the program, somebody is way behind the curve. The other thing is, I would tend to believe that the bigger issue is the Medicare cap issue and the reimbursement rates.

But, Mr. Bilirakis, you are recognized.

Dr. SHULKIN. Yeah.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it. Dr. Shulkin, you mentioned in your testimony about direct scheduling. I want you to elaborate on direct scheduling—

Dr. SHULKIN. Yes.

Mr. BILIRAKIS [continued]. —that is available to certain veterans for certain specialties, you mentioned ophthalmology and I believe one more.

Dr. SHULKIN. Yes.

Mr. BILIRAKIS. Elaborate, for the benefit of our veterans out there, who can direct schedule and why is it only limited to a couple specialties?

Dr. SHULKIN. Right. Right. The way the VA has done this for a long time is you go through a primary care physician, a gatekeeper. So you have to be able to get an appointment with a primary care doctor just to be authorized to get a consult.

I have to tell you, I practice now, I'm a primary care physician in the VA, my first appointment was just to get a pair of shoes. I had to actually approve a consult to get a pair of shoes. It makes no sense. So we've started piloting a program where veterans can now directly schedule, without going through a primary care doctor, in audiology and optometry. It worked terrifically.

We're expanding that now across the system. I think that was done in Florida. We're expanding that across the system. Then I want to look at, exactly as you're saying, other specialties: podiatry, social work, nutrition, you know, all sorts of things that, frankly, veterans can make the decisions themselves, they don't need primary care doctors' time to do it.

Mr. BILIRAKIS. Very good. Another question has to do with walk-in clinics. How many walk-in clinics are out there? Where you mention about access, same-day access—

Dr. SHULKIN. Yes.

Mr. BILIRAKIS [continued]. —is that widespread? Because we do have a walk-in clinic in our outpatient center in Newport Ridge, and I think it works very well.

Dr. SHULKIN. Yeah.

Mr. BILIRAKIS. How many walk-in clinics are out there? How long—what is the average time where a veteran would have to wait to get the same-day access?

Dr. SHULKIN. Yeah. Actually, where I practice in New York City at the VA, that's where I practice, in the walk-in clinic, so we're there—if anybody needs to be seen, we see them that day. Not all of our VA's have walk-in clinics. Of the sample I looked at, for example, of the six in the GAO report, three had walk-in clinics, three didn't. But what many—

Mr. BILIRAKIS. Why don't they?

Dr. SHULKIN. Well, because many, 34 actually have same-day access in their primary care centers. So if you can see your patients through your primary care center, you don't need walk-ins, the other ones do need some type of urgent care visits.

We do know that in areas that are challenged, they've actually begun some pilots with commercial urgent care clinics as well too. So this is part of our Declaration of Access. Everybody needs to get to same-day access for primary care by the end of 2016. Walk-in clinics are certainly a strategy to get there.

Mr. BILIRAKIS. So do veterans who need same-day access, do they all qualify, if they qualify for VA care, to go to a walk-in clinic?

Dr. SHULKIN. We don't have walk-in clinics in every one of our medical centers, but—

Mr. BILIRAKIS. Well, the ones that do?

Dr. SHULKIN. Yep.

Mr. BILIRAKIS. That the centers that do?

Dr. SHULKIN. The ones that do, I can tell you that if there's a walk-in clinic and they are eligible for VA care, they can walk in and be seen that day, yes.

Mr. BILIRAKIS. Thank you. Next question, again for Dr. Shulkin. One of the VA's legislative asks is to have flexibility and budget authority to avoid artificial restrictions that impeded delivery of care and benefits to veterans. However, the VA has experienced many issues in which they attribute to lack of training and education. Not too long ago, the VA encountered a budget shortfall for the same fiscal year, as you know. The VA did not submit to Congress a formal request for emergency funds until months after the VA had already identified a potential budget shortfall as early as March of that year.

This was in part due to the fact that the VA employees were not utilizing the $10 billion appropriated for community care through the Choice program, and utilizing the traditional non-VA care account. The VA's only solution was a potential shutting down of VA medical facilities throughout the country; that's unacceptable. The question is, should Congress allow such flexibility, what assurances do veterans and taxpayers have that employees will be trained this time around properly so that another budget shortfall, nor threats of medical facilities being closed, does not happen again? So give me some assurances, please.

Dr. SHULKIN. Yep. Well, Congressman, I think you got it exactly right, which is what we had was, we had spent all the money in one checking account so it got down to zero, and we had lots of money in the other checking account. In order to be able to give veterans care in the community, we had to come and ask you for authorization at the last minute.

What we're saying is, we don't ever want to do that again. That's not acceptable, it's not the right way to run a system, so we want

the flexibility to use care in the community funds to support veterans who get care in the community.

That means when we train our people in the system how to use it, we can train them that there's one pot of money and now focus on doing the right thing for veterans instead of following rules for seven to eight or nine different pots of money that, frankly, are too complex, and we've shown doesn't work for veterans. So that's why we really do need this type of legislation and we need your support in getting that passed.

Mr. BILIRAKIS. Thank you very much. I yield back. Thank you.

The CHAIRMAN. Thank you very much.

Dr. Ruiz, you are recognized for five minutes.

Mr. RUIZ. Thank you, Mr. Chairman, for holding this hearing. The issues that we are discussing are wrong in so many different levels, and I am going to talk about three. One, are your goals; two, are your data integrity; and, three, is the veterans' experience.

So goals are important because it defines your success, it helps you achieve your objectives. Setting a goal of 30 days is arbitrary, there is no clinical data to suggest that is the best practice anywhere in the health care literature. And you had mentioned a term which earlier in the beginning of your presentation about trying to match scheduling with the clinical practice. Right?

So we know that some illnesses are urgent, and emergent, and we need to really take care of them right away, and some others could be scheduled maybe more than 30 days, like your routine colonoscopies that you get once a year. Right?

So I think that you need to start perhaps changing your premise in getting more towards a clinical approach so that you can take care of your high priorities first and—not necessarily rush—take up a spot for your high priorities with things that can be done in a routine basis.

The second thing is setting up of goals of urgent care appointments within 30 days, which I recently heard of, is nonsensical. Then why are they urgent if you are going to wait 30 days? Usually an urgent is what you call your walk-ins or maybe even within 48 days when you want to match your clinical practice with your scheduling goals.

The third thing that I am concerned about in terms of your goals is the use of the word "same-day access for all primary care and mental health." You are setting yourself up for more controversy by not clearly defining to the veteran what access is. Is it going into—picking up the phone and having—speaking with a scheduler, is that what access means? Is it receiving the appropriate care, is that what access means?

So the second part is your data integrity. Now, we use population studies to reduce the chance that errors are done by chance, so that we can get a statistical significant accounting of whether this is a true problem and whether this is systemic. But the only way that we can really rely on those population studies is if your data is accurate, if your data has integrity, and the GAO is continuing to find faults in the way that you collect data and how you are reporting it. So you can understand why we are still skeptical when you tout the number that 96 percent of all appointments have been seen within this arbitrary goal of 30 days.

The other thing is the way you report data. So you are telling me that by veterans who use VetLink inside the hospitals are telling you that 89 percent of them rate their access good, what—you are giving me data with a very high reporting bias. Of course they are going to rate it good because they are already on the inside of the hospital. How about asking those that don't get access, that are not inside the hospital, to tell us what their access is going to look like?

So for those of us who know statistics and know methodologies, you know, we are skeptical when you report some of these reports to us that may not be as accurate as possible.

And lastly, when we can't rely on the population data, when we can't rely on the integrity, then we go by case studies. And case studies, depending on the accuracy, and the write up, and the details is what oftentimes we are left to look at. So let me tell you about a case of a wounded warrior who actually works in my office, who is a hero in my book, who went for his yearly checkup for the VA.

He is service-connected disabled, manages well, he is prescribed medication through the VA. After waiting 30 minutes on hold, 30 minutes on hold, the veteran was notified that because he had not had an appointment in over a year, he would have to schedule a new patient appointment, even though he was not a new patient.

He agreed to the appointment, asked to schedule that appointment as well. They couldn't fit him in until 134 days later. Again, arbitrary, right? As a result, this veteran elected Choice, but they still said you have to come in and do your new patient appointment before you get to your Choice appointment.

So, one, what does same-day access mean? And, two, why do these arbitrary numbers exist in the first place? And, three, why do they need to have—why do veterans need to have a new patient appointment after a certain amount of time, even though they have been getting prescribed medications, you know, as recent as a month?

Dr. SHULKIN. Okay. Thank you. I appreciate your skepticism. I think most doctors and politicians generally are skeptical of data and I think that's a good thing.

So let me very briefly tell you. First of all, you said it absolutely perfectly, the VA needs to clinically prioritize its appointments. That is exactly what I brought into the system. We used to have 31 ways of ordering a consult, today we have 2. It's either urgent or it's not. There is no 30-day rule for urgent care, I don't know where you got that. That does not exist. Urgent patients have to be seen now, that's why we did the stand-downs. I've never had a patient who has a urgent care need that I wasn't working to get them to be seen right away. That's our goal; get them seen right away when they have an urgent care problem. So I completely agree, and you said it perfectly.

Secondly, same-day access, what does it mean? It means resolving the veteran's needs that day. If they need a prescription refill, they don't have to come in, we can do that on the phone or electronically. If they need to talk about how to understand how to use their treatments, we can do that over the phone or from telehealth. But patients who are sick and need to be seen, should be seen that

day, that's what we're working to get implemented. So I agree with you, we have to set expectations and explain it in a way quicker than we can do today.

The last thing about the veteran's experience. Look, the only thing that matters, are we meeting the needs of veterans? The VetLink system that you talked about asks them when they're in the system, you're exactly right. So we have a second survey called CAHPS, it's what's used by the industry, the private sector industry too.

That asks whether you've been able to get in to see your doctors when you needed, both for routine and urgent care. So we compare ourselves to the private sector using CAHPS, internally we use the VetLink system because that's a point-of-care system. So all of your points are absolutely right, Congressman, and we take them to heart.

Mr. RUIZ. Thank you.

The CHAIRMAN. Dr. Roe?

Mr. ROE. Thank you, Mr. Chairman. And, Dr. Shulkin, you know I have great respect for you and one of the things I don't think I would have said if I were you is, at one year from now things will be different. I am not sure they will be. I hope they will be, but I am not convinced.

Just a couple, three, quick points I would like to have your answer on. One is if the VA is doing its job, why did we need a stand-down? What was that need to be done?

Dr. SHULKIN. Believe me, stand-downs are not the way you run a system. Dr. Roe, absolutely right. If we have to continue to do stand-downs, something's really wrong. The reason why you do a stand-down is because you've reached an unacceptable situation. The day I learned, literally the day I learned, we had 57,000 patients who had urgent consults greater than 30 days, I said there is nothing to do but to declare it an emergency. That's why two weeks from then we had our first stand-down, because it's unacceptable. But that can't be the way that you run the system. You have to put in sustainable fixes, that's what we're doing now.

Mr. ROE. And I looked at the number of schedulers you've got, you've got 32,000 schedulers, that is plenty of schedulers. Because I did the math right quickly in my head, and they scheduled ten people a day which shouldn't overwork anybody. That is way past 70 million schedules—I mean, appointments in a year. So you got that fixed.

If the system works—and I would like to have you guys define what an appointment is. And what I finally figured out through all this is, look, if the day I called you, if you are my doctor and I called, treed, that is the day I want—I am calling to get the appointment. What I would see happening was that you would tell the veteran, well, you don't have—we don't have an appointment the day you want it, but we have got one six, would that be okay? When the veteran says that is okay, that is their desired date, according to you guys.

Just look, the numbers are what they are, just go ahead and say we don't have it until then and if it is a problem, if you prioritize, as Dr. Ruiz said, the sicker patients, then see them early. Why is that hard? Why have we made this so difficult?

Dr. SHULKIN. No. So, Dr. Roe, a couple things, 32,067 schedulers seems like a lot. The only issue I would add to that is it's got a 25 percent turnover rate every year, you know, GS5s, and so you're constantly circulating people in and out.

Mr. ROE. Food restaurant, sounds like.

Dr. SHULKIN. Right. Secondly, seeing the urgent patients first, that's what health care systems need to do, that's what doctors do, absolutely. That was missing from the VA. That's what we're focused on now, I absolutely agree.

I think when you talked about how, you know, we assign clinically indicated dates, preferred dates, that's what the Chairman was talking about when he said there's this negotiation going on, that's where we're confusing people.

So look, we need to do better with that. We can't have it be an arbitrary way of assigning appointments and that's where I think we really need to move towards this veteran experience and seeing if we're meeting the veterans' needs because you can't manipulate data there, right? That's—you're listening to your patients, your customers, the data is what it is, and that's where we need to get to.

Mr. ROE. Yeah. And then if you—if everybody is speaking from the same—singing from the same song book, then you can make some changes, but you—when Ms. Draper comes in with completely different information, we hear from you all, how are we up here on this dais supposed to make any sense out of it?

And, Ms. Draper, a question to you. What would you be recommending to the VA after your analysis? Because, clearly, this is not what the VA is telling us is happening, this investigation that you did.

Ms. DRAPER. Yes. In that report, this recent report, we made three recommendations to VA. One was that we think the entire period that a veteran waits from the time that they first request care to when they actually receive care, that entire wait time should be monitored. There's a lot that can happen between the period a veteran requests care to when that preferred date is set.

So we made a recommendation with which VA concurred that that whole period of time should be monitored. The preferred date is really an artificial measure for the veteran. They really don't understand what that means. And so the veteran's wait time experience is from when they actually request care to when they actually receive it.

Mr. ROE. Got it.

Ms. DRAPER. So that's one. The second piece is that VHA has been without a scheduling policy since 2014. And what they've done, they implemented a scheduling policy in 2010; it was rescinded in 2014 after Phoenix.

And the way that they've provided guidance to the field has been through memos, and that's really not the way to do it; it's been a really piecemeal effort. The field will tell us that it's very confusing because they get memos, they don't know what they're supposed to be doing.

And so you need a really good policy which sets the stage for also really being able to do effective oversight because if you don't have a very clear policy or you don't have steps that you should be look-

ing at in the scheduling process, it's really hard to evaluate whether people are doing the right things or not. And we've heard a lot of confusion about that.

So those are some of the things. And VA, again, concurred with our recommendations. So there's a lot that needs to be done. I would say the other thing related to training is that I know that they have said that they trained over 32,000 schedulers—I don't know if they're all schedulers, but people with scheduling keys which could be other people as well.

But have they evaluated the effectiveness of that training? One of things that we saw when we went into some facilities, we saw schedulers, the same scheduler making multiple mistakes. We didn't see intentional manipulation, but the question to me is how effective is that training? Where's the oversight? And, you know, maybe there's some people that lack the capability or the skills to be able to do this job, and that needs to be accounted for. So there's just a lot of things that go into this whole process.

Mr. ROE. Mr. Chairman, I am going to yield back because I am over time, but there is one other subject that Mr. Takano brought up that we've discussed in the docs caucus, and maybe one of my colleagues will bring it up, is the GME implementation. It may be worth a hearing because what Dr. Shulkin is saying is correct.

We had the VA come over and talk to the entire docs caucus and we walked through that, and I have been walking through that in my local medical center trying to get this done. So I think it would be worthwhile in doing that, because 300, we would like to get them out there, get these young doctors in these training positions. I yield back. Thank you for—

The CHAIRMAN. Thank you very much. And we will. Let's go ahead and take care of that because the issues that you brought up are really the first time that I have heard that, and I think it is something that we need to go ahead and address as quickly as we possibly can. It is an easy fix from a legislative standpoint.

Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman. Secretary Shulkin, shortly after I arrived in Congress in 2013, I noticed a gross discrepancy between what the VA was reporting on wait times in the district that I represent, El Paso, Texas, and what veterans themselves were telling me.

In 2014, because we couldn't resolve that based on the data we were given by the VA and the assurances from one of your predecessors, Dr. Petzel, we commissioned a third-party independent survey of El Paso veterans that returned results with a margin of error under 5 percent, that showed that instead of waiting eight or nine days for primary or mental health care, veterans were waiting over 70 days, over 80 days, for those two respectively.

The conclusion I arrived at, and I still insist upon, is that the only way to find out how long veterans are waiting for care is to ask veterans directly. And so we will continue to survey. We surveyed in 2015; we will survey again this year.

I am glad to hear that you agree with Ms. Draper's conclusion that the VA must measure from the date that the veteran first requested help to the day that that appointment was delivered. And

for anyone who hasn't read this GAO report, this is illustrated graphically on the first page in a way that anyone can understand.

So I have a question about that. When will we receive those numbers, and when will that be standardized as the way that VA measures wait times so that we don't have preferred wait times with multiple points of potential failure and manipulation, and we just have you asked for an appointment on this day, you received it on this day, number one?

And number two, you gave a great presentation in October on the way forward for VHA that acknowledges that today we have 43,000 authorized, funded, but unhired positions within the VA. We will never hire all of them. We are going to leverage capacity in the community. We are going to specialize within the VA on what the VA should be doing best. That is something that needs to happen if we are going to resolve the fact that there is more demand than there is capacity within the VA.

Where are we on that? So those are my two questions, the standardizing of wait time reporting, and where are we on the October plan that you announced at the end of last year?

Dr. SHULKIN. Well, Congressman, I've already acknowledged that our systems for measuring wait times are overly complex and very difficult to understand. Where I believe that we need to go is to simplify this by looking at the veteran experience, by asking our veterans, are we meeting the needs of the veterans in the El Paso community?

That's the way that it's done in the private sector, they don't have these complex wait times. Remember we went out, we asked the Institute on Medicine, we've asked so many consulting companies, I can't even imagine, tell us the right way to do this, the way the private sector's doing it, and they've come back and they said there is no standard.

So I think what VA is doing is, we're measuring so much right now and trying to report everything, we're confusing the picture. So we have to get better at this, and we have to simplify it, and we are going to do that. I think what the GAO report is talking about is the new enrollees and that's where we've concurred that we will measure the full wait time. But I'm not anxious to start redefining wait times and getting even more data and more confusing; I actually want to simplify this.

On the issue of what do we need to do to go forward to work with care in the community, we need the legislation to streamline the care in the community, we need the provider agreement legislation passed because we need to fix this program for veterans, and we do need to work with the private sector.

We are committed to that as well as our Federal partners like DoD, the Indian Health Service, federally qualified health centers. So we think we did present a plan, we know that you're looking very hard at that, and we'd appreciate your support.

Mr. O'ROURKE. So on both of these issues, I would love to follow up with you to get written specifics on just when we'll have wait times reported in the way recommended by GAO. And, two, I want to know specifically what is on our plate that we have to finish in order to allow you to implement what I thought was a very ambitious proposal to make VA work for every veteran and get to what

you describe, which is outstanding care, and that should be the ultimate focus.

When it comes from my colleagues, when it comes to measuring wait times, we have introduced a bill the Ask Veterans Act, which would standardize throughout the country in each of our districts the ability to get objective third-party confirmed wait times, the actual wait times. The VA reports for April of 2016 that veterans are waiting 13 days in my district for primary care, 10 days for mental health care. When I say that in my town halls, I almost get laughed out of the room.

When we report back what veterans have told us in the surveys, they all nod their heads. This confirms the experience that they have had. So we welcome the support and collaboration of my colleagues on this, and I thank you for your commitment for making sure that we report more honest wait times for veterans in our communities.

Dr. SHULKIN. Thank you.

Mr. O'ROURKE. With that. I yield back.

The CHAIRMAN. Mr. Huelskamp, you are recognized for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I think the keyword I have been looking for in my time on here is accountability from the VA employees and leadership. And I want to drill down on a couple situations that I think are pretty striking examples and perhaps, Dr. Shulkin, you can clarify what has occurred here.

But apparently, what I understand is the VA in Puerto Rico has refused to fire a medical center employee who was convicted of crimes related to armed robbery, and apparently in comments to the media a VA spokesman apparently suggested it was okay for VA's employees to participate as long as it was on their free time.

Now, I am sure you don't agree with that. What is the VA doing to take care of this situation in Puerto Rico?

Dr. SHULKIN. Congressman, I am aware of that situation and I don't—it is my understanding, and, you know, I'm very careful, I want to give you accurate information. So if I misspeak on this, I will commit I will get back to you by the end of the day. But it is my understanding that that person is not currently working at the VA in San Juan.

Mr. HUELSKAMP. Is he on paid leave?

Dr. SHULKIN. No. That's not my understanding. Again, I will—I will personally make sure that we confirm that with you. But, no, that is not my understanding, that they are not an employee of the VA.

Mr. HUELSKAMP. Okay. I look forward to that. Second one, VA apparently, as I understand it, still has not disciplined the chief of staff at the Cincinnati VA Medical Center who was found had improperly prescribed controlled substances. What is the status of that particular employee at the VA?

Dr. SHULKIN. That situation, I'm a little bit closer to. If you will recall, I made a administrative decision to suspend their clinical privileges of the chief of staff, and she was actually in a acting chief of staff role, and also to remove her from that role. She is following her due process, which means that the medical staff is looking at the clinical privileges and there's a due process going on, on

the administrative decision I made. So there was both a administrative and clinical decision. But currently she's certainly not in that role, and she is not—

Mr. HUELSKAMP. And I appreciate the follow up on that. So no access to veterans as it stands today? No access?

Dr. SHULKIN. She's not in a clinical role and not in that leadership role, no.

Mr. HUELSKAMP. Okay. And what role is she in?

Dr. SHULKIN. My understanding is she's doing administrative reviews, like quality reviews.

Mr. HUELSKAMP. And has been found improperly prescribed controlled substances and is still doing quality reviews?

Dr. SHULKIN. We had concerns, that's why we took actions. We invited the Inspector General, that was my first request, to come in to take a look at this. I know that the DEA has also come in to take a look at this. We are waiting for their final reports on this before we can make a additional determination about that.

Mr. HUELSKAMP. And thirdly, going back two years, and I am looking at a statement from Mr. Sloan Gibson, it is in June 5th of 2014, and here is the statement. "In Phoenix, we initiated a process to remove senior leaders." And as I understand today, a number of those senior leaders are either still on paid leave or have not been removed, or are still working through the process, in particular, the Chief of Staff Darren Deering. Is that the case that it has taken two years, and Mr. Gibson has yet to fulfill that process and in that process to remove these folks that were covering up secret waiting lists that harmed up to 20 veterans?

Dr. SHULKIN. Yeah. I believe approximately 30 days ago Mr. Gibson did make a disciplinary decision on all three individuals. That decision was removal. They are each in their own process of due—of due process. Dr. Deering is a Title 38 employee, so he has a shorter period of time in which to do that. The other two are Title 5 employees, which is, we know we've talked about as part of the Accountability Act, takes a little bit longer.

Mr. HUELSKAMP. And I am out of time. So that is what I understand about that situation. So June 5th of 2014, the promise is made public, CNN, we are going to take care of this. As we sit here today, April 19th, still not completed the process to take care of someone and get them out of harming our veterans.

You know, Mr. Shulkin, I would ask you to pass on to your superiors, and I appreciate the work you are doing. We have got a VA Accountability Act to take care of this, for some reason the Senate is still sitting on it, they are talking about spending more money instead of taking care of these folks. This is absolutely outrageous, whether it is Puerto Rico, Cincinnati, or Phoenix, still almost two years later and we can't get rid of the folks that have harmed our veterans.

And just like Mr. O'Rourke, I go in town halls and say we have got a VA Accountability Act, they are really working for us, and they all laugh. They have lost all respect within the veterans community. And so we hear these numbers and I appreciate it, and I didn't get a time to ask questions because I have gone over, but I understand, you know, we had 58 cases referred to the Department of Justice for possible criminal charges.

That would be my thought from the Committee if we could find out what the response has been from those Justice Department to those 58 criminal cases and the disposition of those. So with that, Mr. Chairman, I appreciate letting me go over a few seconds. I yield back.

The CHAIRMAN. Thank you.

Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. Secretary, Shulkin, I appreciate your testimony today to say that your intention in your testimony, both written and your earlier testimony, was not to paint, you know, an extraordinarily positive picture, but to say that it paints a picture that we are on track, so I appreciate that.

I have to say, though, in your testimony, when you "That in April 1st, 30″—or "the wait time for VA overall is completed 96 percent of the time within 30 days overall," and that is data, I think, from February. When I was reading your testimony last night, I said to myself, oh, gee, it must be my district that is causing the four percent that is not there.

So I went back to look at the—I went back to look at the data, and as of April 1st, almost 30 percent of our veterans that I represent in the Oxnard CBOC in Ventura County have primary care appointments pending over 30 days. And, actually, I asked my staff for the data this morning and I think based on the data in that one metric, we are the second highest CBOC in the country with Dover, Tennessee, being the highest at 48 days for a pending appointment within 30 days.

So we have a problem, and we have had a problem, and I am extraordinarily excited that the VA Greater Los Angeles health care system has finally hired a medical center director who is permanent. We have had interims now for a year and a half to two years, I have sort of lost count.

But we are working very, very closely with Ann Brown, who was, I believe, is doing a very good job, and is very aware of what is going on in Oxnard. And, clearly, we have had trouble hiring and keeping teams there within the CBOC. I think we have a contracted out facility that plays a role. The Choice Program is not really working too terribly much in our district, so that is not as large a option as that we would like it to be.

So we know these things are happening. I guess, you know, my question is that if I was not watching this closely, my question is, is the VA watching this closely and would you have—nobody brought it to my attention, I just bring it to your attention. And so my concern is, you know, is the VA looking specifically at regional problems that is skewing your data perhaps, to really address these pockets within the country that aren't doing very well at all?

Dr. SHULKIN. Yes, we are tracking this. I think you have it correct, which is—which is that the—this is very different depending upon the geography of the country that you're in. So that we have some VAs that actually don't have backlogs at all, and others, like in your district, that have significant backlogs in primary care.

So we are paying attention to that, we're actually focused on those top 10 to 15 percent. We're sending our veterans engineering resource center teams out now to work with those most distressed

facilities to help them redesign their systems. We're focused on recruitment in areas that really are struggling with recruitment. So we absolutely are focused on that, but I think that it's a relatively new direction for us to focus on those areas that have been so—that really are struggling the way that yours is.

Ms. BROWNLEY. So when did you start working, you know, with—teamed up with the Oxnard facility to help facilitate some of the issues?

Dr. SHULKIN. Well, I think you identified it correctly in your district. You need permanent leadership in place and you need experienced leadership. Ann Brown, which, of course, as you know came from Jesse Brown in Chicago, is one of those experienced leaders. We knew Greater Los Angeles was one of our most challenged facilities, so we brought an experienced leader there. I think you're seeing that makes a big difference. But without having permanent experienced leadership in place, it's very hard to address this in a system as large as we are.

Ms. BROWNLEY. All right, but I can rest assured that the Washington team is working directly with Ann Brown to help facilitate this issue in Oxnard?

Dr. SHULKIN. I've recently been out there to visit with Ann—

Ms. BROWNLEY. Okay.

Dr. SHULKIN [continued].—and the Secretary, some people think he lives in Los Angeles, he goes there so often, so—

Ms. BROWNLEY. And I just want to, you know, say publicly that I believe that Ann is working very, very hard on this and I appreciate her leadership, and she is now giving my district office regular updates. But it is an eyesore compared to, you know, the rest of the country and needs that attention.

So Ms. Draper talked about—or you spoke actually, Mr. Shulkin, about working directly with the GAO now in a team to recognize where some of this—some of these improvements have come from, and I guess I just would ask Ms. Draper, you know, to ask you your feedback in terms of are those meetings productive, and are you meeting on a regular basis with specific agendas?

Ms. DRAPER. Yeah. So there are five criteria for removal from the high risk list. One is leadership commitment, one is capacity, and that's having the necessary resources, people and otherwise; a third piece is the action plan, fourth is monitoring, and then the fifth is demonstrated progress.

So what's happened thus far is that VA provided us a draft action plan in January, and it really addressed one of the five areas, and we felt that the action plan was not sufficient. So we met with them, provided them comments, and then we referred them to an agency we felt has done a really good job making progress on their high-risk status.

So they have gotten that action plan, and we have committed to VA that we will begin meeting with them starting the end of this month and then monthly. I think they are trying to get it on target to get us an action plan, a reliable or feasible action plan by August.

And that includes having metrics that we both can agree that show there's progress made. The first plan did not include that. So there's a lot of work to be done, and we are going to work with

them to provide feedback. It's a little difficult for us because we have to straddle the line of independence, but we can provide them feedback and direct them to other agencies that we feel have made good progress, improving their high-risk status.

Ms. BROWNLEY. Thank you. I apologize for going over. I yield back.

The CHAIRMAN. That is all right.

Dr. Abraham, you are recognized.

Mr. ABRAHAM. Thank you, Mr. Chairman. Like Dr. Roe, Dr. Shulkin, my respect for you personally is great, and I know in my heart of hearts you want to get this right. My concern is, like Ranking Member Brown said, this is way before your time, goes back ten years plus. So, you know, my concern is the culture of the VA, this may be a bridge too far to actually fix this problem within the VA system itself. And, you know, it may be time to look outwardly to a private sector to just do simply the scheduling.

If 89 percent of the veterans are satisfied with their care once they get there, we certainly want to enhance your ability to treat those veterans with the expert care that we know the VA gives our veterans' population. But we are talking today mostly about the scheduling issue where either VA has the inability or they lack resolve to actually get rid of these poor scheduling employees. And it is certainly in the private sector they can fire at will, and they are gone, and they replace them with somebody that does.

And your turnover rate you said 25 percent. You know, that is hard to keep any quality employee on task, on target, with that going on. And certainly, with the $152 million and extrapolate to the $600 million to implement the software program, you dangle that carrot in front of private enterprise, they are going to be knocking your door down to do this. And you know there are businesses that do this for a living, that is all they do is schedule patients.

So, again, just a thought and maybe a pilot program or something could be on the agenda, just to compare how the private sector does. On just the scheduling, I am not talking about health care for the veteran, but just the scheduling the veteran to get the appointment, and, you know, compare it against the VA's track record. So, again, just a thought.

Mr. Reinkemeyer, couple of questions to you. You had said that you guys are hopefully go to each VISN every three years and you look at data reliability, the Veterans Choice Program implementation, and the consult management if I remember the three tagged right. And I guess the first question on the data reliability that you guys are getting from the VA, because the old adage, garbage in garbage out.

If you don't get the data that you need, and if you don't trust the data that you get, then it is hard to make informed decisions. So the question is are you satisfied, are you comfortable to date, with the data that you are receiving from the VA on this issue of scheduling?

Mr. REINKEMEYER. No. We continue to see the data is unreliable, which is one of the reasons why we're going to try to implement this VISN approach. National reviews are great, where we sample so many facilities throughout the country. But we think if we can

push this down to a more local level and feed this information to the VISN management, and give them an opportunity to take control of their VISN and make changes, we think that's going to be more helpful. But the 96 percent, and the data that has been discussed today, we don't see it. I mean, every facility we go to, it's not accurate.

Mr. ABRAHAM. Okay. And my next question to you too, and it has a quote so I want to make sure I get it right. It says in a February 25, 2016, letter to the President of the Office of Special Counsel, said that the VA OIG investigations of whistleblower disclosures regarding wait times in Hines, Illinois"—it is Freeport, Louisiana, which is in my state—"were inadequate."

OCS found that, "The OIG investigations found evidence to support the allegations that employees were using separate spreadsheets outside of the VA's electronic scheduling and patient record systems. However, the OIG largely limited its review to determine whether the separate spreadsheets were 'secret'." Please explain why the OIG limited its review?

Mr. REINKEMEYER. So that review was conducted by our investigative staff, so I was not directly involved with that. I am aware of the concerns and I know Ms. Halliday, my boss, has made sure that we try not to interpret the allegations too strictly. And, you know, I can ask the Office of Investigations to get back to you on their response.

Mr. ABRAHAM. I guess my follow-up question, were there any criminal charges that were sent up to the DOJ for prosecution that you know of?

Mr. REINKEMEYER. So I would say, no, I don't know of them. I know that there were some and there's been discussions, but that's outside of our office.

Mr. ABRAHAM. Okay. Thank you, Mr. Chairman, I yield back.

The CHAIRMAN. Thanks.

Mr. Zeldin, you are recognized.

Mr. ZELDIN. Thank you, Mr. Chairman. Dr. Shulkin, April 7th USA Today story starts with, "Supervisors instructed employees to falsify patient wait times at Veterans Affairs medical facilities in at least seven states." Was that accurate?

Dr. SHULKIN. I've reviewed 72 IG reports, 11 of them were found to have intentional manipulation. So that would be accurate, but it's not representative of the majority of their findings.

Mr. ZELDIN. And of these supervisors, how many of them have been fired?

Dr. SHULKIN. We have for a total of all of those IG reports, when I add up going across that, we have 29 individuals that have been disciplined. I think Chairman Miller before had said four have been fired, I'm aware of five who retired under investigation. So rather than letting the investigation go forward, they decided to retire from Federal service.

Mr. ZELDIN. When you referenced the number 29 disciplined, that is from this USA Today story?

Dr. SHULKIN. From the 72 IG reports that I've reviewed. I sort of—I manually counted them up as we went through each of the accountability actions.

Mr. ZELDIN. Have any supervisors who instructed employees to falsify patient wait times, have any not been disciplined?

Dr. SHULKIN. Oh, I suspect that of people investigated, many—there were many, many more than 29. Probably lots more that were investigated and the evidence did not suggest that there was discipline that needed to be imposed.

Mr. ZELDIN. Okay. Are you saying that there were supervisors who instructed employees to falsify patient wait times who have not been disciplined?

Dr. SHULKIN. Of the investigations that we've done that found intentional manipulation, we then would send in our office of accountability review to do to these investigations. Everybody that was found to have a action or found to have a behavior that required disciplinary action, we have imposed or they have retired.

Mr. ZELDIN. So no one has not been disciplined?

Dr. SHULKIN. Oh, I wouldn't say that.

Mr. ZELDIN. We are going in circles right now.

Dr. SHULKIN. Yep.

Mr. ZELDIN. I am asking about the people who of the supervisors who instructed employees to falsify patient wait times, have any not been disciplined?

Dr. SHULKIN. You know, I don't know the—I don't know what your denominator is. Anybody that has been accused of a manipulation, we have investigated. When we have found that there's evidence that they did do the manipulation, we have implemented disciplinary action.

Mr. ZELDIN. None of those people haven't been disciplined?

Dr. SHULKIN. I am not aware of anybody that we found that was supervising a manipulation that we haven't implemented disciplinary action. Now sometimes after the action, they've appealed and those actions have been overturned.

Mr. ZELDIN. But no supervisor who you have investigated who has instructed employees to falsify patient wait times has not been disciplined?

Dr. SHULKIN. You know, Congressman, I feel like—I feel like I'm being asked some questions about—you have to ask me individuals, you'd have to say—

Mr. ZELDIN. I am asking about anyone.

Dr. SHULKIN [continued]. Well, look—

Mr. ZELDIN. Has anyone not been disciplined?

Dr. SHULKIN. These disciplinary actions have been going on well before I got here. What I—all the information I have, and this is not my responsibility to implement these disciplinary actions, we have an office of accountability review. What I'm telling you is, is that when I've reviewed these reports, when I find that other people have taken disciplinary action against 29 individuals, I'm sure there are many more that have been accused of supervising. So I don't know how to answer your question.

Mr. ZELDIN. Right. Okay. Well, I mean, it is a simple question. There was a USA Today story that says, "Supervisors instructed employees to falsify patient wait times in at least seven states." You are then saying that you investigate it, and if you have evidence to back that up, then the person is disciplined. I am asking

if through that process has anyone not been disciplined, and then we start going around in circles.

We are talking about patient wait times while we are here, we have issues with patient advocates, where I have constituents who will call a patient advocate, they will not get someone on the phone, they will leave a message, sometimes, many times they will not get a call back. Reports about calling a suicide hotline and getting a voicemail, in some cases not getting a call back.

A backlog of appeals this Committee is concerned about, greatly concerning numbers, the Denver VA hospital construction project. I have a constituent, John Mitchell, in an aid and attendance case with over 20 years of service, an Army Ranger in Vietnam with over 16 years in service with special ops. He suffers from traumatic brain injury that's directly connected to his service. One was from an accident in a military vehicle, another one was from a parachute fall.

And because the VA lost his file, he is being denied his benefits. Twenty-year veteran, Vietnam veteran, special ops, and he is unable to take care of himself. And we are getting all these different cases, but the only time that it comes to light for this Committee is when the Committee brings it up to the VA. The VA needs to be bringing these issues up to the Committee beforehand.

When one example after another doesn't come to light until this Committee brings it to light, or the USA Today does, or the Inspector General, or GAO, if it is not initiated by the Department of Veterans Affairs, it looks like a cover-up.

So you say that someone who violates the law, or violates our principles doesn't belong at the VA, well, I would argue that that goes straight up to the top of people who are violating the principles of the VA. And it is greatly concerning that it is this Committee responsible, and it is the GAO responsible, it is the Inspector General, it is the media responsible for bringing this to light, and you don't do that for us.

I yield back.

The CHAIRMAN. Thank you.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman. Just a question about the appointment wait times scandal because I think that we are getting kind of different summaries of it, if you will. And so wasn't the—you said that it wasn't about cash bonuses, but you didn't put a date on that, I guess that the policy had changed. But what was the policy in 2013 when this issue came to light?

Dr. SHULKIN. Congressman, I wasn't here then, so. But I believe that there was wait times as part of people's performance evaluations. And so, Dr. Lynch, am I correct in that?

Dr. LYNCH. Yes.

Dr. SHULKIN. So there was a potential of a financial bonus if people hit certain criteria.

Mr. COFFMAN. Sure.

Dr. SHULKIN. Today, that doesn't exist. There is nobody.

Mr. COFFMAN. So you allowed—people were allowed to retire who are under investigation, who were complicit in manipulating appointment wait times; is that correct? I think—

Dr. SHULKIN. I think I said the investigation didn't to conclude. Before the investigation was able to conclude, they retired from Federal service.

Mr. COFFMAN. So, but this involves fraud and fraud is a criminal issue. How many criminal referrals occurred of people who were involved in this scandal?

Dr. SHULKIN. My understanding—I don't know whether the Inspector General can help us with this—was that we did ask, I think this was actually Senator Blumenthal who asked that the Department of Justice come in to take a look at this, and they ended up declining on looking at most of these cases. But I know that there are referrals that go from the IG to the criminal division.

Mr. COFFMAN. Could someone comment on that?

Mr. REINKEMEYER. There are referrals and I know in every case where we suspect something we will make that referral. I can tell you, and this is not my area of expertise, but I think a lot of the money that you're referring to, the bonuses, while inappropriate, is not necessarily a high dollar amount, and there's not a lot of traction.

Mr. COFFMAN. So fraud is okay if it is a low dollar amount, is that what we are saying here today?

Mr. REINKEMEYER. Not for me, but I'm just saying—

Mr. COFFMAN. Really?

Mr. REINKEMEYER. —the Department of Justice, I think there's not a lot of traction if it's a small dollar amount.

Mr. COFFMAN. That is disappointing, under this administration, that that would occur. And let me state what is current law, and that is if somebody commits fraud, but is awarded a bonus, there is no clawback provision in current law; is that not correct? Who can answer that?

Dr. SHULKIN. I'm not aware of the answer.

Mr. COFFMAN. There is no provision. And, in fact, there is legislation before the Congress, and the position of the VA is neutral on that, which I find is appalling, as a taxpayer and as a veteran, that when somebody gets a bonus that they clearly did not earn, should not have been given, that the only provision in which the VA is allowed to claw it back is if it is given administratively to the wrong person. But if it is given to the person that is the subject matter of the bonus, even if they didn't earn it, there is no provision for clawback. That law needs to change, and the Secretary needs to take a position affirmative for that legislation and not simply sit on the sidelines. This is about cleaning up the VA. And the Secretary was giving a speech in Denver last weekend—well, I think it is two weekends ago—

Dr. SHULKIN. Yes.

Mr. COFFMAN [continued]. —that I was at where he said that the fundamental problem in terms of the appointment wait time scandal was a lack of training of VA personnel; is that correct? Was it due to a lack of training?

Dr. SHULKIN. I think what the Secretary most likely meant was that our system was complex and we weren't spending enough time training. But I don't think he would say that was the only factor. This was—there were many factors involved in this.

Mr. COFFMAN. It really had nothing to do with a lack of training, it had everything to do with people that were fairly skilled at manipulating the system, because what, in fact, they did was to make the numbers look smaller to get these cash awards, is that they pushed veterans out on these secret waiting lists who did not get health care and, in fact, there are veterans who died on those secret waiting lists.

And, you know, I don't know how we ever clean up problems in the VA if we really don't acknowledge their existence, and I really do not believe that the leadership of the VA has acknowledged the depth of the problems that exist here, and that's why they will never be cleaned up under current leadership. I yield back.

Mr. BENISHEK. [Presiding.] Mr. Bost, you are recognized.

Mr. BOST. Thank you, Mr. Chairman. Mr. Shulkin, I have to ask specifically. In the individual VA medical facilities, administrators and/or directors basically have the ability to monitor this with their own facilities, correct, so make sure they are the ones that are in charge of doing that; is that correct?

Dr. SHULKIN. Monitor this wait time?

Mr. BOST. This wait time and all of these.

Dr. SHULKIN. Yes.

Mr. BOST. They are the ones who do that?

Dr. SHULKIN. Yes, sir.

Mr. BOST. Okay. The concern that I have, and I am going to express this—and I am going to tell you about a bill that we are working on that you may be aware of. The problem is I see right now—St. Louis is one of our facilities—in the last 34 months, every 120 days or 280 days, depending on—or 240 days by your rule, we keep circulating directors in and out.

I ran business for years, and if—in 120 days I couldn't get all of my employees' names down, I couldn't—definitely couldn't figure out where the problems were. And whenever—I thought this was only in the St. Louis facility, but our research has found out that there is 40 facilities that are actually in interim directors that are just kind of cycling through like this. It is very hard to have oversight if someone is not there for a long period of time and they understand that is their job. Is there anything being done right now to try to cure those problems?

Dr. SHULKIN. Yes. First of all, I couldn't agree more. You can't solve the problems in the VA unless you have the right leaders in place and they need to be permanent leaders. So we're on the same page. St. Louis, very unfortunate. We actually had named a permanent leader who was coming—

Mr. BOST. He was no longer available.

Dr. SHULKIN [continued]. Yeah. He was coming from Hawaii, and because of personal issues he retired from Federal service. And so now we're back in a national search, and we have some candidates. So I am very focused on getting a leader in St. Louis.

But I don't count 40, I count 34. That's 34 too many. So we have national recruitments out in place. It's one of the reasons why we've asked again for your support for Title 38 legislation, because we need not only accountability in the VA, but we also need market rates that will help us attract the very best who will come to take

these jobs. Right now, there aren't enough people who want to come and take these jobs.

Mr. BOST. Because of salary?

Dr. SHULKIN. I think that the bad press that VA has been getting, our applications are down 78 percent from the date of the crisis. These are known to be very, very tough jobs and the salary is not anywhere near where what the market rates are for these jobs.

Mr. BOST. I am pretty sure that nobody wants to jump on a ship that is sinking. And that is the problem is—or maybe it needs to be sealed up and then bailed out in the condition that it is right now. And I think this is a possible—this just causes a downward spiral and I think it needs to be cured.

Now I am willing to work with you on that, and I understand the legislation we are going to be pushing forward gives the Secretary about 120 days to look over proposals on what it is that we can do and move forward to try to cure these problems.

With that, Mr. Chairman, I yield back.

Dr. SHULKIN. Thank you.

Mr. BENISHEK. Thank you, Mr. Bost.

I am going to yield myself five minutes to ask a few questions. Dr. Shulkin, as you know, we have been aware of this problem with the training and the procedures for these schedulers since 2005 when the Inspector General first reported on it, and it has been 11 years since then. And the Inspector General stated in its August 14 Phoenix report, since July 2005, the Inspector General has published 20 oversight reports on VA patient wait times and access to care, and that the VA has been resistant to change.

I guess my question is about the procedure for responding to and dealing with Office of Inspector General reports. Okay? This is something that I have been working on for years in my position here. Is someone actually put in charge of responding to a specific Inspector General report?

Dr. SHULKIN. Yes. I did not do, when I came into office, a major reorganization of VA leadership because I wanted us focused on this problem, fixing the wait time crisis, not internal politics. But the one thing I did do, was, I established a new deputy undersecretary for organizational excellence, whose position it is to focus on this. That's Dr. Carolyn Clancy.

Mr. BENISHEK. There is one person then—

Dr. SHULKIN. Yes.

Mr. BENISHEK [continued]. —has the responsibility—

Dr. SHULKIN. One office, one person.

Mr. BENISHEK [continued]. —to deal with this?

Dr. SHULKIN. Yes.

Mr. BENISHEK. So then that person will be held responsible for making sure that the Inspector General reported deficiency as corrected?

Dr. SHULKIN. Well, I will be held responsible and the Secretary ultimately is held responsible—

Mr. BENISHEK. Yeah, yeah. But it is difficult because—

Dr. SHULKIN. Yes.

Mr. BENISHEK [continued]. —you know, we have had so many Inspector General reports where the VA Secretary has agreed with the report and agreed to change it.

Dr. SHULKIN. Yes.

Mr. BENISHEK. The way things are going. But nothing has changed in 20, 30 years. You realize that, right? I mean, the Inspector General report—

Dr. SHULKIN. I do realize this.

Mr. BENISHEK. For example, I will give you a good example, identified the fact there is no central hiring process for physicians at the VA. That was reported, I think, 8 times over 30 years. That problem still exists.

Dr. SHULKIN. Yeah.

Mr. BENISHEK. So no one seems to have fixed that problem. So I want to have us where one person is responsible for responding to the Inspector General reports. Let me ask of Mr. Reinkemeyer, has there ever been an accountable employee assigned to fix a problem in your history with the Inspector General?

Mr. REINKEMEYER. So there's always someone assigned, but quite honestly, and I was involved with the first 2005 report, and we reported it. And until 2014, there was really no priority placed to it. We reported it in '05, we reported it in 2007. The right words were said, changes were made, but when we came back two years later, we found that nothing had been put in place.

Mr. BENISHEK. Right. Well, that is my experience as well. They say we are going to fix it, but then nobody is actually responsible, a name of an individual whose job it is, to actually make it happen, never seems to get fixed, you know. You think that legislation mandating that the VA assign a specific accountable employee to fix a problem would be an effective strategy?

Mr. REINKEMEYER. I think Dr. Shulkin was right that ultimately he's responsible and the Secretary. We make our recommendations generally to the Under Secretary for Health assigning responsiblity. I wouldn't think legislation would be necessary, but that's certainly something you can explore.

Mr. BENISHEK. I know, but that is what I mean by saying that, you know, there was this problem for 30 years with the IG telling the VA they need to have a central plan for hiring physicians. They said that to the VA six times over 30 years. The VA's agreed with them six times over 30 years. And, yet, nobody was ever assigned to fix that problem, and it still occurs today that there is no real central plan for hiring physicians within the VA.

So, I mean, you see what I am talking about, Dr. Shulkin?

Dr. SHULKIN. Yeah.

Mr. BENISHEK. That, you know, this is something that is a procedural, the way things are done. I mean, it is given to some Committee, it is given to some department, but then there is nobody actually who is in charge other than you. And then you say, well, you know, we are all working on it.

Dr. SHULKIN. But, Dr. Benishek, what I'm saying is, that is the organizational change I made. I have a brand new deputy undersecretary whose job it is to do that, and they've put together the Office of Medical Inspector, all of the compliance officers, the regulatory officers, the ethics people.

Mr. BENISHEK. What is his name?

Dr. SHULKIN. Well, Dr. Carolyn Clancy. You know Dr. Clancy.

Mr. BENISHEK. Okay. Okay.

Dr. SHULKIN. Yep.

Mr. BENISHEK. So then how many Inspector General reports has he looked at so far in that position?

Dr. SHULKIN. They've been keeping us pretty busy this year. We've looked at at least 72 on the wait times alone, and you've probably sent over a bunch of others on top of that. So I would say—

Mr. BENISHEK. Well, I would like to see—

Dr. SHULKIN [continued]. —probably over 100.

Mr. BENISHEK. I would like to see the Inspector General reports that he has looked at and what exactly he has done to respond to those Inspector General reports.

Dr. SHULKIN. Absolutely.

Mr. BENISHEK. All right. Thank you. I am out of time. And I think everybody has asked their questions. So we are just about ready for the closing.

Ms. Brown has a closing statement she would like to talk about.

Ms. BROWN. Yes. I want to ask Ms. Draper a question.

You mentioned the scheduler and that perhaps they are not getting an adequate training. We all know that a scheduler is an entry-level job. Do you think that the VA needs to do more to upgrade, because once a person is trained in that position, if they see another opening, they want to move up?

Ms. DRAPER. Yeah. Let me just back up a little bit because I think training is an issue, but I think it's much more complicated than that. I think there's oversight issues, the VistA scheduling system is really prone to user error. There's a lot of things that factor into the errors that we've seen.

As far as the schedulers, it is an entry-level position, it's usually generally GS4, 5, 6. In previous work that we've done, we heard from facilities that it's a very high turnover position, I think it's the number one or two clinical position within VHA that turns over each year. And so there's not really a good career path for those individuals.

And what we've heard is when someone demonstrates a high level of capability, they're often scooped up and moved someplace else. I think at one point a couple of years ago, they had instituted in some places a GS6, so there was a career path. My understanding is that that doesn't exist any longer.

It's a lot of pressure and responsibility on these individuals, so, it is important that they have the support, and the training and the oversight.

Because, as I said in my opening remarks, if someone continues to make the same errors, where is the oversight for that, and what happens when that continues to happen? Because that is what we've seen. So it raises the question about oversight. And, you know, quite frankly, whether some of these people are really able to do the jobs that they're put in.

Ms. BROWN. Thank you. Mr. Secretary, last thing. I have gone to the medical schools in the Orlando area with the Secretary, but I didn't know that there was some problems with it. I know we need additional slots. I am hoping that you all will get back with us, and if there is something that we, on our side, need to do, I know we want to do it because we need those additional physi-

cians. And, of course, if they train and have those residents, they will probably stay in the area.

Dr. SHULKIN. Yes. Yes. We would—we'd welcome further discussion on that.

Ms. BROWN. And in closing, I am hoping that the veterans that is listening to what we are doing today understand that we are seeing over 2 million additional veterans in 2015 than 2014, over 226 appointments per day.

So if veterans need to come to the system, don't be dumbed down by what you hear in here, go and get assistance. Go to your Member's office. Go to the VA.

And with that, you know, we all need to soldier up and make sure that the veterans are being taken care of. Thank you, and I yield back the balance of my time.

Mr. BENISHEK. Thanks to the entire panel for being here. You are now excused.

Today we have had a chance to hear about the many ongoing problems related to Veterans Access. Oh, I guess we are going to have the Chairman give a closing statement or something.

The CHAIRMAN. [Presiding.] No. No closing statement. I just confirmed with the Caribbean health care system that the individual that we were discussing is still on the payroll.

Dr. SHULKIN. Thank you for correcting that.

The CHAIRMAN. So, again, the question is, why in the world would somebody who has been convicted of armed robbery still be working at the Department of Veterans Affairs?

Dr. SHULKIN. Okay. Well, hard for me—hard for me to answer that right now. So I think we know owe you an answer.

The CHAIRMAN. Please. Thank you.

Mr. BENISHEK. Thank you, Mr. Chairman.

We have had a chance to hear about many of the ongoing problems related to veterans access to health care that continue to occur today over two years since the wait time scandal.

As we have discussed, the VA has not taken the aggressive steps needed to improve access to care for veterans. Until the VA stops using the excuse of poor training to explain away systemic wait time manipulation, begins holding itself accountable, nothing will change. Dr. Shulkin, it seems to me that the I CARE, and MyVA Access Declaration are just words. These ideas speak to an intent, but to this Committee and to veterans, results are what counts. Slogans and rhetoric designed to deflect blame are not good substitute for action-oriented results.

Until VA addresses the issues we have discussed today, beginning with accountability, our veterans will have to hope the VA gets itself squared away. But as we know, hope is not a plan.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks, and to include extraneous material. And without objection, so ordered.

I would also would like to once again thank all of the witnesses and the audience members for joining us today. And with that, the hearing is adjourned.

[Whereupon, at 12:35 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Chairman Jeff Miller

I would like to welcome everyone to today's hearing titled, "A Continued Assessment of Delays in Veterans' Access to Health Care." This hearing marks two years since this Committee exposed the wait times scandal that gripped the department in 2014. I am proud of the work we have done in those two years, particularly digging into the actions of corrupt bureaucrats who put self-interest ahead of the veterans they are charged with assisting.

The purpose of this hearing is to examine the efforts VA has taken to improve access to care for veterans and to identify where serious issues persist. Based on this Committee's investigation, GAO undertook an audit of new patient primary care wait times at six facilities across VHA. GAO's review found that veterans at those facilities waited between 22 to 71 days, which is significantly more than the five-day average Secretary McDonald declared earlier this month. This discrepancy can be easily explained.

First, VA only tracks and monitors a portion of a veteran's actual wait time when tracking access data. Instead of considering a veteran's wait time to be from the date when the veteran first contacts VA to request an appointment to when the appointment takes place, VA considers a veteran's wait time to be from the date when the veteran wants the appointment to occur to the date when the appointment actually occurs.

This is problematic because it does not take into account: the time it takes a VA scheduler to contact the veteran to schedule the appointment; the fact that it is a regular practice for schedulers to "negotiate" a desired date with a veteran; or the fact that outright manipulation of desired dates to zero-out wait times is one of the most prevalent types of data manipulation occurring in VHA. In effect, VA continues to ignore the main forms of data manipulation, while it continues to come to congress saying it no longer occurs. To this point, you will not find what you do not seek.

The obvious result of VA reporting only a portion of veterans' actual wait times is artificially low results. I still do not understand a culture that persists in presenting inaccurate data. A true picture of wait times, or more importantly the veteran experience, can help us ensure an adequate allocation of resources. But, when this Committee only hears requests for more manpower, more space, and more flexibility, it is hard to reconcile the additional resources with a reported "wait time" of only five days. This discrepancy between reality and VA's claims was captured by GAO in its report where VA data shows that wait times were at best understated by 2° times and at worst 11 times the full wait times experience of veterans reviewed in the audit.

Another tactic VA uses to make its wait times appear lower is to combine the shorter wait times for the large pool of established patients with the longer wait times of the smaller pool of new patients. This dilutes the wait times data making new patients' waits appear shorter since they have been comingled with data from the other cohort.

For years, VA has blamed incorrect appointment scheduling and long wait times on training issues, largely because it was warned about those issues as far back as 2005, when the OIG published a report highlighting improper scheduling practices and poor training. Many OIG and GAO reports since then have found the same scheduling problems. Yet, in the 11 years since, VA continues to blame wait time manipulation on the same cause, a cause over which VA has complete control.

Secretary McDonald has repeatedly asked that we allow him to run VA like a business. But, I can assure you that if an executive running a company used the same excuse to explain away problems 11 years in a row, with no change to show for it, that individual would be out of a job. But, not at VA. Despite years of reports confirming systemic issues, the department has successfully fired just four people

for wait time manipulation while letting the bulk of those behind its nationwide delays-in-care scandal off with no discipline or weak slaps on the wrist.

Another issue regarding accountability is how VA continues to ignore retaliation against whistleblowers who report wrongdoing. The Committee asked VA for all adverse actions where an employee was disciplined for "retaliation against a whistleblower". VA provided the Committee a list showing that as of March 15, 2016, only six individuals were disciplined for whistleblower retaliation.

However, upon further review, one of the listed employees is Sharon Helman, who the committee has shown was not successfully disciplined for whistleblower retaliation and was in fact successfully disciplined for failing to report accepted gifts. Two of the other disciplined employees listed were "Houskeeping Aid Supervisors", who are clearly not high-level supervisors. That leaves three employees: two received reprimands and one received a less-than-fourteen-day suspension. To be clear, according to VA provided documentation, no employee has been removed for whistleblower retaliation. This is representative of the fact that, contrary to public statements by VA officials, whistleblower retaliation appears to most certainly be tolerated by the department.

So now, two years after what was and is a systemic crisis in care being brought to light, it is time for VA to stop using misleading data to tout wait times successes that simply do not show the real wait time experience of veterans. I want to hear what concrete actions have been taken, what fundamental changes have been made, and what tangible, cultural shifts are occurring. Advertising artificially lowered numbers does nothing to stimulate the change needed to improve veterans' access to care.

Prepared Statement of Corrine Brown, Ranking Member

Thank you, Mr. Chairman, for calling this hearing today.

Following the wait time scandal in Phoenix, Congress passed, and President Obama signed, the Veterans Access, Choice, and Accountability Act of 2014. In it, we mandated that there be an Independent Assessment of veterans' health care.

The Assessment highlighted many of the things we hear from our veterans. We hear that VA provides excellent health care, especially health care related to the special needs of our veterans. We also hear that in certain areas, VA is at the forefront of health care in this country. We also hear from our veterans that VA care is often fragmented, and that it can be difficult to navigate and arrange non-VA care. We hear of long wait times and limited access.

Following the assessment, in the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, we mandated a report by the VA regarding a plan for how VA could consolidate all purchased care programs into one New Veterans Choice Program. We received that report late last year and this committee is currently working with the VA on the best way to implement the legislative requests.

The VA is on track to see 6,277,360 unique patients, and 9,247,803 unique enrollees. In FY2015, VA completed 56.7 million appointments, nearly 2 million more than FY2014. That is roughly 226,000 appointments per day.

The number of patients the VA sees would put any other health care system to shame.

I am pleased the GAO studied newly enrolled veterans and their access to primary care. In my conversations with veterans, time and again they say that once you get into the VA system the care is the best in the world. It is this initial appointment that is so hard to get. I am troubled by the GAO findings that "nearly half were unable to access primary care because VA medical center staff did not schedule appointments for these veterans" in a quick timeframe.

The GAO report goes onto say that "veterans' access to primary care is hindered, in part, by data weaknesses and the lack of a comprehensive scheduling policy." Just last week in a Subcommittee hearing, Under Secretary Shulkin and Assistant Secretary Council testified that they were working together through the MyVA initiative to modernize VistA and work on a scheduling system that is focused purely on scheduling. I support the VA in working to fix the scheduling and be able to get data we can trust.

We are at a tipping point right now as to what the VA will look like and the services it will provide for veterans in the coming decades. I look forward to hearing from our witnesses today on what this aspect of the VA will look like in the future.

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

Prepared Statement of David Shulkin, M.D.

Good morning, Mr. Chairman, Ranking Member Brown, and Members of the Committee. Thank you for the opportunity to discuss the efforts that VHA has taken to improve access to care for Veterans. I am accompanied today by Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health for Clinical Operations and Dr. Poonam Alaigh, Senior Medical Advisor.

The year 2014 was one of the most significant times in VA's history. To say that we had a crisis on our hands would be an understatement. After losing the trust of the Nation, and most importantly, Veterans, we had to look at every basic principle of operating a health care system. Without the appropriate data, we were unable to truly understand how much space, staff, and other resources were really needed.

When I first entered this office approximately 9 months ago, I began to realize that the access issues had been slowly building up for many years and that correcting those issues had to be addressed systematically, rather than piecemeal. We needed to re-design and re-launch our approach to access in order to provide the care for Veterans that they have earned and deserved.

As a whole, VA is working to rebuild trust with Veterans and the American people, improve service delivery, and set the course for long-term VA excellence and reform, while delivering better access to care. This initiative is called MyVA. All of us in the VA health care system are focused on the MyVA initiative.

To ensure that VHA remains aligned with MyVA, I developed five priorities that are the focus of VHA. My first priority is to fix the access issues and continue to work on reducing the wait time for Veterans who need our services. In order to do this, we need to get the right leaders in place at VHA who understand that it is their job to take care of Veterans. We also need to change the way that we measure wait times and put in place a new system for how we see Veterans that focuses on the clinical urgency.

Immediate Steps - Addressing Urgent Care Needs

VA's ability to improve access to care and improve the Veterans' experience is tied directly to how we meet the urgent health needs of our Veterans. We must identify who needs the help the most and commit to treating those Veterans who have clinically urgent needs as soon as possible. As long as there is even a single Veteran with an urgent care need that we are not meeting in a timely fashion, we will not be satisfied. That is why VHA hosted two National Access Stand Down events - one on November 14, 2015, and a second on February 27, 2016 - at all VA Medical Centers. The immediate goal of the first event was to connect with Veterans that have urgent health care needs; address their needs; and reduce the number of Veterans waiting greater than 30 days for urgent care. This initiative ensured coordinated efforts to increase access to health care by:

- Maximizing the opportunities for "same day" appointments as much as possible;
- Getting timely and convenient care, referrals and information from any VA medical center, not just the Veteran's preferred VA care facility; and
- Ensuring Veterans see their provider within 30 days of their preferred date or date of clinical need.

The February 27, 2016 event resulted in VA reviewing the records of more than 80,000 Veterans to get those waiting for urgent care off wait lists. Approximately 93 percent of Veterans waiting for urgent care were contacted. Since not every type of clinic appointment has the same urgency, or the same medical risk to the patient in the event of delay, we focused on addressing the highest priority needs first. Both of these events proved to be a success, and the goal is to keep the momentum going. We also know that it will take much more to fix access issues and achieve the goal of providing Veterans same day access for primary care.

Declaration of Access

The focused Access Stand Down events in November 2015, and February 2016, have addressed Veterans with urgent needs and significantly reduced the number of Veterans waiting for care. Moving forward, we developed the "MyVA Access Declaration," a set of foundational principles for every VHA employee to improve and ensure access to care. The MyVA Access Declaration is our pledge to improve access to care for Veterans by committing to a list of access improvements. This list of principles will be distributed to VHA staff and VHA leadership and staff will hold

themselves responsible for meeting these commitments over the course of the next year.

We aspire to provide access to care based on the following core principles:

- Provide timely care including same-day access in Primary Care, as needed;
- Respond to routine clinical inquiries within 2 business days;
- Offer follow-up appointments upon the Veteran leaving the clinic;
- Involve Veterans in the process of making or canceling appointments;
- Not cancel clinic appointments without appropriate Veteran notification and rescheduling;
- Integrate community providers as needed to enhance access;
- Offer Veterans extended clinic hours, and/or virtual care options, such as TeleHealth, when appropriate; and
- Transparently report to the public and manage access to care data for Veterans.

The MyVA Access' goal for 2016 is when a Veteran calls or visits primary care at a VHA Medical Center, their clinical needs will be addressed that day. It is important for Veterans to be in control of their health care. We are changing our old systems that have been in place for decades at VA to a system that works for Veterans and is focused on contemporary practices in access. This initiative and the Declaration represent VA's pledge to improve access to care for all Veterans seeking VA health services. MyVA Access will ensure coordination of initiatives and their rapid deployment to meet the access needs of Veterans at VA medical centers.

Moving toward long-term transformation, VHA has already implemented a number of actions to address access, quality and patient satisfaction within the larger transformation of MyVA. Within the 12 Breakthrough Priorities laid out by Secretary McDonald, 2 focus squarely on health care outcomes, specifically improving access to care and improving community care. Since the introduction of the MyVA initiative, VA has made significant progress in improving access to health care:

- Nationally, VA completed more than 57.36 million appointments from March 1, 2015, through February 29, 2016. This represents an increase of 1.6 million more appointments than were completed during the same time period in 2014 through 2015.
- VHA and Choice contractors created over 3 million authorizations for Veterans to receive care in the private sector from February 1, 2015, through January 31, 2016. This represents a 12 percent increase in authorizations when compared to the same period in 2014 through 2015.
- From fiscal year (FY) 2014 to FY2015, Community Care appointments increased approximately 20 percent from 17.7 million in FY2014 to 21.3 million in FY2015.
- VA completed 96.46 percent of appointments in February 2016, within 30 days of clinically indicated or Veteran's preferred date.
- VA continues to expand and improve the VCL, which has answered nearly 2 million calls since its launch in 2007. Nearly 490,000 calls, or a quarter of these 2 million calls, were answered during the last fiscal year. VCL responders dispatched emergency responders to callers in crisis over 11,000 times last year - over 53,000 times since 2007.
- VHA has increased net onboard staff by over 17,000 employees since the beginning of FY15 through February 29, 2016. This includes over 6,000 nurses (RN, LPN & NA), 1,550 physicians, 112 psychiatrists, and 450 psychologists.
- Women Veterans Call Center (WVCC), created to contact women Veterans to inform them about eligible services. As of February 2016, WVCC received 30,399 incoming calls and made 522,038 outbound calls, successfully reaching 278,238 women Veterans.
- In FY2015, VA activated 2.2 million square feet of space for clinical, mental health, long-term care, and associated support facilities to care for Veterans.
- VA increased its total clinical work (direct patient care) by 10 percent over the last 2 years as measured by private sector standards (relative value units). This increase translates to roughly 20 million additional provider hours of care for our Veterans.
- VHA offers an extensive community provider network of over 257,000 providers through the Patient-Centered Community Care/Choice Programs and more are joining each month.
- VA Telehealth services are critical to expanding access to VA care in more than 45 clinical areas.
- In FY2015, 12 percent of all Veterans enrolled for VA care received Telehealth based care. This includes 2.14 million telehealth visits, touching 677,000 Veterans.

Veteran Experience - Veteran Satisfaction

The ability to describe wait times does not exist anywhere outside of the VA, so there is no standard on how to report wait times. We have gone to such lengths to make sure that we document every aspect of wait time data that we have developed a system that is too complex and has proven too confusing to Veterans, our employees, and Congress. Although the data may be accurate, they do not reflect the actual Veteran experience. Therefore, we have decided to use a singular measure - asking Veterans, our customers - whether they were satisfied with being able to get care when they need it. VHA currently utilizes sign-in kiosks at VA facilities all across the country to assess patient satisfaction, of those Veterans who obtained appointments, with their ability to get their appointment when they wanted it. Eighty-nine percent of Veterans were completely satisfied or satisfied with their ability to get care when they wanted it.

As the Under Secretary, I want to ensure that we can say there are no Veterans who need care now who are not receiving it. We are not fully there yet, but that is the direction to which we are moving.

Legislative Priorities

VA is grateful for your continuing support of Veterans and appreciates your efforts to pass legislation enabling VA to provide Veterans with the high-quality care they have earned and deserve. As the Department focuses on ways to help provide access to health care across the country, we have identified a number of necessary legislative items that require action by Congress in order to best serve Veterans.

Flexible budget authority would allow VA to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.

VA also requests your support for legislation that would allow VA to contract with providers on an individual basis in the community outside of Federal Acquisition Regulations, and includes explicit protections for procurement integrity, provider qualifications, price reasonableness and employment protections. Such legislation will ensure that VA is able to provide local care to Veterans in a timely and responsible manner. VA would support language that addresses concerns related to employment nondiscrimination and equal employment protections. We would have strong concerns with any legislative language, such as that currently being considered by this committee, that rolls back employment protections. VA further requests your support for our efforts to recruit and retain the very best clinical professionals. These include, for example, flexibility for the Federal work period requirement, which is not consistent with private sector medicine, and special pay authority to help VA recruit and retain the best talent possible to lead our hospitals and health care networks.

Conclusion

VA is committed to providing timely access to Veterans as determined by their clinical needs. VA Medical Centers will be making sweeping changes over the next several months to realize the goal of same-day access for our Veteran population. We realize the significant work that remains ahead. The good news is that moving forward, along with Congress, we have an opportunity to reshape the future and make long-lasting valuable changes. We also look forward to the Commission on Care recommendations to inform or planning and execution. We appreciate Congress' support and look forward to responding to any questions you may have.

Prepared Statement of Larry Reinkemeyer

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work concerning veterans' access to health care. The OIG has issued many reports that have addressed various impediments to patient access to health care. Most recently, our audit work has centered on VA's purchased care programs and the challenges VA has faced in administering them. I am accompanied by Mr. Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations.

BACKGROUND

For more than a decade, the OIG has conducted oversight of the Veterans Health Administration's (VHA) performance in providing veterans timely access to care. Our reports have brought attention to problems relating to wait times, scheduling practices, consult management, data integrity, clinician staffing shortages, and the lack of physician and nurse staffing standards. We have repeatedly reported that VHA managers need to improve efforts for collecting, trending, and analyzing clinical data.

Two years ago, VHA's inability to provide veterans timely access to care became the subject of national focus following allegations at the Phoenix VA Health Care System (PVAHCS) in Phoenix, Arizona, that included gross mismanagement of VA resources, misconduct by VA senior hospital leadership, systemic patient safety issues, and patient deaths. On May 28, 2014, we published a preliminary report substantiating serious conditions at the PVAHCS.[1] We provided VA leadership with recommendations for immediate implementation to ensure all veterans receive appropriate care. Our August 26, 2014, final report reflected the full results of our review, including case reviews of 45 patients who experienced unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care.[2] We made 24 recommendations to correct conditions identified at PVAHCS. To date, VHA has implemented 20 of the 24 recommendations.[3] Recommendations addressing potential disciplinary actions, consult reviews, use of the electronic waiting list, and efforts to improve procedures used by schedulers to make appointments will remain open until VHA completes the actions necessary to implement the recommendations.

As we have previously indicated, the surfacing of allegations related to wait times and delays in care at PVAHCS was a watershed event for VA and the OIG. Since April 2014, the national attention sparked by reporting on PVAHCS led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline and the number of inquiries and requests sent to us by Members of Congress. A number of these Hotline contacts continue to allege inappropriate practices by VHA staff that undermine the integrity and reliability of wait time metrics as well as allege that VHA's initiatives to provide veterans community care are not working.

Since the publication of our August 2014 report on PVAHCS, we have initiated a series of audits and reviews evaluating the extent to which veterans are able to receive timely care. Although we have completed audits and reviews and published comprehensive reports, a number of more recent reviews are still in progress. One example is an audit we are conducting at the request of Congresswoman Kyrsten Sinema to review the PVAHCS Human Resources Department to determine how effectively they manage their Medical Support Assistant workforce to facilitate veteran access to outpatient care. The results of our completed work are consistent-VA continues to face challenges in providing timely access to care and the management of consult appointments at various points of service.

HEALTH CARE ENROLLMENT

Veterans are experiencing delays even at the initial application and enrollment for health care. Most veterans must apply and be determined eligible in order to be enrolled for VA health care. Eligibility for enrollment is determined by evaluating evidence of qualifying military service and financial income status, if necessary. The Health Eligibility Center (HEC), a component of VHA's Chief Business Office (CBO), is VA's central authority for eligibility and enrollment processing activities as well as the business owner for the Enrollment System (ES), the authoritative system for veterans' health enrollment and eligibility information. Although ES serves as VHA's official electronic system of record for veteran health care enrollment information, it also contains the names of all VA patients as well as applicants whose military service was not confirmed.

In our September 2015 report, Review of Alleged Mismanagement at the Health Eligibility Center, we substantiated the existence of about 867,000 pending records residing with the HEC that had not reached a final determination as of September 30, 2014. Pending records included entries for over 307,000 individuals reported as deceased by the Social Security Administration. However, due to limitations in the HEC's ES data, we could not reliably determine how many of the pending records

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[1] Interim Report - Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System (May 28, 2014).

[2] Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System (August 26, 2014).

[3] Recommendations 9, 13, 19, and 21 remain open as of April 14, 2016.

existed because of applications for health care. We also determined that employees incorrectly marked unprocessed applications as completed and possibly deleted 10,000 or more transactions from the HEC's Workload Reporting and Productivity (WRAP) tool over the past 5 years. WRAP was vulnerable because the HEC did not ensure that adequate business processes and security controls were in place, manage WRAP user permissions, and maintain audit trails to identify reviews and approvals of any deleted transactions. The HEC identified over 11,000 unprocessed health care applications and about 28,000 other transactions in January 2013. This backlog developed because the HEC did not adequately monitor and manage its workload and lacked controls to ensure entry of WRAP workload into ES. The Under Secretary for Health (USH) and the Assistant Secretary for the Office of Information and Technology concurred with our findings and recommendations. VA implemented Recommendations 2, 7, 9, and 13, and we will continue to follow up until the remaining nine recommendations are implemented.

MENTAL HEALTH CARE

VHA's efforts to increase access to mental health care for veterans face many challenges. These include overcoming stigmas that veterans may associate with seeking care for mental health and fears that associated medical records documenting their care may have an adversarial impact on their lives and employment. Additionally, VHA struggles to attain and retain a sufficient mental health workforce capacity, establish a competency-based practice, and have adequate systems to support improving care nationwide. In the face of these challenges, we continue to focus our efforts on ensuring veterans receive timely access to mental health care. The OIG's Office of Healthcare Inspections has issued a number of reports detailing their reviews of alleged delays in mental health care. [4]

In August 2015, the OIG Office of Audits and Evaluations issued a national review of veterans' access to psychiatrists. [5] We found VHA had not been fully effective in its use of hiring opportunities or its use of existing personnel to improve veterans' access to psychiatrists. From fiscal year (FY) 2012 through FY2014, VHA increased outpatient psychiatrist full-time equivalents (FTEs) by almost 15 percent. However, during that time the number of veteran outpatient encounters with psychiatrists increased by about 10 percent, and the number of individual veterans who received outpatient care from a psychiatrist increased about 9 percent. This means that while VHA significantly increased the number of psychiatrists providing outpatient clinical care since FY2012, it did not show a corresponding increase in veterans receiving care from psychiatrists. In fact, some individual facilities did not increase encounters from FY2012 through FY2014 even with their additional psychiatrist FTEs. This occurred because VHA did not have an effective method for establishing psychiatrist staffing needs. Throughout recent hiring initiatives, VHA did not stress a specific need for psychiatrists; instead, facilities determined their own staffing needs. VHA did not ensure facilities used consistent and effective clinic management practices.

This resulted in 94 of 140 health care facilities that needed additional psychiatrist FTEs to meet demand as of December 2014. We found VHA facilities could have better used about 25 percent of psychiatrist FTE clinical time to see veterans in FY2014, which equated to nearly $113.5 million in psychiatrists' pay. Over the next 5 years, this would equate to over $567 million if clinic management is not strengthened now. The USH agreed to ensure facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed and attain appropriate staffing levels or identify alternative options. The USH also agreed to develop clinic management business rules, reassess the appropriateness of VHA's productivity target for psychiatrists, and develop a mechanism to monitor the variance in which psychiatrists code encounters. Since publication, VA implemented Recommendation 4, which was to develop a mechanism to monitor the variance in which psychiatrists' code encounters and determine appropriate coding guidance and training to ensure consistency.

CONSULT MANAGEMENT

In our August 31, 2015 report, Review of Alleged Mishandling of Ophthalmology Consults at the Oklahoma City, OK, VA Medical Center, we substantiated that oph-

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[4] See Healthcare Inspection - Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness Central Alabama VA Health Care System, Montgomery, Alabama (July 29, 2015) and Healthcare Inspection - Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine (June 17, 2015).

[5] Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists (August 25, 2015)

thalmology and teleretinal imaging staff, and referring providers, acted inappropriately on discontinued consults. We found:

- Ophthalmology staff discontinued about 31 percent more consults than the national average in FY2014, and about 42 percent more in FY2015 (reported as of March 10, 2015).
- Teleretinal imaging staff also discontinued about 9 percent and 10 percent more consults, respectively, than the national average during these same periods.
- Ophthalmology staff discontinued consults without adequate justification and often because they could not provide eye exams to the patients within 30 days.
- Ophthalmology staff and referring providers did not take the necessary steps to refer the patients to non-VA care staff to obtain their medical care outside of the VA.
- Referring providers did not ensure that discontinued teleretinal imaging consults received the appropriate ophthalmology clinic follow-up.

As a result of our inquiries, VA Medical Center (VAMC) leadership reviewed ophthalmology consults discontinued from January 1, 2014, through March 3, 2015, and identified issues with 439 of 1,937 consults. However, ophthalmology leadership did not provide sufficient oversight for processing consults and the VAMC did not have well defined guidance to ensure staff took appropriate actions when processing consults. We recommended the Oklahoma City VAMC Interim Director take appropriate action on patients affected by ophthalmology and teleretinal imaging consults, as well as formalize guidance and train staff on processing consults. Actions by the VAMC to implement Recommendation 2, which was to initiate a review of discontinued teleretinal imaging consults and take action to provide eye care when necessary, remain in progress at this time.

PURCHASED CARE

VA's purchased care programs include the Veterans Choice Program (VCP), Patient Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. VA's purchased care programs are critical to VA in carrying out its mission of providing medical care, including outpatient services, inpatient care, mental health, dental services, and nursing home care to veterans. Our audits, reviews, and health care inspections have reported the challenges VA faces in administering these programs, such as authorizing, scheduling care, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran's VA medical record, and timely and accurate payment for care purchased outside the VA health care system.

Patient-Centered Community Care Network

The PC3 program is a VHA nationwide program that provides eligible veterans access to care through contracts for certain medical services. VA medical facilities use the PC3 program after they have exhausted other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors.

In our July 2015 report, Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues, we examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling. We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care.

VHA also lacked controls to ensure VA medical facilities submit timely authorizations, and Health Net and TriWest schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. The then Interim Under Secretary for Health agreed with our recommendations to ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements. VA has implemented Recommendations 4, which was to revise contract terms to eliminate the option of scheduling appointments before communicating with the veteran.

In our September 2015 report, Review of Patient-Centered Community Care (PC3) Provider Network Adequacy, we reported that inadequate PC3 provider networks

contributed significantly to VA medical facilities' limited use of PC3. VHA spent 0.14 percent, or $3.8 million of its $2.8 billion FY2014 non-VA care budget on PC3. During the first 6 months of FY2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its non-VA care expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate because:

- The PC3 network lacked needed specialty care providers, such as urologists and cardiologists.
- Returned PC3 authorizations had to be re-authorized through non-VA care and increased veterans' wait times for care.
- Non-VA care provided veterans more timely care than PC3.

For these staff, inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and delayed the delivery of care. Further, VHA had not ensured the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the CBO's planning and implementation of PC3, the CBO lacked an effective implementation strategy for the roll-out of PC3, and neither VHA nor Health Net and TriWest maintained adequate data to measure and monitor network adequacy. The Under Secretary for Health agreed with our recommendations to strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex health care initiatives. VA has implemented Recommendation 3, which was to develop action plans to improve provider networks that are unable to provide health care services at the specific geographic locations identified.

Veterans Choice Program

As a result of Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) VA created the Veterans Choice Program (VCP) in November 2014. Following enactment of VACAA, VA turned to Health Net and TriWest, the administrators of the PC3 program, who had provider networks in place Nation-wide. The VCP allows staff to identify veterans to include on the Veterans Choice List, a list that includes veterans with appointments beyond 30 days from the clinically indicated or preferred appointment dates and veterans who live more than 40 miles from a VA facility. Under this program, VA facilities began providing non-VA care to eligible veterans enrolled in VA health care as of August 1, 2014, and to recently discharged combat veterans who are within 5 years of their post-combat separation date. With a key VCP eligibility criterion being a veteran's inability to receive care within 30 days, VHA's schedulers and supervisors must ensure they follow VHA scheduling guidance when calculating wait times.

In our February 2016 report, Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, CO, we substantiated the allegation that eligible Colorado Springs veterans did not receive timely care in six reviewed services. These services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and Primary Care. We found that for 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination staff did not add 173 veterans to the Veterans Choice List in a timely manner and they did not add 56 veterans to the list at all. In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests. We reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days.

As a result, VA staff did not fully use VCP funds to afford Colorado Springs veterans the opportunity to receive timely care. The Eastern Colorado Health Care System Acting Director agreed with our recommendations. Based on actions already implemented, we closed the recommendation to ensure that scheduling staff use the clinically indicated or preferred appointment dates when scheduling primary care patient appointments.

In another February 2016 report, Review of Alleged Patient Scheduling Issues at VA Medical Center, Tampa, Florida, we substantiated that when veterans received appointments in the community through the VCP, the facility did not cancel their existing VA appointments. For example, we found that for 12 veterans, staff did not cancel the veterans' corresponding VA appointments because Non-VA Care Coordination staff did not receive prompt notification from the contractor when a veteran scheduled a VCP appointment and no longer needed the VA appointment. We also

substantiated that the facility did not add all eligible veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List.

This occurred because Tampa VAMC schedulers thought they were appropriately removing the veteran from the Electronic Wait List, when they were actually removing the veteran from the Veterans Choice List. The Director agreed with our recommendations to ensure the facility receives prompt notification of scheduled VCP appointments, determine if the contractor complies with the notification requirements, ensure appropriate staffs receive scheduling audit results and verify correction of errors, and ensure staff receive training regarding management of the Veterans Choice List. Based on actions already implemented, we closed four of the five recommendations, and will follow up to ensure the facility receives prompt notification of scheduled VCP appointments.

NEW OIG OVERSIGHT INITIATIVE

The OIG's Office of Audits and Evaluations recently initiated a pilot project to audit one Veterans Integrated Service Network (VISN) and its facilities to evaluate three key components of access-data reliability of wait time metrics, implementation of VCP, and consult management. Our objective for this pilot is to provide comprehensive and timely oversight at all facilities within a VISN in order to provide facility directors a report detailing their current data and scheduling practices. We hope that by focusing OIG resources on this issue we can audit each VISN and its facilities every 3 years, as we currently do with the Veterans Benefits Administration's regional offices. We feel this work is important and will help provide a veteran-centric view of what actions VISN management is taking to ensure situations like Phoenix do not occur in the future.

CONCLUSION

OIG work has shown that VA faces challenges in providing adequate access to health care. Risks to the timeliness, cost-effectiveness, quality, and safety of veterans' health care raised serious concerns about VA's management and oversight of its health care system and resulted in U.S. Government Accountability Office concluding VA health care was a high-risk area in 2015. A recent announcement by VA to once again change their plans on acquiring a new scheduling package aptly characterizes their inability to provide consistent and meaningful tools and guidance to the VA workforce tasked with ensuring veterans receive timely access to care. A major challenge is in administering its purchased care programs, in part because VHA schedulers and their supervisors do not follow established VHA scheduling guidance. We have a number of active projects involving VHA procedures that ultimately affect veterans' access through the VCP. We will continue to work with VA to provide the independent oversight and objective recommendations to help move these programs and initiatives forward on these issues.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or members of the Committee may have.

Prepared Statement of Debra A Draper

Chairman Miller, Ranking Member Brown, and Members of the Committee:

I am pleased to be here today as you discuss issues concerning veterans' access to health care. My remarks today are based on our report that was released yesterday, VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care. This report is the latest in our ongoing body of work examining veterans' access to timely health care. [1]

[1] See VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care, GAO 16 328 (Washington, D.C.: Mar. 18, 2016). See also GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO 16 24 (Washington, D.C.: Oct. 28, 2015); VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care, GAO 14 808 (Washington, D.C.: Sept. 30, 2014); VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, GAO 13 130 (Washington, D.C.: Dec. 21, 2012); VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access, GAO 12 12 (Washington, D.C.: Oct. 14, 2011); and VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans, GAO 10 294R (Washington, D.C.: Mar. 10, 2010).

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the Nation's largest health care systems; it provided care to about 6.6 million veterans in fiscal year 2014, including an aging veteran population and a growing number of younger veterans returning from military operations in Afghanistan and Iraq. VHA spent about $58 billion for their care in that year. Over the past decade, VHA has faced a growing demand for outpatient primary care services. From fiscal years 2005 through 2014, the number of annual outpatient primary care medical appointments VHA provided through its medical facilities increased by 17 percent, from approximately 10.2 million to 11.9 million. Each year over that period, an average of 380,000 veterans were newly enrolled in VHA's health care system. In fiscal year 2014, VHA provided about 730,000 primary care appointments for new patients-appointments for those patients who had not been seen in a primary care clinic in the past 24 months, including those who were newly enrolled.

Primary care services are often the entry point to the VHA health care system for veterans, and access to these services is critical to ensuring that veterans obtain needed medical care, including specialty care. When veterans need specialty care-such as cardiology or gastroenterology-they are typically referred to specialists by their primary care providers, and each veteran's primary care team manages and coordinates the needed care.[2] Veterans may obtain primary care services at VHA's medical facilities, which include 167 medical centers and more than 800 community-based outpatient clinics. Responsibility for ensuring timely access to primary care rests with 20 regional Veterans Integrated Service Networks (VISN), which oversee the medical centers, and with VHA's central office, which oversees the entire VA health care system.

In recent years, we and others have expressed concerns about VHA's ability to effectively provide and oversee timely access to health care for veterans, which, in some cases, reportedly has resulted in harm to veterans. Our prior work on VHA's oversight of primary and specialty care found VHA did not have adequate data and oversight mechanisms in place to ensure veterans receive timely care. For example, since 2012, we have issued several reports recommending that VA improve appointment scheduling, ensure the reliability of wait-time and other performance data, and improve oversight to ensure VA medical centers provide veterans with timely access to outpatient primary and specialty care, as well as mental health care.[3] Based on these serious concerns about VA's management and oversight of its health care system, we have concluded that VA health care is a high-risk area and, in 2015, added it to our High Risk List.[4] To help improve timely access to health care, Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which provided veterans facing long waits or lengthy travel distances the opportunity to obtain care from providers (non-VA) in the community.[5]

In the context of these serious and longstanding concerns, my testimony today highlights selected findings from our most recent report on veterans' access to primary care. My remarks will therefore focus on the extent to which

1.newly enrolled veterans access primary care in a timely manner; and
2.VHA provides oversight of veterans' access to primary care.

For our report, we reviewed relevant regulations, guidance, and other key documents, as well as interviewed staff with responsibility for ensuring timely access to primary care, including officials from VA, VHA, six VA medical centers, and the six corresponding VISNs that oversee the medical centers in our review.[6] We selected the medical centers based on variation in average wait times for primary care ap-

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[2] VHA provides primary care services through patient aligned care teams consisting of a primary care provider and support staff, including a nurse care manager, clinical associate such as a licensed practical nurse, and administrative clerk.

[3] See GAO 16 328, GAO 16 24, GAO 14 808, GAO 13 130, and GAO 10 294R.

[4] GAO, High Risk Series: An Update, GAO 15 290, (Washington, D.C.: February 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

[5] Pub. L. No. 113–146, 128 Stat. 1754 (2014). Under this authority, VHA created the Veterans Choice Program, which was introduced in November 2014. Under the program, for example, certain veterans are able to receive care in the community, including primary care, if the next available medical appointment with a VA provider is more than 30 days from the date a veteran wants to see a provider or if the veteran lives more than 40 miles driving distance from the nearest VA facility.

[6] These medical centers were: VA Central Western Massachusetts Healthcare System (Leeds, Massachusetts); Tennessee Valley Healthcare System (Nashville, Tennessee); Fayetteville VA Medical Center (Fayetteville, North Carolina); Ralph H. Johnson VA Medical Center (Charleston, South Carolina); VA Eastern Kansas Health Care System (Leavenworth, Kansas); and VA San Diego Healthcare System (San Diego, California).

pointments, facility complexity, and geographic location. From these medical centers, we selected a sample of 60 newly enrolled veterans (10 randomly selected from each of the six medical centers), all of whom had requested VA contact them to schedule medical appointments, but had not been seen by primary care providers. We also selected a sample of 120 newly enrolled veterans (20 randomly selected from each of the six medical centers), all of whom had requested that VA contact them to schedule medical appointments and were seen by primary care providers. We examined the medical records for each of these 180 veterans to determine the history of actions taken to schedule appointments, such as dates the appointments were scheduled and dates veterans were seen by primary care providers, if applicable. We also evaluated VHA's mechanisms for overseeing veterans' access to primary care against the Federal internal control standards related to control activities, information, and monitoring.[7] Additional information on our scope and methodology is available in our report. The work this testimony is based on was performed in accordance with generally accepted government auditing standards.

Problems Newly Enrolled Veterans Faced in Accessing Primary Care and Obtaining Timely Access to Care

Our review of medical records for a sample of newly enrolled veterans at six VA medical centers found several problems in medical centers' processing of veterans' requests that VA contact them to schedule appointments, and thus not all newly enrolled veterans were able to access primary care. For the 60 newly enrolled veterans in our review who requested care but had not been seen by primary care providers, we found that 29 did not receive appointments due to the following problems in the appointment scheduling process:

- **Veterans did not appear on VHA's New Enrollee Appointment Request (NEAR) list.** We found that although 17 newly enrolled veterans in our review requested that VA contact them to schedule appointments, medical center officials said that schedulers did not contact the veterans because they had not appeared on the NEAR list.[8] According to VHA policy, as outlined in its July 2014 interim scheduling guidance, VA medical center staff should contact newly enrolled veterans to schedule appointments within 7 days from the date they were placed on the NEAR list.[9] Medical center officials were not aware that this problem was occurring, and could not definitively tell us why these veterans never appeared on the NEAR list.
- **VA medical center staff did not follow VHA scheduling policy.** We found that VA medical centers did not follow VHA policies for contacting newly enrolled veterans for 12 veterans in our review. VHA policy states that medical centers should document three attempts to contact each newly enrolled veteran by phone, and if unsuccessful, send the veteran a letter. However, for 5 of 12 newly enrolled veterans, our review of their medical records revealed no attempts to contact them, and medical center officials could not tell us whether the veterans had ever been contacted to schedule appointments. Medical center staff attempted to contact the other 7 veterans at least once each, but failed to reach out to them with the frequency required by VHA policy.

For the remaining 31 of 60 newly enrolled veterans included in our review who did not have a primary care appointment:

- 24 were unable to be contacted to schedule appointments or upon contact, declined care, according to VA medical center officials. These officials said that in some cases they were unable to contact veterans due to incorrect or incomplete contact information in veterans' enrollment applications; in other cases, they said veterans were seeking a VA identification card, for example, and did not want to be seen by a provider at the time they were contacted.
- 7 had appointments scheduled but had not been seen by primary care providers at the time of our review. Four of those veterans had initial appointments that

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[7] See GAO, Standards for Internal Control in the Federal Government GAO/AIMD 00 21.3.1. (Washington, D.C.: November 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[8] Veterans who request on their applications for health benefits that VA contact them to schedule appointments are to be placed on the NEAR list. The NEAR list is intended to help VA medical centers track newly enrolled veterans needing appointments.

[9] Department of Veterans Affairs, "Rescission of VHA Outpatient Scheduling Policy and Procedures and Interim Guidance," (Washington, D.C.: July 7, 2014). This interim guidance rescinded and replaced VHA Directive 2010–027 Outpatient Scheduling Processes and Procedures (June 9, 2010).

needed to be rescheduled, which had not yet been done at the time of our review. Appointments for the remaining 3 veterans were scheduled after VHA provided us with a list of veterans who had requested care.

For the 120 newly enrolled veterans across the six VA medical centers in our review who requested care and were seen by primary care providers, we found the average number of days between newly enrolled veterans' initial requests that VA contact them to schedule appointments and the dates the veterans were seen by primary care providers ranged from 22 days to 71 days. Slightly more than half of the 120 veterans in our sample were seen by providers in less than 30 days; however, veterans' experiences varied widely, even within the same medical center, and 12 of the 120 veterans in our review waited more than 90 days to be seen by a provider.

We found that two factors generally impacted newly enrolled veterans' experiences regarding the number of days it took to be seen by primary care providers:

1. **Appointments were not always available when veterans wanted to be seen, which contributed to delays in receiving care.** For example, one veteran was contacted within 7 days of being placed on the NEAR list, but no appointment was available until 73 days after the veteran's preferred appointment date, and a total of 94 days elapsed before the veteran was seen by a provider. In another example, a veteran wanted to be seen as soon as possible, but no appointment was available for 63 days. Officials at each of the six medical centers in our review told us that they have difficulty keeping up with the demand for primary care appointments for new patients because of shortages in the number of providers, or lack of space due to rapid growth in the demand for these services.

2. **Weaknesses in VA medical center scheduling practices may have impacted the amount of time it took for veterans to see primary care providers and contributed to unnecessary delays.** Staff at the medical centers in our review did not always contact veterans to schedule appointments in accordance with VHA policy, which states that attempts to contact newly enrolled veterans to schedule appointments must be made within 7 days of their addition to the NEAR list. Among the 120 veterans included in our review that were seen by primary care providers, 37 (31 percent) were not contacted within 7 days to schedule an appointment; compliance varied across medical centers.

As a result of these findings, we recommended that VHA review its processes for identifying and documenting newly enrolled veterans requesting appointments and revise as appropriate, to ensure that all veterans requesting appointments are contacted in a timely manner to schedule them. VHA concurred with this recommendation, and indicated that by December 31, 2016, it plans to review and revise the process from enrollment to scheduling to ensure that newly enrolled veterans requesting appointments are contacted in a timely manner. VHA also indicated that it will implement internal controls to ensure its medical centers are appropriately implementing the process.

VHA's Oversight of Veterans' Access to Primary Care Is Hindered in Part by Data Weaknesses

VHA's oversight of veterans' access to primary care is hindered, in part, by data weaknesses and the lack of a comprehensive scheduling policy, both of which are inconsistent with Federal internal control standards.[10] These standards call for agencies to have reliable data and effective policies to achieve their objectives, and for information to be recorded and communicated to the entity's management and others who need it to carry out their responsibilities.

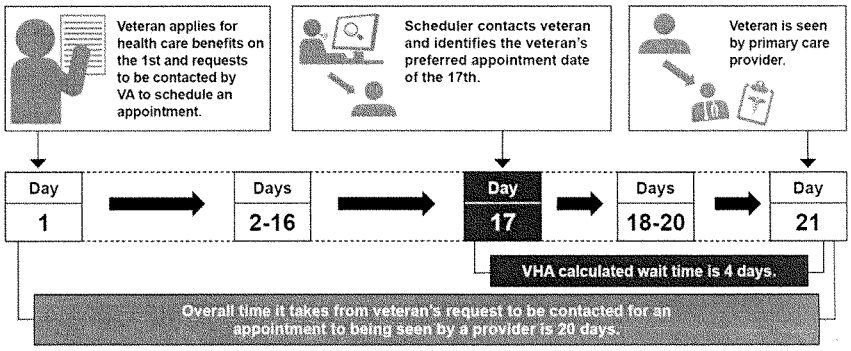
A key component of VHA's oversight of veterans' access to primary care, particularly for newly enrolled veterans, relies on monitoring appointment wait times. However, VHA monitors only a portion of the overall time it takes newly enrolled veterans to access primary care.[11] For newly enrolled veterans, VHA calculates primary care appointment wait times starting from veterans' preferred dates, rather than the dates veterans initially requested that VA contact them to schedule appointments. (A preferred date is the date that is established when a scheduler contacts the veteran to determine when he or she wants to be seen.) Therefore, these data do not capture the time veterans wait prior to being contacted by schedulers,

[10] See GAO/AIMD 00 21.3.1.

[11] We recently reported that VA similarly focuses on only a portion of the overall time veterans wait to see mental health providers. See GAO 16 24.

making it difficult for officials to identify and remedy scheduling problems that may arise prior to making contact with veterans. (See fig. 1.)

Figure 1: Illustration of How the Overall Time It Takes a Veteran to See a Provider May Differ from the Wait Time Calculated by the Veterans Health Administration (VHA)



Sources: VHA (information); GAO (illustration). | GAO-16-562T

Our review of medical records for 120 newly enrolled veterans found that, on average, the total amount of time it took to be seen by primary care providers was much longer when measured from the dates veterans initially requested VA contact them to schedule appointments than it was when using appointment wait times calculated using veterans' preferred dates as the starting point. For example, we found one veteran applied for VHA health care benefits in December 2014, which included a request to be contacted for an initial appointment. The VA medical center contacted the veteran to schedule a primary care appointment 43 days later. When making the appointment, the medical center recorded the veteran's preferred date as March 1, 2015, and the veteran saw a provider on March 3, 2015. Although the medical center's data showed the veteran waited 2 days to see a provider, the total amount of time that elapsed from the veteran's request until the veteran was seen was actually 76 days.

Further, ongoing scheduling errors, such as incorrectly revising preferred dates when rescheduling appointments, understated the amount of time veterans waited to see providers.[12] For example, during our review of appointment scheduling for 120 newly enrolled veterans, we found that schedulers in three of the six VA medical centers included in our review had made errors in recording veterans' preferred dates when making appointments. For example, in some cases primary care clinics cancelled appointments, and when those appointments were re-scheduled, schedulers did not always maintain the original preferred dates in the system, but updated them to reflect new preferred dates recorded when the appointments were rescheduled. We found 15 appointments for which schedulers had incorrectly revised the preferred dates. In these cases, we recalculated the appointment wait time based on what should have been the correct preferred dates, according to VHA policy, and found the wait-time data contained in the scheduling system were understated. Officials attributed these errors to confusion by schedulers resulting from the lack of an updated standardized scheduling directive, which VHA rescinded and replaced with an interim directive in July 2014.[13] As in our previous work, we continue to find scheduling errors that affect the reliability of wait-time data used for oversight, which make it difficult to effectively oversee newly enrolled veterans' access to primary care.

As a result of these findings, we recommended that VHA monitor the full amount of time newly enrolled veterans wait to receive primary care, and issue an updated scheduling directive. VHA concurred with both of these recommendations, and indi-

[12] VHA policy states that when a clinic cancels a veteran's appointment, the preferred date recorded in the initial appointment should be maintained in the system and not revised when the appointment is rescheduled.

[13] Department of Veterans Affairs, Rescission of VHA Outpatient Scheduling Policy and Procedures and Interim Guidance, (Washington, D.C.: July 7, 2014). This interim guidance rescinded and replaced VHA Directive 2010–027, Outpatient Scheduling Processes and Procedures (June 9, 2010). Subsequent to this interim directive VHA issued numerous individual memos to clarify and update its scheduling policies.

cated that by December 31, 2016, it plans to begin monitoring the full amount of time newly enrolled veterans wait to be seen by primary care providers. It also indicated that it plans to submit a revised scheduling directive for VHA-wide internal review by May 1, 2016.

This most recent work on veterans' access to primary care expands further the litany of VA health care deficiencies and weaknesses that we have identified over the years, particularly since 2010. As of April 1, 2016, there were about 90 GAO recommendations regarding veterans' health care awaiting action by VHA. These include more than a dozen recommendations to address weaknesses in the provision and oversight of veterans' access to timely primary and specialty care, including mental health care. Until VHA can make meaningful progress in addressing these and other recommendations, which underscore a system in need of major transformation, the quality and safety of health care for our Nation's veterans is at risk.

Chairman Miller, Ranking Member Brown, and Members of the Committee, this concludes my prepared statement. I would be pleased to answer any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Debra A. Draper at (202) 512–7114 or draper@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions are Janina Austin, Assistant Director; Jennie F. Apter; Emily Binek; David Lichtenfeld; Vikki L. Porter; Brienne Tierney; and Emily Wilson.

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512–4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512–4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149, Washington, DC 20548

Statements For The Record

THE AMERICAN LEGION

The American Legion has been actively tracking the amount of time it takes for veterans to access the health care they have earned for over a decade. In 2002, The American Legion launched the "I Am Not a Number" campaign to identify and document the delays veterans were facing in obtaining medical care from the Department of Veterans Affairs (VA). This project grew into to the "System Worth Saving" (SWS) Task Force of The American Legion. The SWS team has been crisscrossing the country annually with boots on the ground to evaluate the Veterans Health Administration (VHA) in the field ever since. The American Legion has not been shy about raising concerns, such as in the testimony of Mr. Roscoe Butler in March of 2013, fully a year before the Phoenix wait time scandal would break, where Mr. Butler raised concerns about inaccurate self-reporting from the VA as well as the large number of empty medical staff positions that needed to be filled if VA was to have any hope of maintaining manageable wait times for care. [1]

When the scandal broke in Phoenix, The American Legion not only led the chorus demanding accountability, but also continued to put resources toward solving the problems and helping veterans receive care, by establishing Veterans Crisis Command Centers (VCCCs) and conducting town hall meetings to facilitate communication between veterans and the VA and help veterans access with the care they needed. Today, we know from validated reports that there was systemic falsification of wait times at VA medical facilities. [2]

The American Legion and the American people were rightfully concerned. The obvious concerns and the conclusions that can be drawn from this may not be easily solved by some of the pat solutions being thrown around. Some of these concerns are shared by the larger health care industry of America as a whole and while these problems may not be easily solvable - transparency must be a staple of VA, and the ability to report accurately will be critical toward finding solutions for veterans.

Chairman Miller, Ranking Member Brown, and Members of the Committee:

On behalf of National Commander Dale Barnett and the over two million members of The American Legion, we welcome this opportunity to comment on improving the access to the health care system of the Department of Veterans Affairs (VA).

While veterans wait for care in the VA system, many find that the private sector is just as rife with delays and wait times that rival or exceed those at VA. Newspaper reports note "emerging evidence that lengthy waits to get a doctor's appointment have become the norm in many parts of American medicine, particularly for general doctors but also for specialists" [3]. A report from the National Academy of Sciences noted "tremendous variability in wait times for health care appointments exists throughout the United States, ranging from same day service to several months." [4] In addition, veterans have mentioned problems accessing care in the private sector, including a veteran in a major East Coast city who reported a minimum of 90–100 days to get a simple dermatology consult, no better, and in many cases far worse than veterans would be receiving utilizing local VA health care centers.

The American health care system as a whole has problems with wait times, and sometimes it is important to reflect on VA's position not solely as an island, but as

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[1] Witness testimony of Roscoe Butler, The American Legion - HVAC Subcommittee on Oversight and Investigation, ″Waiting for Care: Examining Patient Wait Times at VA″ - March 14, 2013

[2] ″VA Bosses in 7 States Falsified Vets' Wait Times for Care″ - USA Today, Donovan Slack April 7, 2016

[3] New York Times The Health Care Waiting Game - Elisabeth Rosenthal, July 5, 2014

[4] Science Daily Wait times for health care services differ greatly throughout US - July 29, 2015

a barometer that can help forecast what to expect. The American Legion believes that this is an area the Committee could more fully explore by focusing on how to underpin the existing system so that we not only shore up VA, but set the example of how the national health care industry should operate. This wouldn't be the first time innovation at VA would lead the Nation, and The American Legion believes that this Committee has provided excellent oversight and analysis with a comprehensive slate of hearings examining the VHA. In addition, The American Legion believes that a hearing or series of hearings examining VHA in relation to the larger health care picture of America would prove beneficial. Wait times, opioid pain killer prescription, elder care, mental health care, these are all problems that VA must tackle, but they are also problems the American health care landscape as a whole is grappling with, and the comparison and contrasts are illuminating.

While emergency measures such as the Veterans Access, Choice and Accountability Act of 2014[5] (VACAA) provided the opportunity for some relief while utilizing private sector resources as a pressure release valve, the private sector has many of its own struggles with wait times and cannot be seen as a sole solution to the problems of waiting veterans. VACAA and subsequent efforts to consolidate care in the community under a single streamlined system should make the process easier when veterans need help accessing care, and reforming this portion of the system is important. However, this only addresses part of the access problem.

The American Legion recognizes the importance of communication and coordination between all components of the health care community - VA facilities, private sector resources, public-private partnerships such as agreements with teaching hospitals and universities, Veterans Service Organizations (VSOs) and others who provide resources to help veterans, Congressional as well as local governments, and most importantly the veterans themselves. When all of these stakeholders communicate it is easier to determine what resources are available to serve the needs of the veteran. That cooperation can only occur when the communication is open and free from fear of reprisal.

The real and striking problem identified by watchdogs like The American Legion well before the Phoenix scandal broke which was confirmed by the scandal itself, was the culture in VA that led to systemic false reporting of critical information. Without accurate information about the delays veterans were facing, there is no way to correctly identify where help is needed. When self-reporting continued to signify that all was well, those connected to the veterans who were struggling had to find alternative ways of gaining access to more accurate information.

The American Legion made independent, third party oversight visits to facilities through the System Worth Saving Task Force and tried to highlight the problems we saw through testimony before Congress as noted above. Representative Beto O'Rourke from this very committee, frustrated with incongruities of data reported by VA with what the veterans in his district reported regarding mental health care wait times, commissioned private surveys to develop a more accurate picture.

When criticism comes forward to address problems, it must be met productively. Where change is necessitated, it must occur to meet the needs of veterans. As a result of the Phoenix wait time scandal veterans now have new management at VA; from Secretary Bob McDonald, to Undersecretary for Health Dr. David Shulkin, as well as most of VA's senior leadership team. These new leaders have stressed the importance of retraining employees and management at every level to fix these problems.

According to the Independent Assessment[6] VA is inconsistent from region to region. In some regions, VA does an excellent job of managing the health care needs of veterans. Veterans receive treatment within the VA where possible, and overwhelmingly veterans report favorably on the treatment they receive within VA even when they are frustrated with the administrative aspects such as appointments.[7] In some locations when they cannot deliver the care veterans need, they can smoothly make appointments to get the veterans care in the community. This indicates the system has the capacity to deliver the care veterans want and deserve, utilizing the best VA resources and private sector resources in places where this is necessary, but while the capacity is there the consistency of this execution is falling short.

The foundation to build that consistency requires better reporting, better communication between all parties, and better teamwork between all partners. Regional problems can't be fixed unless awareness of those problems filters up to those who can commit the resources necessary to fix the problems and it will take new and

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[5] P.L. 113-146

[6] http://www.va.gov/opa/choiceact/documents/assessments/integrated—report.pdf

[7] Vet Voice Foundation polling data, November 2015

innovative solutions to succeed. Representative Ryan Costello has proposed the VET Act[8] which builds on the example set by American Legion VCCCs and sets up a pilot program using Veteran Engagement Teams to help connect veterans with resources. Representative O'Rourke's Ask Veterans Act[9] proposes surveying veterans directly to get outside the closed loop of VA management reporting on its own progress, and Representative Corrine Brown has introduced legislation that would make VA establish a quadrennial plan for committing funds and coordinating care effectively. These and other ideas will be necessary to help restore trust in the system; even as VA's new management works to do the same.

The American Legion is committed to ensuring that veterans have the best health care system available to meet their unique needs and we are encouraged by some of the progress VA is making[10]. VA's MyVA initiative combined with the successful implementation of VISTA evolution, My Healthy Vet, working weekends to knock down the appointment and consult wait times, and expanding telehealth are just a few examples where VA is showing promise and improvement. The Wait Time scandal illuminated problems within that health care system. In the time of immediate crisis, the most obvious answer to that problem seemed to be that the resources to meet need weren't there and therefore veterans must be turfed off to community providers, but we all see now that it is just not that simple. The solution will require patience and diligence to be sure, but above all honesty and the humility to admit that you need help. Management and employees cannot be afraid of poor reviews causing them to hide their inability to admit they aren't meeting needs. VA cannot be so afraid of criticism that they fall back on knee jerk habits to deny and deflect accusations rather than owning their shortcomings and providing a plan for how they aim to make up for them.

Overwhelmingly - VA still delivers a "System Worth Saving". This is the Nation's largest, most extensive, most comprehensive integrated health care system and is a system that has led the way on integrated health records, on treatment for heart disease, on new and innovative treatments for mental health issues, and especially Posttraumatic Stress Disorder. But this is also a system that needs to be viewed through a lens that not only observes VA's own internal struggles but also the struggles of the Nation's health care landscape as a whole.

The American Legion thanks this Committee for their diligence in pursuing improvements to the VA health care system and for their attentiveness to the struggles of veterans who seek to access care. This Committee was instrumental in calling attention to the initial Wait Time problem, and has been at the forefront of oversight through the past two years of reform efforts. As we continue to work toward the future of veterans' health care, we look forward to continuing the important partnership and dialogue with all partners at the table from veterans to VA to Congress, toward building the robust and dynamic health care system veterans have earned with their service and sacrifice.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861–2700, or wgoldstein@legion.org

Questions and Answers

PASSBACK

QUESTIONS FOR THE RECORD FROM CHAIRMAN JEFF MILLER

Question 1: What is the VHA-wide average wait time for Veterans seeking primary care at VA? Please provide the number for new patients and established patients. Does that average take into account the time from the first contact the Veteran makes with VA until the appointment actually occurs? In other words, does it include the time from the create date to the appointment date, not just from the preferred date to the appointment date.

Department of Veterans Affairs (VA) Response: In April 2016, the average wait time for Primary Care was 4.66 days. This number includes both new and established patient appointments and a new method of computation. This new method uses either the date that an appointment is deemed clinically appropriate by a VA health care provider, the Clinically Indicated Date (CID), or, if no such clinical de-

[8] H. R. 3936
[9] H. R. 1319
[10] http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2775

termination has been made, the date a Veteran prefers to be seen, the Preferred Date (PD), to calculate wait times. The current method reports the wait times for all patients combined, and does not include the create date. This is consistent with the wait time goals of the Veterans Health Administration (VHA) published in the Federal Register on October 17, 2014. [1]

The previous method used to calculate wait times was based on the create date (the date an appointment is made) and the desired date for scheduling an appointment. The create date time stamp provided valuable information for new patients but not for established patients. So, the desired date time stamp required further definition based on the source of the appointment request. VA now uses CID for provider driven appointment requests and PD for patient driven appointment requests. The majority of appointments are made from provider driven requests, and providers must document CID. Use of CID makes the scheduling of appointments less susceptible to manipulation.

Question 2: VA has used the excuse of training problems for more than a decade when addressing wait times errors or manipulation. One very simple way to address training deficiencies is to ensure your over 25,000 schedulers are trained properly, both the trainer and the trainee certify that training is in compliance with VHA policy, and then hold them accountable for actions outside of training. Will VA implement this simple step of requiring a written attestation of competency in order to hold people accountable for the continuing abuses in the scheduling system?

VA Response: In response to the events of 2014, VHA simplified the scheduling procedures and published a Deputy Under Secretary for Health for Operations and Management memorandum on June 9, 2015, which revised procedures to require providers to write a return-to-clinic order and schedulers to enter the date contained in that order as the CID. This new process keeps future appointment decision-making with the provider and patient, rather than the scheduler. Associated training was updated at that point and provided to employees who could schedule appointments. A written attestation is included as part of the training. Additionally, VHA uses the "scheduling trigger tool" database to identify and notify facility leadership of scheduling irregularities. Of note, a root cause of scheduling errors is the highly manual, 30-year old scheduling software. VHA will implement VistA Scheduling Enhancement (VSE) this summer. VSE updates the legacy command line scheduling application with a modern graphical user interface. This capability reduces the time it takes schedulers to enter new appointments, and makes it easier to see provider availability. VSE provides critical, near-term enhancements, including a graphical user interface, aggregated facility views, profile scheduling grids, single queues for appointment requests, and resource management reporting. VHA anticipates this new scheduling software will reduce the number of scheduling errors.

Several initiatives are planned for VHA's "Summer of Scheduling," including:

- **National Rollout of VSE:** The rollout of VSE will be achieved through a train the trainer or "Super User" approach, developing local experts to train others. The rollout will occur between May and July 2016, with ongoing sustainment training.
- **Hire Right, Hire Fast:** This project's goal is to ensure that every facility has the right number of Medical Support Assistants (MSA), with the right skills, and who can provide the right experience for Veterans.
- **Own the Moment:** VA knows that every moment between an employee and a Veteran matters. This project reinforces the importance of serving with a focus on principles and values, empowering VA employees to pursue what's right for the Veteran when procedures serve to limit services.
- **Standardized MSA Onboarding/Training:** New MSA Onboarding would include a two-week training program that draws its curriculum from scheduling rules for technical training, customer experience training, and medical center policies. The onboarding will provide a mentor for all new MSAs and use the VSE "Super Users" model. Deployment will follow the National Rollout of VSE.

Question 3: Who at VA Central Office is responsible for training, and has anyone been held accountable for this, since it has been used as an excuse for wait time manipulation and errors for so long?

VA Response: VHA's Access and Clinical Administration Program Office is responsible for developing scheduler training and policy. This office is creating, in col-

[1] Available at: https://www.federalregister.gov/articles/2014/11/05/2014–26274/publication-of-wait-times-for-the-department-for-the-veterans-choice-program.

laboration with the VA Talent Management Service, a simulation-based learning platform that enhances decision-making by allowing organizations to easily create assessment, education, and training programs to improve outcomes through "real-world" engagement. Simulation-based training is interactive and allows a scheduler to choose various pathways in a decision tree. Once the training is developed and released, each facility will ensure their staff successfully completes the training prior to issuing the scheduling menu options.

Question 4: GAO pointed out in its report that medical center directors are responsible for ensuring any staff who access the scheduling system have completed the appropriate training. Given the numerous instances of improper scheduling that continue to this day, how many directors have been disciplined specifically for the failure to ensure his/her staff is properly trained? Please provide a list of each director, the discipline received, and the specific charge that successfully led to the received discipline.

VA Response: VA's goal continues to be strengthening its culture of accountability and putting a renewed focus on employee-led, Veteran-centric change. Regarding disciplinary actions, no director has been disciplined "specifically for the failure to ensure his/her staff is properly trained;" however, as of July 8, 2016, VA has taken disciplinary action against 52 employees for wait time data manipulation. The breakdown of these actions includes: 17 Suspensions - Less than 14 days, 9 Reprimands, 8 Removals, 5 Admonishments, 4 Suspensions - 14–29 days, 3 Demotions, 2 Employees retired in lieu of, 1 Employee resigned in lieu of, 1 Suspension - over 60 days, 1 Settlement Agreement, and 1 Probationary Termination.

Question 5: Whistleblower disclosures that have been in the media[2] show that Phoenix has had about 33,500 cancelled clinic appointments since October 2015, 10,000 of which had not been rescheduled at least as of February 2016. Please explain this.

VA Response: From October 1, 2015, through March 3, 2016, a total of 33,789 appointments were identified as being cancelled by clinics across all services in the Phoenix VA Health Care System (PVAHCS). This number includes individual appointments, group appointments, Compensation & Pension, and telephone clinics.

VA identified 10,604 of the cancelled appointments as having "No Action Taken." "No Action Taken" could indicate such things as a future appointment scheduled in a different stop code or appointments made in error (e.g., scheduled into the wrong clinic, with the wrong date, for the wrong patient, etc.). A random audit of 100 patient records demonstrated that 14 need to be contacted to attempt to reschedule. Based on the random audit, the facility will review further to determine if any of the Veterans require a follow-up. Additionally, PVAHCS is developing an action plan to review the 10,000 records, with a target completion date of mid-June 2016.

Question 6: According to a recent OIG report on Colorado Springs, 36 percent of the consults reviewed identified that Veterans waited from between 31 to 148 days for a specialty care consult and 78 percent waited for from between 32 to 229 days for a primary care appointment. How is VA addressing the specific problems identified by the OIG?

VA Response: VA Eastern Colorado Health Care System (VAECHCS) has already implemented measures to improve access and to ensure the facility has trained staff to timely process consults. Scheduling staff at the PFC Floyd K. Lindstrom Outpatient Clinic at Colorado Springs received multiple formal training sessions on appropriate scheduling practices in the last several months, which included use of the earliest appropriate date when scheduling new patient appointments. A "stand-down" on December 5, 2015, was also held, where all schedulers were brought in on a Saturday to review and train on all of the critical components of scheduling. Detailed refresher training for all scheduling staff was additionally conducted on March 8–10, 2016. All new schedulers are required to attend and complete formal classroom training, followed by a practicum and assessment of scheduling competencies, before transitioning permanently to their respective clinics. Moreover, scheduling audits continue, with 100 percent of required audits being completed for all scheduling staff in February, March, and April 2016. Based upon the results of the audit reviews, supervisors provide immediate feedback to schedulers, along with any necessary corrective action. In addition to these efforts, consult metrics are being closely monitored as part of the VHA Consult Improvement Initiative.

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[2] Available at: http://www.azfamily.com/story/31371254/va-insider-comes-forward-regarding-recent-controversy-in-vet-health care.

Question 7: In the same report, the OIG found that VA staff did not fully use Veterans Choice Program funds to afford CBOC Veterans the opportunity to receive timely care. Please explain, in detail, where and how that money was spent.

VA Response: The omission of 100 patients from the Veterans Choice List (VCL) occurred in the infancy of the program. Early in implementation, a report to add patients to the VCL did not include all sites of care within VAECHCS. This issue was identified and resolved through training for the Community Care manager, as stated in the facility's initial published response to VA's Office of Inspector General. Veterans Choice Program (VCP) funding that would have been spent for the care of these Veterans remained in the VCP Fund for purposes of paying for other care under the program.

VAECHCS fully supports an eligible Veteran's choice to receive care through VCP. VAECHCS is currently in the top five facilities in the Nation in volume of VCP referrals. Through March of fiscal year (FY) 2016, VAECHCS has referred 27,716 episodes of care to our region's third party administrator, Health Net Federal Services, resulting in 17,251 appointments in the community. To ensure we maintain this success, VAECHCS added VCL entry criteria to the performance plans of schedulers and issued the revised plans during mid-year review in March 2016.

Question 8: GAO noted, as this Committee has for years, that VA's reported wait times data only includes a portion of the time it takes a newly enrolled Veteran to access primary care, by using a Veteran's desired date as opposed to the time the Veteran first contacts VA. Given the fact that calculating wait times in this manner understates actual wait times, why does VA do it this way?

VA Response: There is no clear standard to evaluate appointment wait times. While using the create date is easier to capture and appears to calculate wait times simply, it is not clinically relevant and doesn't reflect the Veterans' preference for when to be seen. In the private sector, most large health care organizations focus on patient satisfaction, and that's where we think VA needs to go.

The create date time stamp may provide useful information for new patients but not for established patients. Our patient population is older and has more chronic conditions. As a result, a very large portion of appointments are "return to clinic." For example, if a Veteran sees a doctor for diabetes and the doctor wants a follow-up appointment in 6 months, it doesn't make sense to report that as a 180 day wait time. While the follow-up care would be delivered at the clinically appropriate time, it would inaccurately inflate a facility's wait time average. A Veteran could see extraordinarily long wait times at a facility due to this inflation and may be discouraged from seeking care there. The desired date time stamp must be further defined based on the source of the appointment request. However, reporting wait times based on create date in addition to our current, more appropriate, practice would risk creating even more confusion. VA now uses the CID for provider driven appointment requests and PD for patient driven requests.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a widely used survey throughout health care in America. A standard set of questions deals with timely access to routine care and care needed right away. Historically, VA has underperformed industry averages. Notably, however, Veteran responses in the first and second quarters of FY2016 were the most favorable since 2013. More than 83 percent of respondents indicated they usually or always received access to routine care when they needed it, and 72 percent of respondents indicated they received access to care needed right away.

Question 9: Officials from each of the facilities audited by GAO stated that they periodically audit scheduled appointments to help ensure schedulers are complying with scheduling practices. Is that a uniform policy across all VHA facilities? If not, please explain why.

VA Response: Yes. Current VHA policy requires scheduling supervisors to audit schedulers on a yearly basis, at a minimum. An updated scheduling directive, currently in the concurrence process, will require quarterly audits. The audit format was standardized and is now a national auditing tool. Some sites are piloting the audit tool. Once the scheduling directive is released, all sites will be trained on the use of the audit tool for quarterly audits for all staff assigned the scheduling menu options.

Question 10: In a December 2012 report, GAO recommended VA improve efficiency and oversight of its scheduling process, including use of the EWL and ensuring appropriate training. Now, over three years later, that rec-

ommendation remains open, and VA continues to blame wait time manipulation on improper training. When is VA planning on fixing its training procedures so it can stop improperly characterizing its attempts to pad numbers on those deficiencies?

VA Response: In May 2014, VA began retraining every employee whose position includes the responsibility of scheduling appointments, to eliminate inconsistencies across VHA or within any VA facility. This training clearly directed that all scheduling of appointments must use the official VA scheduling software and Electronic Wait List (EWL) so that we can better track demand and need for additional resources. Additional training was added and is provided to front line staff on an ongoing basis. To ensure compliance with required directives and policies, VA conducted another review of all schedulers in August 2015. Employees who had not received the required training had their scheduling authority removed and were blocked from scheduling until properly trained.

In spring 2016, VA launched a 2-week, enhanced training program specifically for schedulers and other front line staff, which will focus on critical customer service skills. MSA onboarding, to include its mentorship program, will also support technical and policy training. Additionally, VA requires each Veterans Integrated Service Network (VISN) Director and Medical Center Director to conduct Scheduling Inspections on a regular basis at VA hospitals and clinics. Over 11,500 of these inspections have occurred, and this practice will continue. Finally, an interactive training program is being developed for scheduling staff, which will be released after the scheduling directive is approved.

Question 11: A consistent weakness that has been highlighted with regard to scheduling practices is the lack of effective oversight. What is the role of VISNs and central office with regard to oversight?

VA Response: In May 2014, VA began retraining every employee whose position includes the responsibility of scheduling appointments, to eliminate inconsistencies across VHA or within any VA facility. This training clearly directed that all scheduling of appointments must use the official VA scheduling software and EWL so that we can better track demand and need for additional resources. Additional scheduler training on updated scheduling procedures was conducted in the summer of 2015. To ensure compliance with these new procedures, VHA directors certified that all schedulers completed the appropriate training. Employees who were not properly trained had their scheduling authority removed and were blocked from scheduling until properly trained.

Additionally, VA requires each VISN Director and Medical Center Director to conduct Scheduling Inspections on a regular basis at VA hospitals and clinics. Over 11,500 of these inspections have occurred, and this practice will continue. We have made a deliberate effort to educate our staff. In addition to training, we have multiple audit tools in place that actively scan VA's metadata to look for abnormalities in the scheduling process. Use of the "scheduling trigger tool" database to identify and notify facility leadership of scheduling irregularities is an additional protection against scheduling errors. Any such abnormalities are flagged and provided to facility leadership for appropriate follow-up. VA's tracker tools identify the error and log the appropriate action taken to remediate that error.

VA's new scheduling software, VSE, will change the business processes that schedulers use to make, cancel, and reschedule appointments. These business processes are anticipated to make scheduling more reliable and reduce errors. Specifically, VSE will:

- Eliminate the ability to "zero out" appointments;
- Improve the accuracy of lists;
- Eliminate cancellation by clinic errors;
- Improve the accuracy of CID/PD for multiple book appointments; and
- Eliminate "next available" errors.

Question 12: Why are audits and external reviews still finding errors in scheduling appointments in spite of training? What is VA doing to ensure these errors stop?

VA Response: One reason is that schedulers are generally entry level employees who experience a 25 percent turnover each year. The Hire Right, Hire Fast initiative is intended to ensure MSAs with the right skills are in the right place to provide a premium experience to Veterans. Medical center directors will certify required administrative baselines to ensure successful implementation. Additionally, the current scheduling process is complex, requiring schedulers to manually apply many of the business rules and procedures that could be done by an electronic

scheduling system. VA deployment of VSE will update VA's legacy "roll and scroll" scheduling application with a modern graphical user interface. This capability will reduce the time it takes for schedulers to enter new appointments and make it easier to see provider availability. VSE implementation creates a need to update schedulers on new software functions and procedures. VA will combine VSE training with a module focused on critical customer service skills.

Question 13: With regard to the designation of Veteran's health care as one of GAO's high-risk programs, what does VA expect to accomplish in this regard through the end of the current administration?

VA Response: VA's Under Secretary for Health, Dr. David Shulkin, has a vision for a system that provides same day access to primary care and mental health care. Same day access is defined as the ability of a facility to address a Veteran's clinical needs the day that a Veteran calls or visits a VHA medical center. Central to this vision is a commitment to enhanced access and a consistent set of expectations regarding what a Veteran deserves when s/he enters any VHA facility. This commitment is summarized in the MyVA Access Declaration and the Veteran experience statement.

Our goal is to provide same day access for primary care and mental health care by December 2016. This means that when Veterans call or visit a VHA medical facility, VHA will connect them to their primary care provider, connect them to an alternate provider, such as a walk-in clinic or emergency room, or attend to their needs by telephone, through telemedicine or other available methods, on the same day as when the care they need is deemed medically necessary. In addition, Veterans reporting or identified as being in crisis, including suicidality, will receive an immediate crisis response. When Veterans call for a new mental health appointment, they will receive a suicide risk screening and immediate care, if needed. Veterans already engaged in mental health care identifying a need for urgent attention will speak with a provider that same day.

We will accomplish this through a firm commitment to our foundational principles, known as the MyVA Access Declaration. These foundational principles support our collective commitment to our Veteran population and serve as a pledge to Veterans regarding their ability to access care in a timely manner. The MyVA Access Declaration is as follows:

1. Provide timely care, including same-day services in Primary Care, as needed;
2. Provide timely Mental Health care, including same day services, as needed;
3. Provide Veterans medically necessary care from another VA Medical Center while away from their primary facility;
4. Respond to routine clinical inquiries within 2 business days;
5. Offer appointments and other follow-up options upon leaving a clinic;
6. Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances;
7. Integrate community providers, as appropriate, to enhance access;
8. Offer Veterans extended clinic hours and/or virtual care options, such as Telehealth, when appropriate; and
9. Transparently report access to care data to Veterans and to the public.

Dr. Shulkin recognizes VHA medical facilities' efforts, the collective commitment to the above MyVA Access Declaration, and the need for additional support to achieve same day access to care. Accordingly, he charged a team of clinical and administrative field and central office leaders to identify, evaluate, and recommend high impact solutions for application across the health care system. Multiple high impact solutions were selected for rapid deployment.

Local deployment of these solutions is supported by VHA's Veteran Engineering Resource Center (VERC). VERC's mission is to facilitate innovative solutions to health care delivery challenges identified by national, network, and facility leadership, as well as to propose important opportunities for change and improvement. In support of MyVA Access, the VERC provides a continuum of support, including face-to-face training and support to the VHA medical facilities as they implement the solutions critical for improving access. Local deployment is also supported by other trained improvement professionals, such as Systems Redesign Coordinators, Transformation Coaches, and other internal subject matter experts.

Specific planned accomplishments prior to December 2016 include:

- MyVA Access VERC partners are engaging VHA health systems and coordinating implementation planning through local leadership teams.
- In May 2016, VHA's Office of Operations and Management commenced training to 116 Group Practice Managers (GPM) from 92 VHA facilities across the coun-

try. GPMs provide oversight of all VA Medical Facility Ambulatory Care Services, including Primary Care, Mental Health, Specialty Care, and outpatient surgical clinics. This oversight includes resource utilization, patient scheduling, Veteran access, and clinic efficiency. GPMs facilitate critical discussions related to the clinical practice and identify potential alternatives and subsequent outcomes.

- The GPM training focused on the tools and resources needed for successful clinical operations management. Topic areas included open access in primary care, optimizing the health operations dashboard, and meeting the mental health needs of Veterans in a timely manner. The training will continue in August 2016.
- VSE will begin implementation in late 2016 and will facilitate Veteran-centric and consistent experience when scheduling follow-up appointments. The scheduler is able to quickly and easily see multiple clinic profiles in one calendar view, and the enhanced graphical user interface allows users to seamlessly navigate through the scheduling process. An improved reporting structure will also create a quick report to measure and track supply, demand, and utilization.
- Direct Scheduling for audiology and optometry will be in place nationally by December 2016. Through direct scheduling, audiology and optometry clinics will be able to immediately see Veterans upon request, without first requiring a consult from their primary care provider.
- The Telemental Health Hub Expansion initiative includes four regional hubs that have defined relationships with several facilities with particular challenges in their ability to provide timely mental health care. The first hub will begin providing services on zJune 6, 2016, and the other hubs will commence later this summer. All hubs will be operational by the end of the calendar year.

Question 14: Has VA conducted any analyses of its capacity, including health care providers, specialty services, and other needs, by facility, and if so, what do these analyses show, and what are VA's plans for ensuring adequate capacity?

VA Response: Yes. VA assesses the capacity and staffing of each VA medical facility. Establishing, filling, and projecting requirements for VA's health care system is a complex task. There is no "one size fits all" solution, making it particularly challenging for VA's large health care system. Many factors influence the ability of VA to meet the critical needs of a medical facility. Specifically, Primary Care panel capacity varies by facility, but, as of May 2016, the average is 88 percent. This means that approximately 740,000 additional Veterans can be accommodated at present staffing levels. Currently, 33 sites are above 95 percent of capacity, with 8 of them over 100 percent. As demand increases, sites generally add Primary Care teams within local constraints on budget, space, and recruitment ability.

VHA has taken a number of steps in recent years to improve clinical staffing management of medical professionals and support staff. This includes establishing team based, patient-centered care, development of productivity standards, and integration of workforce and succession planning.

Question 15: The GAO report discusses the lack of a comprehensive national scheduling policy, which has contributed to at least some of the observed scheduling problems. In your response to GAO's recommendation to finalize and disseminate such a policy, you noted a completion date of May 1, 2016. If the scheduling policy was rescinded in 2014, why has it taken so long to revise it? Further, what steps are you taking to ensure you will meet the May 1 completion date?

VA Response: The Outpatient Scheduling directive was ready for review in February 2016; however, the directive had to be rewritten to include content from the handbook. The directive was submitted for review on May 20, 2016. In the meantime, the 2010 scheduling directive has not been rescinded. Once the 2016 directive is released, it will replace the 2010 scheduling directive.

In the last four years, VHA has undergone changes that affected the policies and procedures in the directive. With the implementation of VSE, Veteran Appointment Requests, the Direct Patient Scheduling Application, the Choice initiative, and changes to performance measures, the directive has been under a constant state of revision. A scheduling directive stand down was held in Washington, DC, inviting individuals on a concurrence list to attend and review the draft directive. Following the stand down, 74 questions/comments from the group were forwarded for action. These questions/comments have been addressed in the current draft of the directive and are now awaiting final review. Once approved, the directive will return to concurrence for final signature.

Question 16: The GAO report also recommended improved efforts to ensure newly enrolled Veterans requesting an appointment are contacted in a timely manner, and the importance of monitoring the full amount of time newly enrolled Veterans wait to be seen. In your response to the GAO's recommendations, you noted a completion date of December 31, 2016. What steps are you taking to ensure you will meet the completion date?

VA Response: Welcome to MyVA (W2MyVA) provides newly enrolled Veterans a warm welcome to VA, an overview of benefits for which they may qualify, and assistance with scheduling their first appointment by a warm transfer of the Veteran to the facility of their choice. After hours, the facility's phone number is provided to the Veteran to call at his/her convenience. Outbound calls are completed within 5 business days from the enrollment date.

VA is developing a monitoring plan to gauge the "Veteran Feel" (how long it actually takes/overall time) from application to scheduled appointment. VHA will monitor timeframes on a consistent, frequent basis to detect deficiencies in the processes of providing newly enrolled Veterans with access to care. The National Elapsed Time report will be updated to calculate the time between application and appointment. Time frames will be monitored to improve visibility and accountability, allowing oversight of successful scheduling for newly enrolled Veteran appointments.

Steps that are in place to meet the completion date include the following:

- Submit revised specifications to VSSC - target June 2016;
- Update W2MyVA Report and National Elapsed Time Report - target July 2016;
- Test the revised reports - target September 2016;
- Submit Communication Plan to VISN and facility level - target September 2016; and
- Complete revised W2MyVA Report and National Elapsed Time Report - target October 1, 2016.

Question 17: Does VA know which facilities are in greatest need of using contracted, non-VA care, and does it know the specialties for which Veterans are most likely to use such care? If so, what plans are VA undertaking to ensure that these services are available on a contracted basis to Veterans and that Veterans receive timely access to this care?

VA Response: There is very similar utilization of community care across VHA; however, the top 5 facilities utilizing community care include VAECHCS, the Kansas City VA Medical Center (VAMC), the Alaska VA Healthcare System, the Spark M. Matsunaga VAMC, and PVAHCS, which collectively encompass 11.4 percent of total utilization in FY2016 by all medical centers. There were two significant front runners for categories of care being requested: Ophthalmology and Optometry; closely followed by Primary Care and Physical Therapy.

Based on data trends and forecasting, VA works with HealthNet and TriWest to identify and target specialties and providers of need. Both contractors have continuously worked with local VA medical facilities and VISNs to identify needed specialties and bring those providers into the network. As of May 2016, the Choice Provider Network has grown by 85 percent. In April 2015, the network had 191,237 providers and facilities contracted. As of May 31, 2016, the network has 353,674 providers and facilities contracted. In the event that either contractor is unable to provide the necessary service and returns the authorization to VA, VA may utilize Veterans Choice Provider Agreements in accordance with established protocol to purchase the care directly.

Question 18: Does VA ever cancel Veteran applications for health care without receiving written authorization from the Veteran? If so, when is doing so proper?

VA Response: In accordance with 38 Code of Federal Regulations § 17.36(d)(5), a Veteran enrolled in the VA health care system will be disenrolled only if the Veteran submits a signed and dated document stating that the Veteran no longer wishes to be enrolled or VHA determines that the Veteran is no longer in a priority category eligible to be enrolled.

Question 19: In Dr. Shulkin's written testimony, he stated that VA has "gone to such lengths to make sure that we document every aspect of wait time data." How can VA say that it documents every aspect of wait time data when it only captures a small portion of the time a Veteran actually waits?

VA Response: In the past, VA computed wait times for new patients based on the create date - the date on which an appointment was made. Under this method,

a computer-generated time stamp was applied that did not reflect the Veteran's preference or what was deemed clinically necessary by a health care clinician. VA computed wait times for established patients using a desired date - the date the patient wanted to be seen or the date clinically indicated by a provider when the Veteran needs care.

The create date time stamp may provide useful information for new patients but not for established patients. Our patient population is older and has more chronic conditions. As a result, a very large portion of appointments are "return to clinic." For example, if a Veteran sees a doctor for diabetes and the doctor wants a follow-up appointment in 6 months, it doesn't make sense to report that as a 180 day wait time. While the follow-up care would be delivered at the clinically appropriate time, it would inaccurately inflate a facility's wait time average. A Veteran could see extraordinarily long wait times at a facility due to this inflation and may be discouraged from seeking care there. The desired date time stamp must be further defined based on the source of the appointment request. However, reporting wait times based on create date in addition to our current, more appropriate, practice would risk creating even more confusion. VA now uses the CID for provider driven appointment requests and PD for patient driven requests.

As VA refocused its efforts on Veterans' perceptions, VA sought best practices from several industry experts, Veterans, and Veteran service organizations to develop a wait time metric that balances Veterans' preferences and provides the best clinical care. VA determined that the preferred date would be used for all patients and reported in a consistent manner, as it most accurately reflects the Veteran's and physician's preference.

As the health care industry and private sector have demonstrated, patient wait time data is but one of many indicators used to monitor access and measure customer satisfaction. VHA is now utilizing realtime Veteran responses to access - a system called VetLink, where Veterans check in at kiosks and are asked if they were satisfied with their ability to get an appointment on time. Our VetLink data shows that Veterans who were surveyed at the time of clinic check-in report that they are satisfied or very satisfied with their scheduled appointment nearly 90 percent of the time. In our new survey of Care in the Community, 85 percent of Veterans were satisfied with their experience of Care in the Community and 77 percent scored their VA Community Care Provider an 8 or higher on a scale of 10.

Question 20: In his testimony, Dr. Shulkin stated VA is planning to measure access to care by simply asking Veterans whether they were satisfied with being able to get care when they need it. How will such a vague, subjective standard alone provide more accurate data than also objectively monitoring the full time a Veteran waits for care?

VA Response: We recognize that Veterans are still waiting too long for care. However, in an effort to determine how we can better meet Veterans' needs, Veteran satisfaction is an essential and complementary component. Veterans have expressed that wait times are not the only worthwhile indication of their experience with VA, and that's why we must transform the way we do business. We have learned that figures measuring the wrong metric can cause unintended consequences and confusion, like the 14 day metric in 2014 that was central to employees working to a metric rather than the real needs of patients. Further, arbitrary wait time metrics, alone, are clinically irrelevant. For example, if a patient's condition requires an appointment within a week, a 14 day wait is a failure, albeit within the stated limit. VA will not do away with wait time metrics, but we must expand how we assess access, in the same way the private sector does.

VA is working hard to increase access to care. We have hired more doctors and nurses; increased clinic space; extended clinic hours; and worked more closely with community providers to refer Veterans. Additionally, we focus first on patients with the most urgent health care needs. To improve customer service, VA is collaborating with private sector companies known for providing positive experiences to their customers to understand how we can ensure the highest quality care to the Veterans we serve. Hearing directly from Veterans that we are effectively serving them is the best gauge of success.

VHA is the only health care system in the country that publicly reports wait times, but we have also come to realize the shortcomings in how this figure was captured in our scheduling systems. For instance, we cannot readily distinguish appointments for urgent needs (for which same or next-day access is critical) from appointments for routine check-ups or follow-up. Nor can we parallel our performance with private sector providers, because they do not routinely collect or publish comparable data. At best, our wait time metric is an "operational indicator" that we will

continue to use on a daily basis to address the match between patient demand and capacity to deliver care.

We made the commitment in 2016 to use feedback from the Veterans we serve as our most important accountability measure for Access. We have adopted the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey, which is the industry standard used by every large integrated health care delivery system in the United States. The CAHPS survey includes several questions about Veteran's experience getting care for routine and urgent needs over the prior 6 month period. We know, from CAHPS, that Access is a problem for a significant proportion of our Veterans, although they do give us high marks for the quality and comprehensiveness of our care once they are seen. Asking the Veteran what their experience with Access has been will ensure our efforts will stay truly focused on their needs. This Veteran-centric approach to assess Veteran satisfaction is also in line with the MyVA Access Declaration Statement principles.

QUESTIONS FOR THE RECORD FROM CONGRESSWOMAN JACKIE WALORSKI

Question 1: VA has stated that IT scheduling software was the reason for manipulated wait times, but as we discussed in the April 14 joint Subcommittee hearing, this is a self-inflicted wound. Will VSE and VSR prevent employees from manipulating data, and will it have audit controls that cannot be shut-off so that any changes are documented?

VA Response: VSE is VA's new scheduling software. Among other things, it will change the business processes that schedulers use to make, cancel, and reschedule appointments. These updated business processes are anticipated to make scheduling more reliable in VA, reduce scheduling errors, and eliminate scheduling manipulation. Specific process improvements will include:

• Eliminating the ability to "zero out" appointments:
- In legacy VistA, the application allows schedulers to first enter a preferred date and then search for available appointment slots. Once available slots are found, the scheduler can go back and change the preferred date to match the open appointment slot. This is known as "zeroing out" waiting times.
- VSE does not allow zeroing out appointments. In VSE, the first step is to create an appointment request document by entering the date the patient wants or needs to be seen. Once entered, the date cannot be changed. The second step is to display the calendar and make the appointment. Even if multiple calendar queries are necessary to find an open appointment date in the calendar, the original preferred date remains "greyed out" and unable to be changed.
• Improving the accuracy of lists:
- In legacy VistA, when an appointment is made from any of numerous lists, the scheduler must both make the appointment and intentionally remove the patient request from the list. If the scheduler fails to remove the patient from the list, duplicate appointments may be made.
- VSE consolidates all of the current waiting lists (Appointment, Electronic Wait List, Consults, New Enrollee Appointment Request, and Recall) into a single request queue. Appointments may only be made by opening the request from the consolidated list. Appointment creation in VSE automatically closes out the request resulting in improved accuracy of the "lists."
• Eliminating cancellation by clinic errors:
- In legacy VistA, when a user cancels a patient by clinic, they must write down the CID/PD on a piece of paper. Then the user makes a new appointment and transfers the CID/PD manually to the correct field in the new appointment. This is the standard way that the correct CID/PD is preserved.
- In VSE, when the user chooses cancel by clinic, the original CID/PD is "greyed out" and preserved. The cancellation request then reverts to the request list. When a new appointment is made from that request, the original CID/PD is automatically entered into the new appointment.
• Improving the accuracy of CID/PD for multiple book appointments:
- In legacy VistA, when making sequential appointments, for example, for group clinics, the CID/PD from the first appointment in the sequence was used as the reference point for each subsequent appointment. This inflated wait time measurements.
- In VSE, when making sequential appointments, the CID/PD is entered once when making the first appointment in the sequence and the computer calculates the correct CID/PD for each subsequent appointment. If future appointments in the sequence are cancelled and rescheduled, the correct CID/PD is used for the rescheduled appointment.

• Eliminating "next available" errors:
- In legacy VistA, the user must respond to the question "is this a next available appointment?" If the user answers "yes," the CID/PD is set to "today." If the user answers "no," the CID/PD must be entered by the user. The easiest way to use legacy VistA is to respond "yes" to this question, artificially inflating wait times.
- In VSE, the workflow is totally redesigned. The user enters the CID/PD as a first step. Once entered, it cannot be changed. When entered correctly, the application displays the appropriate times on the calendar, making appointing more efficient.

However, we recognize that a technical response, alone, will not serve to develop a premium Veteran-centric mindset in VA employees. To foster enthusiasm for Veteran service in VA's workforce, VA will implement structural processes to reinforce a high performing ethos with passionate leadership. In the fall of 2014, the Secretary of Veterans Affairs, Robert A. McDonald, announced the transformational initiative, MyVA, with an emphasis on executing and cascading principles embedded in the 2014–2020 Strategic Plan. Wait time goals were eliminated from network and facility directors' performance plans, and managers will be trained to use performance indicators, goals, and awards that are appropriate for the Veteran service environment. This will help VA leaders to use performance data in the appropriate way, to identify challenges and begin a conversation about root causes and potential remedies; not as input solely for punishment and reward.

To address Secretary McDonald's MyVA Breakthrough Priority of improving employee experience, the Leaders Developing Leaders program was established. Leaders Developing Leaders will transform VA from a rules-based to a principles-based organization by developing authentic servant leaders. Leaders Developing Leaders will reach approximately 7,300 VA leaders and front line staff and will result in more than 400 projects to strengthen leadership skills and enhance the culture of VA.

As leaders and their teams adopt this mindset and put it into practice, teams will experience greater levels of trust, engagement, and enhanced productivity. The MyVA ultimately effect culture change within the organization that is more closely aligned to, and more effectively supports, long-term organizational goals and innovation.

Question 2: A VA Policy from the Northern Indiana Health Care System states that a Primary Care Provider "has no obligation to follow a treatment plan or medication provided by the community provider if they disagree with the plan.." How is that Veteran-centric? Are VA physicians required to at least contact the Choice provider to discuss the recommended treatment and coordinate any changes prior to substituting their own treatment? If not, why not?

VA Response: There is both a VHA policy and a local policy that outline processes for co-management of patient care. Outlined in the Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care report, care coordination for all Veterans in the future will fall along a continuum of intensity, from basic care coordination or patient navigation to care or disease management to case management. This continuum is influenced by a variety of factors: the complexity of clinical conditions, Veteran preference for engagement, the primary care provider, and the care setting. VA currently offers many diverse care coordination programs that can be difficult to understand and navigate, but we plan to consolidate these programs into an integrated, enterprise-wide model implemented locally. As care coordination matures at VA, it will be provided as a service to community providers who care for Veterans in need of more intensive coordination. The impact of this coordination continuum is to enable Veterans to receive the type of care management and coordination necessary to achieve positive health care outcomes.

Question 3: At the Marion VAMC, a Veteran with Alzheimer's was seen by a non-VA specialist. That physician prescribed non-formulary medication that VA then would not authorize. VA required its formulary drugs to be tried first, with suitable time for evaluation for each of these drugs separately, before allowing a non-formulary request to even be considered. How is that Veteran-centric? Are VA physicians required to first contact the non-VA specialist to discuss the situation? If not, why not?

VA Response: As with all other VA medical centers, the Marion VAMC has a policy which requires providers to first prescribe medications that are on our formulary. If a request is made to utilize a non-formulary medication, either by a community provider or a VA provider, we first see if we have a suitable medication on

our formulary that has the same indication and efficacy. If it is found that a formulary medication is either not tolerated or is insufficiently efficacious, then a provider may request a medication that is not on the VA formulary.

VHA would happily provide more specific information regarding this Veteran if more details and a privacy release from the Veteran are provided. In addition, VHA could ensure ongoing coordination of services for this Veteran.

Question 4: In another example, a disabled Veteran rated at 60% for back and nerve damage has been denied for care closer to home and instead VA is requiring the Veteran to drive 64 miles round trip three times a week for treatment at VA. How is this Veteran-centric care?

VA Response: VHA would happily provide more specific information regarding this Veteran if more details and a privacy release from the Veteran are provided. VA authorizes care in the community in accordance with applicable law, including the Choice Act, and VA policy. With respect to VCP, Veterans may be eligible based on wait-times, residence, or because they face an unusual or excessive burden in travel. Eligibility determinations based on the unusual or excessive burden criterion are made at the local level based on the particular facts of the Veteran's circumstances.

Question 5: In Evansville, Indiana, VA staff discussed a provider staffing shortage that required the Call Center to stop making and/or rescheduling appointments for primary care. The facility specifically indicated "appointment slots are limited, and we are hoping this will decrease the amount of movement of the patients." This is alarming. Please tell me what VA Central Office is doing to correct these types of actions.

VA Response: Capacity at the Evansville Health Care Center is adversely affected by five Patient Aligned Care Team (PACT) clinician vacancies. To assure patients are scheduled appropriately, appointments are triaged by clinical staff so that each Veteran's needs are properly addressed through the correct appointment type. Types of appointments include face-to-face appointments with a provider; phone appointments with a provider; appointments with ancillary services as indicated; appointments at other locations; or CHOICE.

Calls to the Evansville Health Care Center (HCC) do not go through the Call Center. The facility uses the nationally approved call tree for Primary Care and calls go directly to the clinic. If the extension is busy, the call will route to the next available clinic in the Primary Care queue. In the event a Veteran would call the Marion VA Medical Center number and request to speak to an Evansville HCC clinic, the call would be transferred to the appropriate location with a warm hand-off or a message entered in the Computerized Patient Record System for the clinic to return the call to the Veteran.

Question 6: The Evansville VA has assigned Veterans to "vacant panels," which, according to a whistleblower, means there is a documented appointment but no doctor to see the Veteran. Why are these patients not sent to Choice?

VA Response: Evansville HCC currently has five PACT clinician vacancies and two float position vacancies. Provider vacancies resulted from clinician retirement, transfer, or separation. No new Veterans have been assigned to panels without a provider to see the Veteran. For Veterans previously assigned to a vacant panel, several options for appointment are offered to each Veteran:

- The six staffed PACT teams utilize two slots a day for appointments for Veterans assigned to vacant panels.
- Vacant panels are clinically reviewed to determine how best to meet each Veteran's needs - through face-to-face or phone appointments with PACT or appointments with an ancillary service such as Behavioral Medicine, Social Work, Nutritionist, etc.
- If appointments are not available on the Veteran's preferred date, the Veteran is offered an appointment at other Community Based Outpatient Clinic locations.
- If no other location with earlier appointments is acceptable to the Veteran, the Veteran is offered the next available appointment at the Evansville HCC. If the wait time is greater than 30 days, the Veteran is offered community care through VCP.

Letter From Michael J. Missal to Chairman Jeff Miller

The Honorable Jeff Miller Chairman
Committee on Veterans' Affairs United States House
of Representatives Washington, DC 20515

Dear Chairman Miller:

At the Committee's April 19, 2016, hearing on "A Continued Assessment of Delays in Veterans' Access to Health Care," the Office of Inspector General (OIG) indicated that it would provide additional information in response to questions asked by Congressmen Hueslkamp, Coffman, and Abraham regarding the number of OIG referrals made to the U.S. Department of Justice in connection with our investigations into allegations of manipulation of appointment wait times throughout the Veterans Health Administration. Additionally, Congressman Abraham inquired about the scope of the OIG's work in response to allegations of secret wait lists at the Edward Hines, Jr., VA Hospital in Hines, Illinois, and the Overton Brooks VA Medical Center in Shreveport, Louisiana. Enclosed is our response to those questions.

Thank you for the opportunity to provide this information for the hearing record.

Sincerely,

MICHAEL J. MISSAL

Enclosure

Copy to: The Honorable Corrine Brown, Ranking Minority Member
The Honorable Tim Huelskamp
The Honorable Mike Coffman
The Honorable Ralph Abraham

Additional Questions and Answers

Mr. Huelskamp: I understand we had 58 cases referred to the Department of Justice for possible criminal charges. What has the response been from the Justice Department for those 58 criminal cases and the disposition of those?

Mr. Coffman: How many criminal referrals occurred of people who were involved in this [wait times] scandal?

Mr. Abraham: Were there any criminal charges that were sent up to the DOJ for prosecution that you know of?

OIG Response: The VA Office of Inspector General (OIG) opened 116 investigations at 100 unique Veterans Health Administration (VHA) sites regarding allegations that wait times for outpatient appointments were manipulated to give the appearance of a shorter wait for care or that consult appointments were inappropriately cancelled with apparent false justifications. We opened more than one investigation at some individual VHA facilities when allegations appeared to be unrelated schemes.

To date, the OIG made formal referrals to the Department of Justice for 57 of the 116 investigations. Federal prosecutors indicated that 51 of the investigations do not warrant further consideration. Opinions regarding prosecutorial merit for four investigations are currently pending. One case was accepted for prosecution in Georgia, and the defendant, Cathedral Henderson, was indicted on July 8, 2015.[1] The trial in this case is scheduled for May 23, 2016. A second case, which initially started as a wait times investigation but became a conflict of interest case, was accepted for prosecution, and the defendant, Sharon Helman, pled guilty on March 1, 2016, to making a false statement.

To date, we have referred supporting evidence or detailed memoranda regarding 81 sites to VA's Office of Accountability Review for any administrative action VA deems appropriate. In February 2016, we began releasing the findings of the completed investigations by state so that veterans and Congress could have a complete picture of the work completed in their state. To date, we have published 76 administrative summaries of investigation. As we continue to complete these investigations, we intend to post them to this webpage.

[1] http://www.justice.gov/usao-sdga/pr/va-employee-charged-falsifying-medical-records-numerous- veterans.

Mr. Abraham: In a February 25, 2016, letter to the President from the Office of Special Counsel, [OSC] said that VA OIG investigations of whistleblower disclosures regarding wait times at Hines, Illinois, and Shreveport, Louisiana, which is in my state, were inadequate. OSC found that, "the OIG investigations found evidence to support the allegations that the employees were using separate spreadsheets outside of the VA's electronic scheduling and patient record systems. However, the OIG largely limited its review to determine whether the separate spreadsheets were 'secret.'" Please explain why the OIG limited these reviews?

OIG Response: Thank you for the opportunity to explain this matter more fully. OSC has two specific functions under Title 5 U.S.C. Section 1213 and 1214.

- Under Section 1213, OSC has the authority to accept complaints or disclosures of violations of law, rule, regulation, gross mismanagement, gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. OSC does not, however, have authority to investigate these allegations. If OSC determines that the matter should be investigated, OSC is required, within 15 days of receiving the allegations, to refer the matter to the head of the agency for investigation. For disclosures specific to VA, the Secretary of Veterans Affairs is the individual to whom the referral is sent under Title 5 U.S.C. Section 1213. Under the statute, the head of the agency is required to conduct an investigation and provide a written report that includes specific information defined in the statute within 60 days. The OIG does not receive Section 1213 referrals from OSC and has no statutory responsibility to conduct an investigation or provide a written report to OSC. If the OIG has ongoing work relating to a Section 1213 referral, that work is provided to VA and may be the basis for VA's report to OSC.
- Under Section 1214, OSC has the authority to investigate allegations of prohibited personnel practices. When OSC conducts an investigation that requires the production of records maintained by the OIG, OSC sends a written request to the OIG's Information Release Office and the records are provided as allowed by statute. We are not aware of any request by OSC for documents that have not been timely provided to OSC pursuant to its Section 1214 authority.

On June 5 and December 22, 2014, respectively, OSC, under its statutory authority granted under Title 5 U.S.C. Section 1213, referred allegations to the Secretary of Veterans Affairs for investigation concerning the Edward Hines, Jr., VA Hospital (Hines VA Hospital) in Hines, Illinois, and the Overton Brooks VA Medical Center (VAMC) in Shreveport, Louisiana. VA submitted its responses to OSC in July and August 2015, respectively. VA's responses to OSC relied on two prior OIG investigations conducted at each facility. In its February 25, 2016, letter to the President, OSC opined that:

"The OIG investigations that the VA submitted in response to both referrals are incomplete. They do not respond to the issues that the whistleblowers raised. The OIG investigations found evidence to support the whistleblowers' allegations that employees were using separate spreadsheets outside of the VA's electronic scheduling and patient records systems. However, the OIG largely limited its review to determining whether these separate spreadsheets were "secret."

However, neither of the OIG wait time investigations cited by OSC in its letter to the President was conducted in response to a Section 1213 referral from OSC to the VA Secretary. In both cases, OSC made a Section 1213 referral to the VA Secretary months after the OIG investigations had begun.

Overton Brooks VAMC, Shreveport, Louisiana

This OIG investigation was conducted in response to a complaint to the OIG Hotline on June 11, 2014, to which the complainant attached what was referred to as a "secret wait list" that was "obtained from the Mental Health shared drive in Shreveport." The complainant alleged that a specific VA employee had ordered other employees that she supervised to "not have clerks place persons on the electronic wait list and keep a separate list." The complainant stated that he "got his hands on the list after a Nurse gave [him] her password to the list." The OIG interviewed the complainant on June 18, 2014, more than 6 months prior to OSC's December 22, 2014, Section 1213 referral to VA. During that taped interview, the complainant stated that he did not have personal knowledge of the purpose of the list and told the investigators that other individuals had told him about the list. Further, the individuals the complainant identified as having knowledge of the "secret list" were interviewed but did not support the complainant's allegations. In this case, the OIG investigation did not substantiate the allegations the complainant raised in his OIG

Hotline complaint. The allegations attributed to the complainant in the December 22, 2014, Section 1213 OSC referral to the Secretary were not raised by the complainant during the OIG investigation. In addition, neither the complainant nor OSC provided any documentation or other information to support the allegations in the Section 1213 referral.

As discussed in the Administrative Summary of Investigation published on our website, the investigation was expanded proactively to look at wait time manipulation in non-mental health areas. Mental health was not included in the investigation because mental health issues were the subject of a separate health care inspection that was initiated in response to a September 19, 2014, request by the then Ranking Member of the Senate Veterans' Affairs Committee, Senator Richard Burr. During that inspection, additional issues relating to mental health were raised and made part of the inspection. The inspection report was published on the OIG website in January 2016, a month before OSC wrote a letter to the President.

The OIG completed investigation was referred to VA's Office of Accountability Review (OAR) in August 2015. It is our understanding that VA then provided the required Section 1213 written report to OSC on or around August 26, 2015. Unfortunately, there were no communications between the OIG and OSC regarding the Section 1213 referral to VA before or after VA sent the written report to OSC. In addition, we are not aware of any communications between OSC and VA regarding the written report between August 26, 2015, and OSC's February 25, 2016, letter to the President.

Edward Hines, Jr. VA Hospital, Hines, Illinois

The OIG investigation at the Hines VA Hospital began in response to reports by various Chicago and national media outlets regarding "secret backlog lists." The media reports were generated by information provided to the media by a complainant. After seeing the media reports, the OIG immediately began an investigation. Beginning on May 14, 2014, OIG investigators made numerous attempts to interview the complainant. She agreed to be interviewed on May 27, 2014. In addition, on May 21, 2014, the OIG received a letter from Senator Mark Kirk requesting that the OIG investigate allegations that "veterans at the Hines VA facility were provided informational briefings and general consultations in lieu of medical care in order to meet the VA's mandated fourteen-day window for appointments." In addition, Senator Kirk advised that his office had "received additional reports that veterans seen within the fourteen-day window were sometimes not able to see a doctor, and instead met in group consultation/informational sessions without actually receiving medical care." Senator Kirk requested that the OIG investigate three specific issues, which are addressed in our Administrative Summary of Investigation. OSC did not submit a Section 1213 referral to the Acting VA Secretary until June 5, 2014, after our investigation into the complainant's allegations and Senator Kirk's request for an investigation had begun.

As noted in our Administrative Summary of Investigation relating to the Hines VA Hospital that is published on our web site, during the interview the complainant made a number of allegations but did not provide documentation or other information to support her allegations. The complainant did provide two emails that she claimed supported the allegations; however, investigative interviews with the authors of the emails did not support the complainant's claim. The complainant admitted to having no personal knowledge of any other scheduling manipulations or improprieties at the Hines VA Hospital or first-hand knowledge of patient deaths or drastic changes in patient conditions relating to wait times or scheduling manipulation at Hines. Although the complainant stated that they had been contacted by 20–25 people who claimed to have knowledge of these issues, the complainant refused to provide names or further information such as details of these contacts. Further, the complainant also claimed to have relevant documentation but refused to provide it without written assurance that they would not be held responsible for violating the Health Insurance Portability and Accountability Act, an assurance the OIG has no authority to make. In addition, the complainant specifically denied that they had any additional emails, documents, or evidence to provide. Despite the fact that the allegations lacked specificity and the complainant could or would not provide any supporting evidence, the OIG conducted an investigation of the allegation relating to the mental health service and an investigation into scheduling issues in other clinical areas.

The June 5, 2014, Section 1213 referral to VA consisted of general allegations from the complainant but also lacked specificity, investigative leads, and supporting documentation. In addition, the discussion in the referral letter did not include the names of the employees who complained to the complainant or would have relevant information, the names of the supervisors who engaged in the conduct, a specific

date or timeframe during which the conduct occurred, or a specific clinic. Although several services were listed, the list is followed by "and other units." Such vague allegations coupled with the fact that the complainant did not provide more specific information to the investigators rendered it difficult, if not impossible, to fully investigate.

OIG work at the Hines VA Hospital was not limited to wait time allegations. In April 2014, we issued a report concerning unnecessary cardiac interventions and poor management of cardiovascular care. We are currently doing follow-up work on this issue. In the original work, we engaged the services of consultants, including a non-VA thoracic surgeon to review patient records and to identify if any patients were harmed. In the follow-up work, we engaged a non-OIG consultant to assist in the evaluation of clinical cases.

The Hines VA Hospital investigation was sent to VA's OAR on January 26, 2015. It is our understanding that VA provided OSC with a written report compliant with Section 1213 in September 2015. It was not until we saw OSC's letter to the President that we learned OSC had concerns. There was no communication between OSC and OIG staff regarding this matter.