S. HRG. 114–299

GAO'S HIGH-RISK LIST AND THE VETERANS HEALTH ADMINISTRATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

APRIL 29, 2015

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APRIL 29, 2015

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GAO'S HIGH-RISK LIST AND THE VETERANS HEALTH ADMINISTRATION

WEDNESDAY, APRIL 29, 2015

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

The Committee met, pursuant to notice, at 2:35 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Boozman, Rounds, Tillis, Sullivan, Blumenthal, Brown, Tester, Hirono, and Manchin.

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

Chairman ISAKSON. I call this hearing of the Senate Veterans' Affairs Committee to order.

We appreciate our witnesses being here today. We are here to talk about the GAO's High-Risk List, something the VA enjoys a prestigious place on in many areas. I appreciate the testimony we are about to hear. I read a lot of the testimony last night before the hearing today and I think this will be a meaningful and important hearing.

As of April 1, 2015, more than 100, approximately 68 percent, of GAO's recommendations are still open, and 40 percent of the recommendations are more than 3 years old. These are VA recommendations. GAO meets regularly with the VA to discuss what is needed to get off of the list. It should not take a public scolding like a hearing of this type for the VA to implement both GAO and IG recommendations.

It is unclear from VA's testimony if they even understand the importance of being on the list or off the list, for that matter. Nowhere in VA's testimony do they address the specific concerns raised over the years by GAO or the IG. The testimony only outlines the programs VA has said it put in place for a long time. If those programs had worked, VHA would not have been placed on the list to begin with. VA should not simply focus on the number of recommendations they can close. They should focus on all the recommendations. Much like the scandal that erupted in Phoenix this time of year, the problem was not isolated to Phoenix but it was systemic in nature.

Historically, the government as a whole performs very poorly in the area of information technology and VA is no exception. Federal IT has been the area of concern for GAO. Protecting our veterans' personal health care information is a fundamental trust of the VA,

yet it continues to be a security issue, most recently highlighted by the IG, whose report and testimony today, I might add, is outstanding. Allowing contractors to access VA's network from foreign countries, particularly China, raises enormous red flags. The IG's testimony outlines the fact that the VA has over six thousand—six thousand—outstanding systems security risks that have not been remediated.

It is time we raised the visibility of this problem to a public hearing, and I am delighted to turn it over to Ranking Member Richard Blumenthal.

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

Senator BLUMENTHAL. Thanks, Mr. Chairman, and thank you once again for your leadership on these issues we have found in the VA.

This week, I received an update from the GAO on the VA's progress in addressing some of the recommendations since the announcement of VHA's inclusion on the High-Risk List. I also understand that the VA and GAO are meeting periodically in an effort to address some of the outstanding recommendations. These recommendations deal with deep seated, systematic problems in Veterans Health Administration, including inadequate oversight and accountability, ambiguous policies and inconsistent processes, information technology challenges, inadequate training for VA staff, and unclear resource needs and allocation priorities.

The services that you provide are to people who are accustomed to a chain of command and to people being held accountable in that chain of command. When someone fails to do his or her job, they are fired. I would like to see the same accountability in the VA and in the Federal Government that we see in the United States military most of the time—not all of the time, but at least where men's and women's lives are at stake. They are in our health care system every bit as they are in combat. I would like to see the same expectation of accountability, and I hope that the GAO's report and its list will indicate that the time for accountability is now.

I share the Chairman's concerns and I expect a very productive and informative hearing today. Thank you.

Chairman ISAKSON. Thank you, Senator Blumenthal.

We will go directly to our testimony. I welcome Senator Brown to our hearing today. Thank you for being here.

We have three witnesses to testify, Debra Draper, Ph.D., Doctor, Director of Health Care Team, the Government Accountability Office; John Daigh, Doctor, Assistant Inspector General for Healthcare Inspections, Office of the Inspector General, and Mr. Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations, Office of Inspector General; and we all know Carolyn Clancy, Dr. Carolyn Clancy, Interim Under Secretary for Health, Department of Veterans Affairs, accompanied by Stephen Warren, the Executive in Charge for the Office of Information Technology and the Chief Information Officer.

We will begin with Dr. Draper.

STATEMENT OF DEBRA A. DRAPER, Ph.D., DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DRAPER. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, I appreciate the opportunity to be here today to discuss the addition of veterans' health care to GAO's High-Risk List for the first time in 2015.

Since 1990, GAO has regularly reported on government operations that we have identified as high risk due to their vulnerability to fraud, waste, abuse, and mismanagement, or the need for transformation to address economic, efficiency, or effectiveness challenges. In my testimony today, I will address the specific areas of concern that led to VA health care being added to GAO's High-Risk List and actions needed for its removal.

In designating VA health care as high risk, we categorize our specific concerns into five broad areas. The first area of concern is VA's ambiguous policies and inconsistent processes. This has led to inconsistencies in how facilities interpret policies and carry out processes at the local level. In 2012, for example, we reported that unclear policies led staff at VA facilities to inaccurately record the required days for outpatient medical appointments and to inconsistently track new patients waiting for medical care.

The second area of concerns is inadequate oversight and accountability. Specifically, we found that certain aspects of facilities implementation of VA policies are not routinely assessed, oversight activities are often impeded by VA's reliance on facilities' self-reported data, and oversight activities are not always sufficiently focused on compliance with requirements. The facilities' self-reported data lack independent validation and often are inaccurate or incomplete.

The third area of concern is VA's information technology challenges. In various reports, we identified extensive limitations in the capacity of existing technology systems, information technology systems, including systems that are outdated and inefficient. For example, we have reported on VA's failed attempts to modernize its appointment scheduling system, which is prone to user error and manipulation.

The fourth area of concern is inadequate staff training. In a number of reports, we identified gaps in VA training that places the quality and safety of veterans' health at risk. For example, in our October 2014 report on VA's implementation of its new nurse staffing methodology, staff reported that the training was time consuming to complete and difficult to understand. They also said it was difficult finding the time to complete the training while also carrying out their patient care responsibilities.

The fifth area of concern is unclear resource needs and allocation priorities. In various reports, we discussed gaps in the data VA needs to efficiently identify resource needs and ensure that resources are effectively allocated across its health care system. In May 2013, for example, we reported that VA lacked critical data needed to efficiently assess whether the use of non-VA providers was more cost effective than augmenting its own capacity to deliver some services.

VA has taken actions to address some of our recommendations related to its health care system, including those related to the five

broad areas of concern just discussed. However, there are more than 100 recommendations that have yet to be fully resolved.

It is critical that VA leaders act on the findings of its Office of the Inspector General, GAO, and others to develop and implement solutions that mitigate risk for the timeliness, cost effectiveness, quality, and safety of veterans' health care. The Veterans Access, Choice, and Accountability Act included a number of provisions intended to help VA address systemic weaknesses. Effective implementation, coupled with sustained Congressional intention, will help ensure that VA continues to make progress in improving veterans' health care.

We plan to continue monitoring VA's efforts to improve its health care system. We currently have work underway focusing on areas such as veterans' access to primary care and mental health care services, primary care productivity, non-VA care, and mechanisms VA uses to monitor quality of care.

An assessment of the status of VA health care's high-risk designation will be done during our next update in 2017 using the five criteria for removal from the High-Risk List. These include leadership commitment, capacity, development of an action plan, monitoring, and demonstrated progress.

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

[The prepared statement of Ms. Draper follows:]

PREPARED STATEMENT OF DEBRA A. DRAPER, PH.D., DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony

Before the Committee on Veterans' Affairs, U.S. Senate

For Release on Delivery
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VETERANS AFFAIRS HEALTH CARE

Addition to GAO's High Risk List and Actions Needed for Removal

Statement of Debra A. Draper
Director, Health Care

GAO-15-580T

April 29, 2015

VETERANS AFFAIRS HEALTH CARE

Addition to GAO's High Risk List and Actions Needed for Removal

GAO Highlights

Highlights of GAO-15-580T, a testimony before the Committee on Veterans' Affairs, U.S. Senate.

Why GAO Did This Study

VA operates one of the largest health care delivery systems in the nation, including 150 medical centers and more than 800 community-based outpatient clinics. Enrollment in the VA health care system has grown significantly, increasing from 6.8 to 8.9 million veterans between fiscal years 2002 and 2013. Over this same period, Congress has provided steady increases in VA's health care budget, increasing from $23.0 billion to $55.5 billion.

Risks to the timeliness, cost-effectiveness, quality, and safety of veterans' health care, along with other persistent weaknesses GAO and others have identified in recent years, raised serious concerns about VA's management and oversight of its health care system. Based on these concerns, GAO designated VA health care a high-risk area and added it to GAO's High Risk List in 2015.

Since 1990, GAO has regularly updated the list of government operations that it has identified as high risk due to their vulnerability to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

This statement addresses (1) the criteria for the addition to and removal from the High Risk List, (2) specific areas of concern identified in VA health care that led to its high-risk designation; and (3) actions needed to address the VA health care high-risk area.

View GAO-15-580T. For more information, contact Debra A. Draper (202)-512-7114, draperd@gao.gov.

What GAO Found

To determine which federal government programs and functions should be designated high risk, GAO considers a number of factors. For example, it assesses whether the risk involves public health or safety, service delivery, national security, national defense, economic growth, or privacy or citizens' rights, or whether the risk could result in significantly impaired service, program failure, injury or loss of life, or significantly reduced economy, efficiency, or effectiveness. There are five criteria for removal from the High Risk List: leadership commitment, capacity (people and resources needed to resolve the risk), development of an action plan, monitoring, and demonstrated progress in resolving the risk.

In designating the health care system of the Department of Veterans Affairs (VA) as a high-risk area, GAO categorized its concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of veterans' health care, into five broad areas:

1. **Ambiguous policies and inconsistent processes**. GAO found ambiguous VA policies lead to inconsistency in the way its facilities carry out processes at the local level, which may pose risks for veterans' access to VA health care, or for the quality and safety of VA health care.
2. **Inadequate oversight and accountability**. GAO found weaknesses in VA's ability to hold its health care facilities accountable and ensure that identified problems are resolved in a timely and appropriate manner.
3. **Information technology challenges**. Of particular concern is the outdated, inefficient nature of certain systems, along with a lack of system interoperability.
4. **Inadequate training for VA staff**. GAO has identified gaps in VA training that could put the quality and safety of veterans' health at risk or training requirements that were particularly burdensome to complete.
5. **Unclear resource needs and allocation priorities**. GAO has found gaps in the availability of data required by VA to efficiently identify resource needs and to ensure that resources are effectively allocated across the VA health care system.

VA has taken actions to address some of the recommendations GAO has made related to VA health care, including those related to the five broad areas of concern highlighted above; however, there are currently more than 100 that have yet to be fully resolved. For example, to ensure that processes are being carried out more consistently at the local level—such as scheduling veterans' medical appointments—VA needs to clarify its existing policies, as well as strengthen its oversight and accountability across its facilities. The Veterans Access, Choice, and Accountability Act of 2014 included a number of provisions intended to help VA address systemic weaknesses in its health care system. Effective implementation, coupled with sustained congressional attention to these issues, will help ensure that VA continues to make progress in improving the delivery of health care services to veterans. GAO plans to continue monitoring VA's efforts to improve veterans' health care. An assessment of the status of VA health care's high-risk designation will be done during GAO's next update in 2017.

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

I am pleased to be here today to discuss managing risks and improving health care in the Department of Veterans Affairs (VA), an area that was added to GAO's High Risk List for the first time in 2015.[1]

Since 1990, we have regularly reported on government operations that we have identified as high risk due to their vulnerability to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. Our high-risk program—which is intended to help inform the congressional oversight agenda and to guide efforts of the administration and agencies to improve government performance—has brought much-needed focus to problems impeding effective government and costing billions of dollars. In 1990, we designated 14 high-risk areas. Since then, generally coinciding with the start of each new Congress, we have reported on the status of progress to address previously designated high-risk areas, determined whether any areas could be removed or consolidated, and identified new high-risk areas.[2]

Risks to the timeliness, cost-effectiveness, quality, and safety of veterans' health care, along with other persistent weaknesses we have identified in recent years, have raised serious concerns about VA's management and oversight of its health care system. Based on these concerns, we designated VA health care a high-risk area and added it to the High Risk List in 2015—one of two areas added this year, for a total of 32 high-risk areas on the 2015 list. In particular, increasing enrollment and expenditures for VA health care, the growing demand for services, new legislative requirements, and ongoing problems offering timely, coordinated care to veterans contributed to this designation.

VA operates one of the largest health care delivery systems in the nation, and it is growing. As of fiscal year 2014, VA was operating an expansive system of health care facilities, including 150 medical centers and more

[1]GAO, *High Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[2]Since 1990, a total of 57 different areas have appeared on our High Risk List, 23 have been removed, and 2 have been consolidated. On average, high-risk areas that have been removed from the list remained on it for 9 years after they were initially added.

than 800 community-based outpatient clinics nationwide. In the years since the United States began conducting military operations in Afghanistan and Iraq, enrollment in the VA health care system has increased significantly—from 6.8 million veterans in fiscal year 2002 to 8.9 million veterans in fiscal year 2013. Consequently, VA has faced a growing demand by veterans for its health care services, a trend that is expected to continue. For example, the total number of annual outpatient medical appointments VA provided increased by 39.9 million visits (about 85 percent) between fiscal years 2002 and 2013. Over that same period, Congress provided steady increases in VA's annual health care budget, with amounts more than doubling, increasing from $23.0 billion to $55.5 billion between fiscal years 2002 and 2013. Despite these substantial budget increases, for more than a decade there have been numerous reports—by GAO, VA's Office of the Inspector General, and others—of VA facilities failing to provide timely health care. In some cases, the delays in care or VA's failure to provide care at all have reportedly resulted in harm to veterans.

In response to these and other serious and longstanding problems with veterans' access to care, which were highlighted in a series of congressional hearings in the spring and summer of 2014, Congress enacted the Veterans Access, Choice, and Accountability Act of 2014,[3] which provides $15 billion in new funding for VA health care. Generally, this law requires VA to offer veterans the option to receive hospital care and medical services from a non-VA provider when a VA facility cannot provide an appointment within 30 days, or when veterans reside more than 40 miles from the nearest VA facility. Under the law, VA received $10 billion to cover the expected increase in utilization of non-VA providers to deliver health care services to veterans. The $10 billion is available until expended and is meant to supplement VA's current budgetary resources for medical care. Further, the law appropriated $5 billion to increase veterans' access to care by expanding VA's capacity to deliver care to veterans by hiring additional clinicians and improving the physical infrastructure of VA's facilities. It is therefore critical that VA ensures its resources are being used in a cost-effective manner to improve veterans' timely access to health care.

[3]Pub. L. No. 113-146, 128 Stat. 1754 (Aug. 7, 2014)

While timely and cost-effective access to needed health care services is essential, it also is imperative that VA ensures the quality and safety of the services it provides. With the increased utilization of non-VA providers that is expected to occur as a result of the Veterans Access, Choice, and Accountability Act, veterans may be required to navigate multiple complex health care systems—the VA health care system and those of non-VA providers—to obtain needed health care services. Coordination of care between VA and non-VA providers is critical. Without it, there is increased risk of unfavorable health outcomes for veterans. For example, a lack of care coordination may lead to unnecessary duplication of services, which is not only costly, but also may pose health risks to veterans who may receive care that is not needed. Moreover, the quality of care may be adversely affected if important clinical information is not promptly communicated between VA and non-VA providers. Safeguarding the quality and safety of health care services provided within VA facilities is also essential. A series of infectious disease outbreaks at several VA facilities over the past several years—and allegations that VA officials may have withheld information about the outbreaks from the public—have raised concerns about the effectiveness of patient safety practices at VA's facilities.

In my statement today, which is based on our February 2015 *High-Risk Series: An Update*,[4] I will address (1) the criteria for additions to and removals from GAO's High Risk List, (2) specific areas of concern identified in VA health care that led to its high-risk designation; and (3) actions needed to address the VA health care high-risk area.

[4]GAO-15-290.

High Risk List Designation Status Depends on Program Significance, Effects, and Status of Corrective Measures

Criteria for Addition to the High Risk List

To determine which federal government programs and functions should be designated high risk, we use our guidance document, *Determining Performance and Accountability Challenges and High Risks*.[5] Further, we consider qualitative factors, such as whether the risk

- involves public health or safety, service delivery, national security, national defense, economic growth, or privacy or citizens' rights; or
- could result in significantly impaired service, program failure, injury or loss of life, or significantly reduced economy, efficiency, or effectiveness.

We also consider the exposure to loss in monetary or other quantitative terms. At a minimum, $1 billion must be at risk, in areas such as the value of major assets being impaired; revenue sources not being realized; major agency assets being lost, stolen, damaged, wasted, or underutilized; potential for, or evidence of, improper payments; and presence of contingencies or potential liabilities. Before making a high-risk designation, we also consider corrective measures planned or under way to resolve a material control weakness and the status and effectiveness of these actions.

Criteria for Removal of High-Risk Designation

Since 1990, more than one-third of the areas previously designated as high risk have been removed from the High Risk List because sufficient progress was made in addressing the problems identified. Nonetheless, 11 issues have been on the High Risk List since the 1990s and 6 of these were on our original list of 14 areas in 1990.

[5]GAO, *Determining Performance and Accountability Challenges and High Risks*, GAO-01-159SP (Washington, D.C.: November 2000).

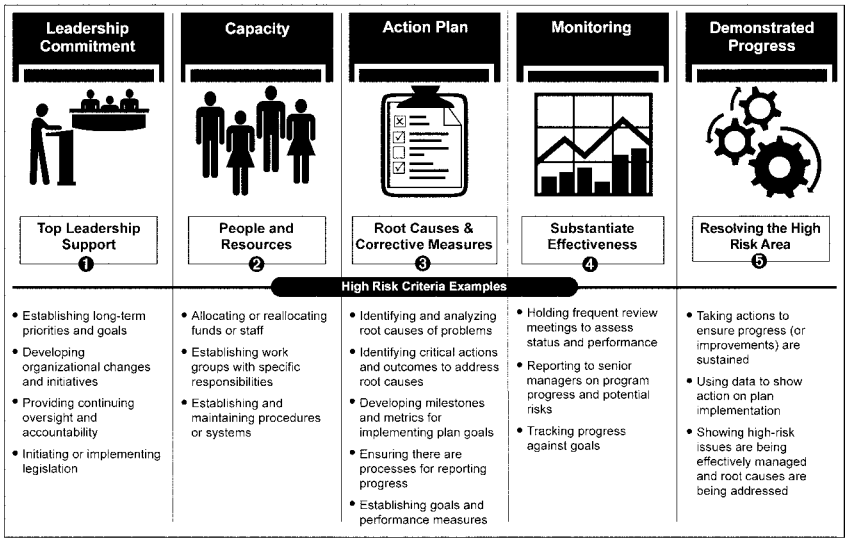
Our experience with the high-risk series over the past 25 years has shown that the key elements needed to make progress in high-risk areas are top-level attention by the administration and agency leaders grounded in the five criteria for removal from the High Risk List, as well as any needed congressional action.[6] The five criteria for removal are

- **Leadership Commitment**. Demonstrated strong commitment and top leadership support.
- **Capacity**. Agency has the capacity (i.e., people and resources) to resolve the risk(s).
- **Action Plan**. A corrective action plan exists that defines the root cause, identifies solutions, and provides for substantially completing corrective measures, including steps necessary to implement solutions we recommended.
- **Monitoring**. A program has been instituted to monitor and independently validate the effectiveness and sustainability of corrective measures.
- **Demonstrated Progress**. Ability to demonstrate progress in implementing corrective measures and in resolving the high-risk area.

These five criteria form a road map for efforts to improve and ultimately address high-risk issues. Addressing some of the criteria leads to progress, while satisfying all of the criteria is central to removal from the list. Figure 1 shows the five criteria for removal as a designated high-risk area and examples of actions taken by agencies in response.

[6]GAO-01-159SP.

Figure 1: Five Criteria for Removal from the GAO High Risk List



Source: GAO analysis of agencies' actions to address high-risk issues and GAO criteria for removal from the High Risk List in GAO-01-159SP. | GAO-15-580T

Five Broad Areas of Concern Contributed to Designation of VA Health Care as High Risk

In designating VA as a high-risk area, we categorized our concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of veterans' health care, into five broad areas: (1) ambiguous policies and inconsistent processes, (2) inadequate oversight and accountability, (3) information technology challenges, (4) inadequate training for VA staff, and (5) unclear resource needs and allocation priorities. We have made numerous recommendations that aim to address weaknesses in VA's management and oversight of its health care system. Although VA has taken actions to address some of them, more than 100 recommendations have yet to be fully resolved, including recommendations related to the following five broad areas of concern:

- ***Ambiguous policies and inconsistent processes.*** Ambiguous VA policies lead to inconsistency in the way VA facilities carry out processes at the local level. In numerous reports, we have found that this ambiguity and inconsistency may pose risks for veterans' access to VA health care, or for the quality and safety of VA health care they receive.

  For example, in December 2012, we found that unclear policies led staff at VA facilities to inaccurately record the required dates for appointments and to inconsistently track new patients waiting for outpatient medical appointments at VA facilities. These practices may have delayed the scheduling of veterans' outpatient medical appointments and may have increased veterans' wait times for accessing care at VA facilities. In some cases, we found that staff members were manipulating medical appointment dates to conform to VA's timeliness guidelines, which likely contributed further to the inaccuracy of VA's wait-times data for outpatient medical appointments. Without accurate data, VA lacks assurance that veterans are receiving timely access to needed health care.

  In our November 2014 report, we found that VA policies lacked clear direction for how staff at VA facilities should document information about veteran suicides as part of VA's behavioral health autopsy program (BHAP). The BHAP is a national initiative to collect demographic, clinical, and other information about veterans who have died by suicide and use it to improve the department's suicide prevention efforts. In a review of a sample of BHAP records from five VA facilities, we found that more than half of the records had incomplete or inaccurate information. The lack of reliable data limited the department's opportunities to learn from past veteran suicides and ultimately diminished VA's efforts to improve its suicide prevention activities.

  We have also identified gaps in VA policies related to facilities' response to adverse events—clinical incidents that may pose the risk of injury to a patient as the result of a medical intervention or the lack of an appropriate intervention, such as a missed or delayed diagnosis, rather than due to the patient's underlying medical condition. Specifically, we found that VA policies were unclear as to how focused professional practice evaluations (FPPE) should be documented, particularly what information should be included. An FPPE is a time-limited evaluation during which a VA facility assesses a provider's professional competence when a question arises regarding the provider's ability to provide safe, quality patient care. In our December 2013 report, we found that gaps in VA's FPPE policy

may have hindered VA facilities' ability to appropriately document the evaluation of a provider's skills, support any actions initiated, and track provider-specific incidents over time.

- ***Inadequate oversight and accountability***. We also have found weaknesses in VA's ability to hold its health care facilities accountable and ensure that identified problems are resolved in a timely and appropriate manner. Specifically, we have found that (1) certain aspects of VA facilities' implementation of VA policies are not routinely assessed by the department; (2) VA's oversight activities are not always sufficiently focused on its facilities' compliance with applicable requirements; and (3) VA's oversight efforts are often impeded by its reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete.

  In a July 2013 report, for example, we found that VA needed to take action to improve the administration of its provider performance pay and award systems. In that report, we found that VA had not reviewed performance goals set by its facilities for providers and, as a result, concluded that VA did not have reasonable assurance that the goals created a clear link between performance pay and providers' performance in caring for veterans. At four VA facilities included in our review, performance pay goals covered a range of areas, such as clinical competence, research, teaching, patient satisfaction, and administration. Providers who were eligible for performance pay received it at all four of the facilities we reviewed, despite at least one provider in each facility having personnel actions taken against them related to clinical performance in the same year. Such personnel actions resulted from issues including failing to read mammograms and other complex images competently, practicing without a current license, and leaving residents unsupervised during surgery.

  In March 2014, we found that VA lacked sufficient oversight mechanisms to ensure that its facilities were complying with applicable requirements and not inappropriately denying claims for non-VA care. Specifically, the March 2014 report cited noncompliance with applicable requirements for processing non-VA emergency care claims for a sample we reviewed. The noncompliance at four VA facilities led to the inappropriate denial of about 20 percent of the claims we reviewed and the failure to notify almost 65 percent of veterans whose claims we reviewed that their claims had been denied. We found VA's field assistance visits, one of the department's primary methods for monitoring facilities' compliance with applicable requirements, to be lacking. In these annual on-site reviews at a sample of VA facilities, VA officials were to examine the financial,

clinical, administrative, and organizational functions of staff responsible for processing claims for non-VA care; however, we found that these visits did not examine all practices that could lead VA facilities to inappropriately deny claims. Further, although VA itself recommended that managers at its facilities audit samples of processed claims to determine whether staff processed claims appropriately, the department did not require VA facilities to conduct such audits, and none of the four VA facilities we visited were doing so.

In a September 2014 report and in three previous testimonies for congressional hearings, we identified weaknesses in VA's oversight of veterans' access to outpatient specialty care appointments in its facilities. VA officials told us they use data reported by VA facilities to monitor how the facilities are performing in meeting VA's guideline of completing specialty care consults—requests from VA providers for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure, such as a colonoscopy—within 90 days. We found cases where staff had incorrectly closed a consult even though care had not been provided, and found that VA does not routinely audit consults to assess whether its facilities are appropriately managing them and accurately documenting actions taken to resolve them. Instead, we found that VA relied largely on facilities' self-certification that they were doing so.

- ***Information technology challenges***. In recent reports, we also have identified limitations in the capacity of VA's existing information technology (IT) systems. Of particular concern is the outdated, inefficient nature of certain systems, along with a lack of system interoperability—the ability to exchange information—which presents risks to the timeliness, quality, and safety of VA health care.

  For example, we have reported on VA's failed attempts to modernize its outpatient appointment scheduling system, which is about 30 years old. Among the problems cited by VA staff responsible for scheduling appointments are that the system requires them to use commands requiring many keystrokes and that it does not allow them to view multiple screens at once. Schedulers must open and close multiple screens to check a provider's or a clinic's full availability when scheduling a medical appointment, which is time-consuming and can lead to errors. VA undertook an initiative to replace its scheduling system in 2000 but terminated the project after spending $127 million over 9 years, due to weaknesses in project management and a lack of effective oversight. The department has since renewed its efforts to replace its appointment scheduling system, including launching a

contest for commercial software developers to propose solutions, but VA has not yet purchased or implemented a new system.

In 2014, we found that interoperability challenges and the inability to electronically share data across facilities led VA to suspend the development of a system that would have allowed it to electronically store and retrieve information about surgical implants (including tissue products) and the veterans who receive them nationwide. Having this capability would be particularly important in the event that a manufacturer or the Food and Drug Administration (FDA) recalled a medical device or tissue product because of safety concerns. In the absence of a centralized system, at the time of our report VA clinicians tracked information about implanted items using stand-alone systems or spreadsheets that were not shared across VA facilities, which made it difficult for VA to quickly determine which patients may have received an implant that was subject to a safety recall.

Further, as we have reported for more than a decade, VA and the Department of Defense (DOD) lack electronic health record systems that permit the efficient electronic exchange of patient health information as military servicemembers transition from DOD to VA health care systems. The two departments have engaged in a series of initiatives intended to achieve electronic health record interoperability, but accomplishment of this goal has been continuously delayed and has yet to be realized. The ongoing lack of electronic health record interoperability limits VA clinicians' ability to readily access information from DOD records, potentially impeding their ability to make the most informed decisions on treatment options, and possibly putting veterans' health at risk. One location where the delays in integrating VA's and DOD's electronic health records systems have been particularly burdensome for clinicians is at the Captain James A. Lovell Federal Health Care Center (FHCC) in North Chicago, the first planned fully integrated federal health care center for use by both VA and DOD beneficiaries. We found in June 2012 that due to interoperability issues, the FHCC was employing five dedicated, full-time pharmacists and one pharmacy technician to conduct manual checks of patients' VA and DOD health records to reconcile allergy information and identify possible interactions between drugs prescribed in VA and DOD systems.

- ***Inadequate training for VA staff.*** In a number of reports, we have identified gaps in VA training that could put the quality and safety of veterans' health at risk. In other cases, we have found that VA's training requirements can be particularly burdensome to complete, particularly for VA staff who are involved in direct patient care.

In a November 2014 report that examined VA's monitoring of veterans with major depressive disorder (MDD) and whether those who are prescribed an antidepressant receive recommended care, we determined that VA data may underestimate the prevalence of MDD among veterans and that a lack of training for VA clinicians on diagnostic coding may contribute to the problem. In a review of medical record documentation for a sample of veterans, we found that VA clinicians had not always appropriately coded encounters with veterans they diagnosed as having MDD, instead using a less specific diagnostic code for "depression not otherwise specified." VA's data on the number of veterans with MDD are based on the diagnostic codes associated with patient encounters; therefore, coding accuracy is critical to assessing VA's performance in ensuring that veterans with MDD receive recommended treatments, as well as measuring health outcomes for these veterans.

In a May 2011 report, we found that training for staff responsible for cleaning and reprocessing reusable medical equipment (RME), such as endoscopes and some surgical instruments, was lacking. Specifically, VA had not specified the types of RME for which training was required; in addition, VA provided conflicting guidance to facilities on how to develop this training. Without appropriate training on reprocessing, we found that VA staff may not be reprocessing RME correctly, posing patient safety risks.

In our October 2014 report on VA's implementation of a new, nationally standardized nurse staffing methodology, staff from selected VA facilities responsible for developing nurse staffing plans told us that VA's individual, computer-based training on the methodology was time-consuming to complete and difficult to understand. These staff members said they had difficulty finding the time to complete it while also carrying out their patient care responsibilities. Many suggested that their understanding of the material would have been greatly improved with an instructor-led, group training course where they would have an opportunity to ask questions.

- ***Unclear resource needs and allocation priorities***. In many of our reports, we have found gaps in the availability of data required by VA to efficiently identify resource needs and to ensure that resources are effectively allocated across the VA health care system.

  For example, in October 2014, we found that VA facilities lacked adequate data for developing and executing nurse staffing plans at their facilities. Staffing plans are intended to help VA facilities identify appropriate nurse staffing levels and skill mixes needed to support

high-quality patient care in the different care settings throughout each VA facility, and are used to determine whether their existing nurse workforce sufficiently meets the clinical needs of each unit, or whether facilities need to hire additional staff. At selected VA facilities, staff members responsible for developing and executing the nurse staffing plans told us that they needed to use multiple sources to collect and compile the data—in some cases manually. They described the process as time-consuming, potentially error-prone, and requiring data expertise they did not always have.

In a May 2013 report, we found that VA lacked critical data needed to compare the cost-effectiveness of non-VA medical care to that of care delivered at VA facilities. Specifically, VA lacks a data system to group medical care delivered by non-VA providers by episode of care—all care provided to a veteran during a single office visit or inpatient stay. As a result, VA cannot efficiently assess whether utilizing non-VA providers is more cost-effective than augmenting its own capacity in areas with high non-VA health care utilization.

In a September 2014 report, we identified concerns with VA's management of its pilot dialysis program, which had been implemented in four VA-operated clinics. Specifically, we found that, five years into the pilot, VA had not set a timetable for the completion of its dialysis pilot or documented how it would determine whether the pilot was successful, including improving the quality of care and achieving cost savings. We also found that VA data on the quality of care and treatment costs were limited due to the delayed opening of two of the four pilot locations. Veterans who receive dialysis are one of VA's most costly populations to serve, but VA has limited capacity to deliver dialysis in its own facilities, and instead refers most veterans to non-VA providers for this treatment. VA began developing its dialysis pilot program in 2009 to address the increasing number of veterans needing dialysis and the rising costs of providing this care through non-VA providers.

Sustained Attention and Focus Needed to Resolve More than 100 Recommendations for Improvement in VA Health Care

VA has taken actions to address some of the recommendations we have made related to VA health care; however, there are currently more than 100 that have yet to be fully resolved, including recommendations related to the five broad areas of concern highlighted above. For example, to ensure that its facilities are carrying out processes at the local level more consistently—such as scheduling veterans' medical appointments—VA needs to clarify its existing policies. VA also needs to strengthen oversight and accountability across its facilities by conducting more systematic, independent assessments of processes carried out at the local level, including how VA facilities are resolving specialty care consults and processing claims for non-VA care. We also have recommended that VA work with DOD to address the administrative burdens created by the lack of interoperability between their two IT systems. A number of our recommendations aim to improve training for staff at VA facilities, to address issues such as how staff are cleaning, disinfecting, and sterilizing reusable medical equipment, and to more clearly align training on VA's new nurse staffing methodology with the needs of staff responsible for developing nurse staffing plans. Finally, we have recommended that VA improve its methods for identifying VA facilities' resource needs and for analyzing the cost-effectiveness of VA health care.

The recently enacted Veterans Access, Choice, and Accountability Act included a number of provisions intended to help VA address systemic weaknesses. For example, the law requires VA to contract with an independent entity to (1) assess its capacity to meet the needs of veterans who use the VA health care system, given their current and projected demographics, (2) examine VA's clinical staffing levels and productivity, and (3) review VA's IT strategies and business processes, among other things. The new law also establishes a 15-member commission, to be appointed primarily by bipartisan congressional leadership, which will examine how best to organize the VA health care system, locate health care resources, and deliver health care to veterans. It is critical for VA leaders to act on the findings of this independent contractor and congressional commission, as well as on those of VA's Office of the Inspector General, GAO, and others, and to fully commit themselves to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality, and safety of the VA health care system.

It is also critical that Congress maintain its focus on oversight of VA health care. In the spring and summer of 2014, congressional committees held more than 20 hearings to address identified weaknesses in the VA health care system. Sustained congressional attention to these issues will help ensure that VA continues to make progress in improving the delivery of health care services to veterans.

We plan to continue monitoring VA's efforts to improve the timeliness, cost-effectiveness, quality, and safety of veterans' health care. To this end, we have ongoing work focusing on topics such as veterans' access to primary care and mental health services; primary care productivity; nurse recruitment and retention; monitoring and oversight of VA spending on training programs for health care professionals; mechanisms VA uses to monitor quality of care; and VA and DOD investments in Centers of Excellence—which are intended to produce better health outcomes for veterans and service members. An assessment of the status of VA health care's high-risk designation will be done during our next update in 2017.

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

For further information about this statement, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Key contributors to this statement were Jennie Apter, Jacquelyn Hamilton, and Alexis C. MacDonald.

Related GAO Products

VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data. GAO-15-55. Washington, D.C.: November 12, 2014.

VA Health Care: Actions Needed to Ensure Adequate and Qualified Nurse Staffing. GAO-15-61. Washington, D.C.: October 16, 2014.

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.: September 30, 2014.

VA Dialysis Pilot: Documentation of Plans for Concluding the Pilot Needed to Improve Transparency and Accountability. GAO-14-646. Washington, D.C.: September 2, 2014.

Veterans' Health Care: Oversight of Tissue Product Safety. GAO-14-463T. Washington, D.C.: April 2, 2014.

VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit. GAO-14-175. Washington, D.C.: March 6, 2014.

Electronic Health Records: VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration. GAO-14-302. Washington, D.C.: February 27, 2014.

VA Surgical Implants: Purchase Requirements Were Not Always Followed at Selected Medical Centers and Oversight Needs Improvement. GAO-14-146. Washington, D.C.: January 13, 2014.

VA Health Care: Improvements Needed in Processes Used to Address Providers' Actions That Contribute to Adverse Events. GAO-14-55. Washington, D.C.: December 3, 2013.

VA Health Care: Actions Needed to Improve Administration of the Provider Performance Pay and Award Systems. GAO-13-536. Washington, D.C.: July 24, 2013.

VA Health Care: Management and Oversight of Fee Basis Care Need Improvement. GAO-13-441. Washington, D.C.: May 31, 2013.

VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement. GAO-13-130. Washington, D.C.: December 21, 2012.

VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking. GAO-12-669. Washington, D.C.: June 26, 2012.

VA Health Care: Weaknesses in Policies and Oversight Governing Medical Supplies and Equipment Pose Risks to Veterans' Safety. GAO-11-391. Washington, D.C.: May 3, 2011.

Chairman ISAKSON. Thank you, Dr. Draper.

Dr. Daigh.

STATEMENT OF JOHN D. DAIGH, JR., M.D., C.P.A., ASSISTANT INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GARY ABE, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL

Dr. DAIGH. Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, I am honored to attend this hearing.

The Office of the Inspector General's work through its Office of Healthcare Inspections, Office of Audit and Evaluations, and Office of Investigations supports the decision of GAO to place Veterans Health Administration on its High-Risk List.

There have been a number of recent hearings which have identified many of the issues that VA must address, from business processes, IT capabilities, organizational structure, to personnel practices. VA leadership has committed to make these changes.

The Choice Act recognizes that VA cannot provide all the medical care that veterans require. The decisions to make or buy health care must be done carefully and with broad community input. I hope that stakeholders will test the decisions VA makes over the coming months primarily by assessing the impact that decisions have upon the quality of health care provided.

With that, Mr. Abe from the OIG Office of Audits and Evaluations and I will be pleased to answer your questions.

[The prepared statement of Dr. Daigh follows:]

PREPARED STATEMENT OF JOHN D. DAIGH, JR., M.D., CPA, ASSISTANT INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, Thank you for the opportunity to discuss the Office of Inspector General's (OIG) health care reviews and audits of programs and performance of the Veterans' Health Administration (VHA). I am accompanied by Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations, Office of Inspector General.

VHA is at risk of not performing its mission as the result of several intersecting factors. VHA has several missions, and too often management decisions compromise the most important mission of providing veterans with quality health care. Leadership has too often compromised national VHA standards to meet short term goals. The Veterans Integrated Service Networks (VISN) do not consistently support local VA medical centers (VAMC) to encourage success and proactively address areas of risk. Resource management data gaps make the cost-effective delivery of a national benefit challenging. VHA's internal processes are inefficient and make the conduct of routine business unnecessarily burdensome.

PRIMARY MISSION IS QUALITY HEALTH CARE

VHA has many missions, the first of which should be the delivery of high quality health care. The first test of a management decision should be an assessment of its impact upon the delivery of quality health care. For example, veterans who receive their medical care through the VA need timely access to emergency care. The management of a possible myocardial infarction, stroke, or appendicitis requires not only a sophisticated emergency room and readily available imaging, but hospital specialty treatment rooms and dedicated teams to provide timely critical care. Many smaller hospitals cannot provide timely expert care for patients with these conditions. VHA's decision to operate an emergency room or urgent care center should have the quality delivery of this care as its most important standard. Arguments that veterans prefer to receive their care at VA or that this care creates contracting difficulties are secondary to the imperative that high quality care be provided. All medical care provided at each facility should be considered against this test.

VHA LEADERS MUST SET HIGH STANDARDS AND SUPPORT SUBORDINATES

The many OIG reports on the Phoenix VA Health Care System and problems with the VA appointment system highlight the challenges leaders must overcome if quality health care is to be provided.

Since May 28, 2014, we have issued four reports on the Phoenix VA Health Care System (PVAHCS).[1] The initial two reports (May 2014 and August 2014) were the

[1] *Healthcare Inspection—Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona*, February 26, 2015; *Interim Report—Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona*, January 28, 2015; *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health*

result of work by a multidisciplinary staff from the OIG's Office of Audits and Evaluations and Office of Healthcare Inspections. The OIG found patients at the PVAHCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them. Patients frequently encountered obstacles when they or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while traveling or temporarily living in Phoenix. The problems in Phoenix were due to a failure by management to recognize the increased demands on the facility and to request and apply the resources to address those demands either through increased staffing or increased use of non-VA fee care.

Also, senior headquarters and facility leadership were not held accountable for implementing action plans that addressed compliance with scheduling procedures. The use of inappropriate scheduling practices caused reported wait times to be unreliable. The underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA and PVAHCS's senior leadership ranks and mid-level managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible.

In our first two reports, we made 24 recommendations to VA to implement immediate and substantive changes to their policies and procedures. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans. As of March 3, 2015, 18 recommendations from these reports remain open. In response to our work, VA reported it took immediate action to ensure that 3,400 veterans who we identified needed health care services received medical appointments. Our review identified that use of unofficial wait lists and manipulation of wait time data were pervasive practices in VA. As a result, VA reported it took immediate actions to reach out to over 266,000 veterans to get them off wait lists and into clinics, made nearly 912,000 referrals to private health care providers for needed care, and scheduled approximately 200,000 new VA appointments nationwide for veterans. These reports brought much needed accountability over serious access issues, led to changes in the highest level of VA leadership, and enactment of the Veterans Access, Choice, and Accountability Act of 2014 (also known as The Choice Act), which expanded veterans' access to care outside the VA system and included a $16 billion increase in VA's funding.

The most recent reports issued by the OIG's Office of Healthcare Inspections were the results of information received during the work conducted at the PVAHCS during the spring and summer of 2014. Our January 28, 2015, interim report on PVAHCS's Urology Services requires VA's immediate attention. It is also indicative of the challenges that VA faces in staffing and coordinating non-VA care. After experiencing a staffing shortage within the PVAHCS Urology Department, some patients were referred to non-VA urologists via voucher or fee basis authorization. In 23 percent of cases reviewed, we found approved authorizations for care, notations that authorizations were sent to contracted providers, and scheduled dates and times of appointment with non-VA urologists but no scanned documents verifying that patients were seen for evaluations and, if seen, what the evaluations might have revealed. This finding suggests that PVAHCS has no accurate data on the clinical status of the patients who were referred for urologic care outside of the facility.

VHA ORGANIZATIONAL ENTITIES MUST BE MORE EFFECTIVE

The current VISN structure has not worked effectively to support and solve problems facing hospitals. A VISN contains medical facilities of varying size and capability. For example, one requirement for all medical facilities is that their providers be properly credentialed and privileged. One aspect of privileging providers is the presentation of physician performance data to the hospital privileging committee. In a forthcoming report on solo physicians' professional practice evaluations, we found that in hospitals where there are specialty units with small numbers of providers, it is difficult to obtain unbiased peer reviews of clinical cases and appropriate assessments of clinical performance by peers. The VISN structure has been inconsistently effective in addressing this issue.

Each VISN has a different internal organization and each medical facility has a different internal structure. This lack of standardization makes the dissemination of information and policy to facilities challenging and the acquisition of critical data from facilities more difficult. When we tested facility compliance with directives re-

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Care System, August 26, 2014; *Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*, May 28, 2014.

garding the proper treatment of reusable medical equipment, we found significant non-compliance with initial policy statements.[2] When we looked at VA data on compliance with instructions to address shortcomings in the consult management process, there was wide variance across the VISNs in compliance with instructions.[3]

RESOURCE MANAGEMENT

VHA's budget and execution data across the system does not permit ready analysis at the Department or clinic level across VHA. The cost of providers and support staff is often a relevant cost in health care financial analysis. VHA does not have an adequate system to build the human requirements to provide health care appropriate for financial analysis. In recognition of this issue, Congress passed The Choice Act which requires the OIG for the next 5 years to report on the staffing needs of VHA and to audit the accuracy and timeliness of payments made under this law within 30 days after VHA has spent 75 percent of the $9.7 billion in funding authorized for patient care. Our first report was issued on January 30, 2015, in which we noted that the five occupations with the largest staffing shortages were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist.[4] The data presented is VHA's "wish" list for talent, not a requirement driven list. The requirement for VHA to develop a staffing methodology is not new. OIG assessed whether VHA has an effective methodology for determining physician staffing levels for 33 of VHA's specialty care services.[5] Audits and inspections continue to identify the need for VHA to improve its staffing methodology by implementing productivity standards. Public law mandates VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. We found VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for all specialties and VA medical facility management did not develop staffing plans. This occurred because there is a lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans. Other essential personnel in a hospital, to include pharmacists, dieticians, physical therapists, also do not have staffing standards.

Each VISN and hospital has its own unique organizational chart. The combination of a lack of a robust capability to determine requirements and a lack of organizational standardization impedes the ability of managers to make effective financial decisions.

OPERATIONAL EFFICIENCY MUST IMPROVE

A number of VHA's internal operations and systems, which should be seamless to providers, do not function well. The appointment system inefficiencies have contributed to wait time problems. Medical consultation software was permitted to devolve such that information within the system was not standard and in many cases not reliable. This has resulted in patients who were lost to appropriate colon cancer screening. The process of hiring a new employee is extremely cumbersome and is but one element of the human resources management program that must improve. The work-arounds and lost productivity attributed to these "systems" makes the delivery of quality care much more difficult.

THE VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014

Implementation of the Veterans Access, Choice, and Accountability Act of 2014 is a considerable challenge for VA. In addition to coordinating care for patients outside the VA system, VA also has to ensure that payments are made timely and accurately and that results of medical appointments are shared between VA and non-VA providers. These issues have been problematic in the past for VA. The OIG has provided significant oversight of billing issues in the non-VA Fee Care program over the last several years.[6]

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[2] *Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities*, June 16, 2009; *Follow-Up Colonoscope Reprocessing at VA Medical Facilities*, September 17, 2009.

[3] *Healthcare Inspection—Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet*, December 15, 2014.

[4] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, January 30, 2015.

[5] *Audit of Physician Staffing Levels for Specialty Care Services*, December 27, 2012.

[6] *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, August 3, 2009; *Veterans Health Administration—Review of Outpatient Fee Payments at the VA Pacific Islands Health Care System*, March 17, 2010; *Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program*, June 8, 2010; *Audit of Non-VA Inpatient Fee*

NON-VA CARE

Non-VA medical care is care provided to eligible veterans outside of VA when VA facilities are not feasibly available. It consists of two major programs, Non-VA Care Inpatient and Outpatient programs and Patient-Centered Community Care (PC3).

The OIG has continued to report that VHA faces significant challenges to address serious nationwide weaknesses in its Non-VA Care Inpatient and Outpatient programs. Total annual Non-VA Care Program disbursements have grown from about $4.4 billion in fiscal year (FY) 2009 to about $5.6 billion in FY 2014.

As early as 2009, we reported that VHA improperly paid 37 percent of outpatient fee claims resulting in $225 million in overpayments and $52 million in underpayments. We estimated $1.1 billion in overpayments and $260 million in underpayments over the next 5-year period if VHA did not strengthen its processes for authorizing fee care services. In FY 2010, we reported that VHA improperly paid 28 percent of inpatient fee claims resulting in net overpayments of $120 million and estimated $600 million in improper payments could be processed over the next 5-year period.

In response to our August 2010 audit of Non-VA Inpatient Fee Care Program, VHA agreed there will be general cost savings and efficiencies realized with consolidating the fee program's claims processing system to achieve better economies of scale. Although specific cost savings depend on the actual consolidated strategy VA selects and on how well VA implements the chosen strategy, we conservatively estimated that current program inefficiencies cost VHA about $26.8 million in FY 2009, and could cost about $134 million through FY 2015. Today, we do not see VHA moving forward with an actual consolidation strategy for payment processing in the fee care program.

In September 2013, VA awarded Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation PC3 contracts totaling $5 billion and $4.4 billion, respectively. The expected life of the contracts is a base year plus 4 option years. VHA established the PC3 contracts to provide veterans timely access to high-quality care from a comprehensive network of non-VA community providers.

This week we plan to publish the first of five projects that are reviewing various aspects of VA's PC3 contract and the effectiveness of its implementation. All five focus on the operational risk areas that directly affect veterans' waiting times, access to services, and continuity of care. The remaining four projects are reviewing whether PC3 contracted care issues are causing delays in patient care; whether PC3 networks are providing adequate veteran access to care; whether PC3 contractors are providing VHA with timely medical documentation; and the effectiveness of PC3 contract pricing. We plan to issue the remaining four reports in FY 2015.

The report published this week was requested by the House Appropriations Committee to review VA's FY 2014 PC3 costs and VA's FY 2014 budget submission that stated PC3 contracts would save $13 million in FY 2014. Our analysis of available PC3 data determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate in FY 2014. VA paid the PC3 contractors approximately $18.9 million in FY 2014:

- $15.1 million (80 percent) for implementation and administrative fees
- $3.8 million (20 percent) for health care services

These same health care services would have cost about $4.0 million if they had been purchased under the non-VA care program. Thus, PC3 cost about $14.9 million more than if VA had used the non-VA care program to purchase the same health care services. This occurred because VA did not conduct adequate price analyses to support its cost-savings estimate. Further, VA lacked an implementation plan to ensure the utilization of PC3. Thus, VA could not ensure it achieved the estimated cost savings and recouped the fees paid to the PC3 contractors. VA simply assumed that the PC3 contractors would develop adequate provider networks; VA medical facilities would achieve the desired 25 to 50 percent contract utilization rates; and the accrued PC3 cost savings for health care services would more than offset the contractors' fees. These flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent utilization rate in FY 2014.

Care Program, August 18, 2010; *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System*, November 8, 2011; *Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado*, April 12, 2012; *Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations*, August 20, 2012; *Veterans Health Administration—Review of South Texas Veterans Health Care System's Management of Fee Care Funds*, January 10, 2013.

OPIOID MANAGEMENT AT VA FACILITIES

Of increasing concern in VA and in the Nation is the use of opioids to treat chronic pain and other conditions. In May 2014, we issued a national review, *Healthcare Inspections—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy*, that described some of the issues facing patients on high dosages of opioids. In addition to this national review, we have issued nine reports detailing opioid prescription issues within VA since 2011.[7] Patients prescribed opioids frequently have complex co-morbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications even leading to death. These patients remain a high risk population.

VHA'S HOMELESS PROGRAM

In FY 2015 we reported that VHA missed 40,500 opportunities where the National Call Center for Homeless Vet Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services from VA medical facilities. We assessed the effectiveness of VHA's National Call Center for homeless veterans in helping veterans obtain needed homeless services.[8] The call center is VA's primary vehicle for communicating the availability of VA homeless programs and services to veterans and community providers. Our oversight identified serious problems in the Call Center's intake and referral processes that were seriously hampering the Call Center's effectiveness and services to homeless veterans. Of the approximately 51,500 referrals made in FY 2013, the Call Center provided no feedback or improvements to VAMCs to ensure the quality of the homeless services and closed 47 percent of referrals even though the VA medical facilities had not provided the homeless veterans any support services.

VA PROCUREMENT PRACTICES

We have continually reported in VA's Performance and Accountability Report the challenges VA faces in the area of procurement, to include planning, solicitation, negotiation, award, and administration. Many of our reports have identified weaknesses in procurement actions that did not provide assurance that VHA obtained fair and reasonable prices or that competition requirements were met.[9] Today VHA still needs a modern inventory system. In FY 2012, we reported VHA needs to strengthen VAMC management of prosthetic supply inventories to avoid spending funds on excess supplies and to minimize risks related to supply shortages. VAMCs spent about $35.5 million to buy prosthetic supplies in excess of current needs. Also, VAMCs increased the risks of supply expiration and disruptions to patient care due to supply shortages.[10] We recommended VHA implement a modern inventory system and strengthen management of prosthetic supply inventories. As an interim measure to address recommendation from our 2012 report, VHA implemented system patches while a new system is in development.

In FY 2012, the Office of Management and Budget stated Government spending for support service functions quadrupled over the past decade. Previous OIG audits identified recurring systemic deficiencies in virtually all phases of VHA's contracting processes. In our November 2014 audit report, we noted that VHA's support service contract costs increased 60 percent from approximately $503 million for about 5,100

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[7] *Healthcare Inspections—Alleged Inappropriate Opioid Prescribing Practices Chillicothe VA Medical Center, Chillicothe, Ohio*, December 9, 2014; *Healthcare Inspections—Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama*, July 17, 2014; *Healthcare Inspection—Medication Management Issues in a High Risk Patient Tuscaloosa VA Medical Center, Tuscaloosa, Alabama,* June 25, 2014; *Healthcare Inspection—Quality of Care Concerns Hospice/Palliative Care Program Western New York Healthcare System, Buffalo, New York*, June 9, 2014; *Healthcare Inspections—Alleged Improper Opioid Prescription Renewal Practices San Francisco VA Medical Center, San Francisco, California*, November 7, 2013; *Healthcare Inspection—Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic*, August 21, 2012; *Healthcare Inspection—Alleged Improper Care and Prescribing Practices for a Veteran Tyler VA Primary Care Clinic, Tyler, Texas*, August 19, 2011; *Healthcare Inspection—Patient's Medication Management Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska*, August 10, 2012; *Healthcare Inspection—Prescribing Practices in the Pain Management Clinic at John D. Dingell VA Medical Center, Detroit, Michigan*, June 15, 2011.

[8] *Veterans Health Administration—Audit of the National Call Center for Homeless Veterans*, December 3, 2014.

[9] *Audit of VHA's Support Service Contracts, November 19, 2014; Audit of VHA Acquisition and Management of Prosthetic Limbs*, March 30, 2012.

[10] *Audit of VHA's Prosthetics Supply Inventory Management*, March 30, 2012.

contracts in FY 2012 to just over $805 million for about 4,700 support service contracts in FY 2014. VHA did not have effective internal controls or follow existing controls to ensure adequate development, award, monitoring, and documentation of support service contracts. The contract deficiencies included insufficient documentation of key contract development and award decisions, assurance that paid invoice amounts were correct and funds were de-obligated following the contract completion, and a complete history of contract actions in VA's mandatory Electronic Contract Management System.

During FYs 2012 and 2013, we estimated VA made about 15,600 potential unauthorized commitments valued at approximately $85.6 million, which require ratification actions. Unauthorized commitments are agreements that are not binding solely because the Government representative who made them lacked the authority to enter into that agreement on behalf of the Government. Unauthorized commitments include commitments made by individuals who do not have valid warrants or exceed the limitations of their warrant authority. The significant number of unauthorized commitments we identified exemplifies persistent weaknesses in VA procurement practices and especially using purchase cards. Further, the practice of institutional ratifications does not hold individuals accountable for this serious offense.

VA CONSTRUCTION PROGRAM

In FY 2014, we issued a report on VA's management of several health care center leases that found that VA's process was not effective and did not fully account for expenditures.[11] Among our recommendations was to establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities and establish central cost tracking to ensure transparency and accurate reporting on health care center expenditures.

We also reviewed VHA's non-recurring maintenance program where expenditures increased from $824 million in FY 2008 to $1.8 billion in FY 2013.[12] We reported that VHA did not have an adequate process to track how much of the over $1.8 billion in non-recurring maintenance funds medical facilities spent to address its nearly $10.7 billion facility maintenance backlog.

In FY 2013 we reported VHA did not adequately review individual projects to ensure proper use of minor construction funds.[13] Specifically, VA medical facilities integrated design and construction work for 7 of 30 minor construction projects into 3 combined projects that exceeded the $10 million minor construction spending limit. This occurred because VHA did not effectively oversee project execution after funding was distributed to individual project accounts. As a result, VHA violated the Antideficiency Act by integrating design and construction work for five minor construction projects into two combined projects by exceeding the $10 million minor construction threshold. VHA would have likely committed a third Antideficiency Act violation if we had not identified two other minor construction projects that integrated design and construction work into a single contract solicitation, which VHA suspended while in the award process.

INFORMATION TECHNOLOGY MANAGEMENT

VA launched the Project Management Accountability System (PMAS) in June 2009. We followed-up to assess whether the Office of Information and Technology (OIT) took effective actions to address recommendations we made to strengthen PMAS in two prior audit reports.[14] We reported in 2015 that OIT has taken steps to improve PMAS, but more than 5 years after its launch, OIT has not fully infused PMAS with the discipline and accountability necessary for effective oversight of IT development projects. Two OIT offices did not adequately perform planning and compliance reviews. The PMAS Business Office (PBO) still had Federal employee vacancies and the PMAS Dashboard lacked a complete audit trail of baseline data. Project managers continued to struggle with capturing increment costs and project teams were not reporting costs related to enhancements on the PMAS Dashboard.

These conditions occurred because OIT did not provide adequate oversight to ensure our prior recommendations were sufficiently addressed and that controls were operating as intended. OIT also did not adequately define enhancements in the

[11] *Review of VA's Management of Health Care Center Leases*, October 22, 2013.
[12] *Audit of Non-Recurring Maintenance Program*, May 7, 2014.
[13] *Review of Minor Construction Program*, December 17, 2012.
[14] *Follow-Up Audit of the Information Technology Project Management Accountability System*, January 22, 2015; *Audit of the Project Management and Accountability System Implementation*, August 29, 2011.

PMAS Guide. As a result, VA's portfolio of IT development projects was potentially being managed at an unnecessarily high risk.

Since approximately 2000, VA has made a number of unsuccessful efforts to replace VHA's Veterans Health Information Systems and Technology Architecture. VA canceled the Replacement Scheduling Application (RSA) project.[15] A March 2009 memo from the Under Secretary for Health to the Acting Assistant Secretary for Information and Technology stated that the RSA project had not developed a single scheduling capability it could provide to the field nor was there any expectation of delivering a capability in the near future. The memo also stated that after more than 5 years and a cost of more than $75 million, the RSA failed to deliver a useable product because of ineffective planning and oversight.

We reported that because the RSA project lacked defined requirements, an information technology architecture, and a properly executed acquisition plan, RSA was at significant risk of failure from the start. We suggested that VA needed experienced personnel to plan and manage the development and implementation of complex information technology projects effectively. We also suggested that a system to monitor and identify problems affecting the progress of projects could support VA's leadership in making effective and timely decisions to either redirect or terminate troubled projects. Since the cancelation of the RSA project, VA has continued to seek solutions to replace its current scheduling system.

In another OIG audit we assessed OIT's management of VHA's Pharmacy Reengineering program (PRE), and reported that OIT needed stronger accountability over cost, schedule, and scope.[16] We also reviewed allegations that VHA's Chief Business Office (CBO) violated appropriations law by improperly obligating a total of $96 million of medical support and compliance funds to finance the development of the Health Care Claims Processing System (HCCPS).[17] We substantiated that $92.5 million was improperly obligated, The CBO spent approximately $73.8 million and $18.7 million remains obligated. Medical support and care appropriations are only authorized for administering medical, construction, supply, and research activities. By using MS&C appropriations, VHA avoided competing with other VA projects for IT appropriations.

INFORMATION TECHNOLOGY SECURITY

In May 2014, we published our annual assessment of VA compliance with the Federal Information Security Management Act (FISMA) and applicable National Institute of Standards and Technology guidelines.[18] We contracted with the independent accounting firm CliftonLarsonAllen LLP to perform this audit. We found that VA had made progress developing policies and procedures but still faced challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted, FISMA audits continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems.

Weaknesses in access and configuration management controls resulted from VA not fully implementing security control standards on all servers and network devices. VA has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, database and server platforms, and Web applications VA-wide. Further, VA has not remediated approximately 6,000 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its overall information security posture.

As a result of the FY 2014 consolidated financial statement audit, CliftonLarsonAllen LLP concluded a material weakness still exists in VA's information security program. We recommended the Executive in Charge for Information and Technology implement comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems. We plan to issue the FY 2014 FISMA audit results shortly.

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[15] *Review of the Award and Administration of Task Orders Issued by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, August 26, 2009

[16] *Audit of Pharmacy Reengineering Software Development Project*, December 23, 2013.

[17] *Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System*, March 2, 2015.

[18] *VA's Federal Information Security Management Act Audit for Fiscal Year 2013*, May 29, 2014.

CRIMINAL ACTIVITY

Threats and Assaults—Since October 1, 2013, we conducted more than 1,000 preliminary inquiries and full investigations relating to threats made against or by VA employees and against facilities resulting in 44 arrests and/or involuntary commitments. Although most threat-related investigations do not result in judicial action, we take all threats seriously. We also conducted 17 assault investigations resulting in 24 arrests, and 9 sexual assault investigations resulting in 4 arrests. These investigations involved veterans assaulting VA employees and other veterans, as well as VA employees assaulting veterans and other VA employees. In one investigation, a veteran was sentenced to 2 years' incarceration after pleading guilty to threatening to kill Atlanta, Georgia, VAMC medical staff by going to his residence to get a weapon, return, and shoot them in the head if he was not granted a 100 percent disability pension rating. The veteran left the VAMC and before he could return he became engaged in a shootout with local police at his residence after the officers responded to a domestic disturbance call.

Drug Diversion—Since October 1, 2013, we have arrested 184 individuals who diverted and/or sold controlled and non-controlled substances from and at VA facilities. Among them were VA health care providers who stole pain medications intended for specific patients and consumed them while on-duty and delivering patient care; patients who sold their prescribed drugs to other VA patients; individuals who sold contraband drugs such as heroin at VA facilities; and employees of delivery services, including the U.S. Postal Service, who stole prescription drugs intended for VA patients. As a result of one such investigation, a Long Beach, California, VAMC pharmacist, three pharmacy technicians, and a distribution supervisor pled guilty to stealing more than 16,000 tablets of prescription medications.

Identity Theft, Procurement Fraud, and Improper Payments—We have recently added headquarters staff to focus our national efforts to combat identity theft, procurement fraud, and improper payments resulting from criminal conspiracy. During this time period, we arrested 16 individuals who stole veterans' personally identifiable information (PII) for a variety of criminal schemes, but primarily to facilitate Federal income tax refund fraud exceeding $6 million. In one investigation, a former VAMC clerk and a VA volunteer were sentenced to 72 months' and 48 months' respectively for exchanging VA patients' PII for money and illicit drugs.

As a result of an OIG investigation, 14 individuals were prosecuted on bribery charges, including an engineer at the East Orange, New Jersey, VAMC who was convicted of conspiring with a contractor to defraud VA of more than $6 million. In another investigation, a former VA contracting officer in Palo Alto, California, VAMC, was convicted for accepting more than $100,000 in cash, vacations, and other items of value in exchange for her influence in awarding contracts. To date, this investigation has resulted in criminal charges against two other VA employees and one contractor. In a third investigation, we convicted the former Director of the Cleveland, Ohio, and Dayton, Ohio, VAMCs on 64 corruption-related charges related to the sale of confidential information about VA contracts and projects to multiple contractors; one of the contractors used the inside information to obtain an advantage in securing a contract valued at approximately $20 million.

We have recently initiated efforts to identify and thwart national criminal schemes to redirect VA benefits by defrauding the multi-agency *eBenefits* system, as well as to detect billing fraud in non-VA fee care and overseas medical care programs. One of our investigations, resulted in the conviction of a Department of Defense employee living in Germany for defrauding VA and the Office of Personnel Management of more than $2.2 million in medical reimbursements, which exposed considerable vulnerabilities in VA's overseas medical care program.

Eligibility Fraud in Service-Disabled Veteran-Owned Small Business (SDVOSB) Program—We continue to aggressively pursue allegations of eligibility fraud involving companies and individuals taking advantage of set-aside contracting in VA's SDVOSB program supporting VHA healthcare delivery requirements. To date, our investigations have resulted in the indictment of 45 individuals and 5 companies. Defendants have been sentenced to a cumulative total of imprisonment exceeding 26 years and fines and restitution exceeding $14 million. Sixty individuals and companies deemed culpable of committing this type of fraud have been referred to VA for suspension and debarment action to exclude them from receiving future contracts.

Beneficiary Travel Fraud—We have worked closely with VA to identify, investigate, prosecute, and deter fraud associated with VA's beneficiary travel reimbursement program, whose expenditures approached $797 million in FY 2014. We believe our efforts with VA to enhance VA's data mining efforts and develop more effective warning posters to be placed where veterans submit claims for these beneficiary

travel benefits, coupled with increased media attention resulting from DOJ press releases, have played a significant role in deterring such crime. VA reports expending nearly $43 million fewer dollars in this program in FY 2014 than in FY 2012.

CONCLUSION

The issues confronting VHA are issues that the OIG has long reported as serious and in need of attention at the VA Central Office, at the Veteran Integrated Service Network, and at the facility levels. The rededication by senior leadership and renewed commitment by employees to meet the expectations of veterans and the Nation is a step in the right direction. The OIG will continue to report on these issues until we see that change has occurred and that it is not just a temporary adjustment.

Mr. Chairman and Members of the Committee, Mr. Abe and I will be pleased to answer your questions.

Chairman ISAKSON. Thank you, Dr. Daigh.

Dr. Clancy.

STATEMENT OF CAROLYN M. CLANCY, M.D., INTERIM UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY STEPHEN W. WARREN, EXECUTIVE IN CHARGE AND CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION TECHNOLOGY

Dr. CLANCY. Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to participate in this hearing and discuss VHA's inclusion on the GAO's 2015 High-Risk Series Report. I am accompanied by Mr. Stephen Warren, the Department's Chief Information Officer.

The Secretary and I, along with all of our senior leadership, are strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost effectiveness, quality, and safety of the VA health care system. In 2014, we established a Blueprint for Excellence, a detailed road map for the evolution of health services provided by VHA. It provides guidance for the alignment of resources to transform VA health services from being provider-centric to veteran-centric and begins to offer a pathway for addressing GAO's five high-risk areas.

VHA has the capacity to address the problems GAO clearly identified in the report. I have directed all senior leaders in VHA to identify resource needs in their areas of control to ensure that our strategic plans support resolution of GAO's high-risk areas. Our budget cycle is built to fund the actions necessary to support these strategic goals.

In the coming months, we will be refining our corrective actions plans for each high-risk area and will be using input from the GAO, the Inspector General, and our other advisory groups to identify root causes and develop critical actions.

With regard to national policies and processes, VHA is integrating our policy and operations together, our leaders together across major business lines, such as primary care, surgical care, mental health, and so forth, so that policy and implementation are much more closely linked. Importantly, health care is a pretty dynamic enterprise, so our policies have to be flexible enough to accommodate evolving standards for clinical care as well as requisite clinical judgment. We will continue to improve our processes and

their implementation to address GAO and IG findings and ensure we provide timely, high-quality care to all veterans.

With respect to oversight and accountability, we recently restructured the Office of the Medical Inspector into an integral element of our oversight and compliance programs and that office's policies and procedures were revised to place a higher premium on quality and safety. Now, the Medical Inspector reports directly to the Under Secretary for Health, and this is a first foundational block in our developing a robust internal audit process.

Concerning information technology, we are modernizing VA's Electronic Health Record, which is the most widely used electronic health record in this country. We are developing a new web-based enterprise health management platform which will allow us to continue to share data on millions of servicemembers and veterans, both with the Department of Defense as well as community partners.

Human capital training is critical to ensure veterans receive safe care, and our front-line providers need to have effective training on national policies and procedures. The bottom line is, our training has to empower employees and make it easy for every employee to do the right thing every time.

Concerning resource needs and allocation priorities, we are implementing an enterprise-wide planning, programming, budget, and execution program to make sure that planning and prioritization are tightly linked with budget and execution. That has not been the case, I would have to say. This approach does include training in human capital requirements.

Monitoring of corrective action plans and progress will be reported on a regular basis. As we implement corrective measures, we will be providing GAO with documentation of our progress and we will be seeking input from the GAO and the Office of the Inspector General to ensure that our actions are meeting the intent of their recommendations. We are committed to long-term durable solutions and sustained improvement in the high-risk areas.

By way of positive news, from the first quarter of fiscal year 2014 to the first quarter of fiscal year 2015, 71 percent of our facilities have made meaningful improvement as judged by our comprehensive system of measures, which is called SAIL. I look forward to showing you other improvements we have made.

In addition to the five high-risk areas, GAO's report mentioned that VA has many recommendations that have yet to be fully resolved, and VHA and GAO have established a new process to enhance our collaboration for reviewing open recommendations and documentation that GAO needs to assess those completed actions.

In conclusion, I want to say that the review and assessment of our programs is something that we welcome as part of our commitment to providing the best health care to veterans. VHA must operate with accountability, with integrity, reliability, and transparency to earn and maintain the trust of veterans, stewards of the system, and the public. We need to build for success but at the same time be ever vigilant for weaknesses, failure, and opportunities to eliminate waste. We look forward to building a better and stronger system for our Nation's veterans and demonstrating substantial progress in the five high-risk areas. This transformation we are un-

dertaking represents probably the greatest enhancement in health care for veterans that will be made in a generation and we are taking this very seriously.

This concludes my testimony. We would be happy to answer your questions.

[The prepared statement of Dr. Clancy follows:]

PREPARED STATEMENT OF DR. CAROLYN M. CLANCY, INTERIM UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to participate in this hearing and to discuss the Veterans Health Administration's (VHA) inclusion on the Government Accountability Office's (GAO) 2015 High Risk Series report. I am accompanied today by Stephen Warren, Executive in Charge for the Office of Information Technology and Chief Information Officer for the Department of Veterans Affairs (VA).

We welcome VHA's inclusion in the 2015 High Risk Series report. The report comes at a critical time for VHA and highlights issues that are important to Veterans and the public. In many ways, VHA is on the cutting-edge of the health care industry. We recognize that we need to make significant improvements. VA recently implemented important changes to remedy many of the issues and concerns identified by GAO. In September 2014, VA began the *MyVA* initiative, which focuses VA's efforts to view customer service from a Veteran's perspective. With this initiative, VHA's future goals are to ensure that:

1. Veterans have a clear understanding of VA and where to go for what they need within any of VHA's facilities;
2. VA employees are empowered with the authority, knowledge, and tools they need to solve problems and take action, and;
3. The products and services that VHA delivers to Veterans are integrated within the organization.

VA will continue to identify and rectify issues within our Department. We respect GAO's work and take their recommendations regarding VA programs and policies very seriously. Therefore, we share GAO's goal of ensuring Veterans are provided with the high quality health care they have earned and deserve.

GAO categorized its concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of the health care the department provides into five broad areas: (1) policies and processes: (2) oversight and accountability: (3) information technology: (4) training for VA staff; and (5) resource needs and allocation priorities. VHA is taking the following steps to address these high risk areas GAO has identified.

Policies and Processes

VHA has subject matter experts in all program areas responsible for developing and maintaining national policies. The subjects of these national policies can range from something as extremely complex as organ procurement for transplants, to something as fundamental as the handbook on employee uniforms. Before VHA issues a national policy, the policy undergoes thorough review and approval to ensure it is compliant with law and regulation. During policy development, subject matter experts obtain input from relevant VA stakeholders. All national policies undergo labor and management review. In addition, all policies undergo an extensive concurrence process before they are published for national implementation.

Importantly, health care is a dynamic industry, and our policies must be flexible enough to accommodate evolving standards for clinical care. In addition, VHA policies strive to accommodate clinical care standards that can vary across the country. We will continue to improve our processes and implementation of policies to address the GAO and Office of the Inspector General (OIG) findings.

Oversight and Accountability

The Office of the Medical Inspector (OMI) is an integral element of VHA's oversight and compliance program. Responsible for assessing the quality of VA health care through site-specific investigations and system-wide assessments, OMI reports directly to the Under Secretary for Health. OMI's policies and procedures were restructured in 2014 to ensure that health care quality and patient safety remain a primary and constant focus.

OMI exercises its traditional oversight role by investigating concerns about the quality of health care that VHA provides to Veterans. These concerns may come to

our attention via VHA's internal monitoring of activities, complaints from individual Veterans, issues raised by Members of Congress, or whistleblower allegations referred by the Office of Special Counsel (OSC). In carrying out these investigations, OMI conducts record reviews, site visits, interviews, and surveys. In each instance, OMI produces comprehensive reports containing recommendations for quality improvements to VA medical centers, Veterans Integrated Service Networks (VISN), and VHA Program Offices, and then works with them to ensure that corrective actions are completed. OMI's analyses have changed local and national health care policy and procedures.

OMI meets monthly with the Assistant Inspector General, Office of Health Care Inspections, to review cases and health care issues that each are addressing to share information about ongoing and planned inspections, and to avoid duplication of effort. In addition, OMI meets regularly with OSC to review the status of whistleblower investigations, and to discuss schedules for reports and other deliverables. These meetings have improved communication between OSC and VA on investigative findings, ensuring complaints are thoroughly examined and that whistleblowers receive the protections they are entitled to under the law.

As part of VHA's "Blueprint for Excellence," OMI is expanding beyond its traditional investigative functions to create an internal audit capability within VHA, based on the core elements of risk assessment, testing of critical control measures, and for-cause investigation. The information and data gathered through audit and assessment activities helps VHA to better identify system vulnerabilities and manage risks across VHA.

Last summer, VA established the Office of Accountability Review (OAR) to ensure that appropriate leadership accountability actions are taken when facility leaders are implicated in findings by the OIG, OMI, or other oversight bodies. OAR reports directly to the Secretary and thus functions independently of VHA.

VHA also has other offices that have roles in VHA's integrity, oversight, and compliance activities. Taken collectively, these activities help ensure integrity and accountability across VA's health care system. The improved cooperation we are fostering will help overcome some of VHA's current challenges in providing effective health care oversight, and support efforts to restore Veterans' and the public's trust.

Information Technology

VHA runs the largest health care system in the country; delivering the quality care Veterans deserve is not possible without innovative information technology and data sharing. VA's Electronic Health Record (EHR), VistA,[1] is the most widely used EHR in the United States, and VA is working rapidly to modernize it. VA is developing a new web application and services platform called the Enterprise Health Management Platform (eHMP). eHMP is the VistA application clinicians will use during their clinical interactions with Veterans. eHMP brings exciting new features to the clinician, including Google-like search capabilities and information buttons that help clinicians find needed information much faster than current systems. VA is already piloting eHMP, and expects to deploy it to 30 sites by the end of the calendar year, with full rollout—including regular updates—over the next three years.

VA continues to work with the Department of Defense (DOD) on health data interoperability, but it is important to note that the two Departments already share health care data on millions of Servicemembers and Veterans. In fact, the two Departments share more health data than any other health care entities in the Nation. In addition to sharing health care data, VA and DOD have also paved the way for standardizing health care data, so that regardless of what system a clinician uses, the data is available in the right place and in the right way; for example, Tylenol and acetaminophen appear in the same place in the record because the system understands, through our data standardization, that they are the same medication. Today, VA and DOD clinicians can use the Joint Legacy Viewer (JLV) to see VA and DOD data on a single screen in a Servicemember or Veteran's record. Eventually, eHMP will replace JLV and will allow clinicians to see VA, DOD, and third-party provider data in their regular clinical care tool.

Training for VA Staff

VHA understands that training is a critical element of development and we are committed to offering innovative training that utilizes clinical simulation, medical modeling, and other emerging technologies for our clinical, administrative and technical staff. VHA's Employee Education System holds 13 national and two state system-wide accreditations supporting VHA's clinical/professional continuing education requirements. With its interagency shared training, VHA continues to expand ca-

[1] Veterans Health Information Systems and Technology Architecture

pacity by leveraging learning content offered through other Federal agencies. VHA is also partnering with the VA Learning University to improve our training materials and methodologies. Our priority is to continue to assess target audience satisfaction, appropriate content level, and various methods of delivery to improve training outcomes.

Resource Needs and Allocation Priorities

In order to meet the VA's health care mission most effectively, VHA must share a customer service perspective that places Veterans' needs—and VHA's ability to meet those needs—as paramount. Staff offices must leverage all possible authorities and streamline processes to promote agility compared with the efficiency of the best private sector health systems. VA and VHA are moving forward with implementing a planning, programming, budget and execution program that will ensure our medical care planning and prioritization drives the budget request and execution.

CONCLUSION

Mr. Chairman, VA welcomes the review and assessment of its programs as part of its commitment to providing the best health care to Veterans. We look forward to building a better and stronger Federal agency for our Nation's Veterans. This concludes my testimony. My colleague and I are prepared to answer any questions you or other Members of the Committee may have.

Chairman ISAKSON. Thank you, Dr. Clancy.

Mr. Warren, did you have any comments you wanted to make?

Mr. WARREN. No, sir, I am here just in a supportive role.

Chairman ISAKSON. Just in case she needs some help?

Mr. WARREN. Yes, sir.

Chairman ISAKSON. I think she will probably do fine.

Dr. Clancy, did you read Dr. Daigh's report?

Dr. CLANCY. I did, yes.

Chairman ISAKSON. Dr. Daigh, I want to compliment you on your testimony.

Dr. DAIGH. Thank you, sir.

Chairman ISAKSON. On page 5—I want Dr. Clancy to listen to this very closely—as early as 2009, we were—"we" being Dr. Daigh's office—reported that VHA improperly paid 37 percent of outpatient fee claims, resulting in $225 million in overpayments and $52 million in underpayments. We estimate that $1.1 billion in overpayments and $260 million in underpayments over the next 5 years if VA does not change their policy. Is that correct, Dr. Daigh?

Dr. DAIGH. Yes, sir.

Chairman ISAKSON. Dr. Clancy, this last Friday, on a day off, I was joined by the Ranking Member Richard Blumenthal, some of the Colorado delegation, and some House members. We went to Denver, CO, where the hospital being built in Denver for the veterans is 427.5 percent over budget. The planning started in 2004 and is about 50 percent finished. It is just ironic to me that if the 2009 recommendations to the VHA by Dr. Daigh's office had been followed and resulted, we would save $1.1 billion over 5 years. That is exactly the amount of cost overrun in the hospital in Denver.

The point I want to make is this. The High-Risk List is important because it demonstrates to you where you have got a high risk for failure or problems in your system. VA is bereft, to me, of any response mechanism within it to respond to crises other than kicking the ball down the field.

Dr. Daigh's recommendations were clear and succinct. VA's problems are clear and succinct. It would seem to me if I had a $1.1 billion cost overrun in Denver and I had a $1.1 billion rec-

ommendation that I could save over 5 years by just changing my policy in fee-based care, that I would follow. Why do you think nothing was done over that 5-year period of time with non-VA care?

Dr. CLANCY. I think what has happened historically, and Dr. Daigh, I think, has been consistently very clear about this, is that every single one of our facilities was doing the non-VA care on their own, and as you know, we have now got multiple pathways for helping veterans to get care in the community, and moreover, every year, we were doing a higher and higher volume.

We have an internal Compliance and Business Integrity Unit. These are certified auditors that help with some of this. I think there were so many different approaches that there were not sufficient eyes on making sure that it was done consistently and reliably. Those processes have been consolidated as a result of the new law into one central business office, and I am going to be honest and say that we need a lot of work to get this right.

I have all my senior leaders in D.C. this week so that they have got a very, very clear idea of what needs to happen, and it has got to happen consistently at every facility. There is no excuse for that.

Chairman ISAKSON. Dr. Daigh, following up on the non-VA care, and I read your testimony, did you make specific recommendations as to what VHA needed to do to correct the problem?

Dr. DAIGH. I will ask Mr. Abe to answer that.

Chairman ISAKSON. That is fine.

Mr. ABE. Yes, we did——

Chairman ISAKSON. Before you go any further, did you ever get a response after you made those recommendations from VA?

Mr. ABE. Yes. Yes, we did.

Chairman ISAKSON. And that response was, this is the way we have always done it?

Mr. ABE. Not quite, but——

Chairman ISAKSON. Almost.

Mr. ABE. But, we did make recommendations that, the biggest problem has to do with how they are organized in regards to that for every medical facility at the time, they are doing their own fee basis claims processing. When you try to establish policies and procedures and make sure all 150 facilities understand that, it is very difficult.

When they process claims, we found, like you say, many improper payments, and a lot of it just had to do with the understanding of the Medicare rate or the rates that they are being billed and what rates they should be paying.

One of our recommendations that has been implemented and, I think, is a good first start is that the major thing that we asked is that they get closer to Medicare rates. By legislation, they had to ask that they could use Medicare rates. So far, I would say about 80 percent, 90 percent of the procedures, the services that they are providing from non-VA care is Medicare rates, which makes it a lot easier for them to process, although they still have a lot of problems.

Since 2009, when we did that first audit, VA put themselves on the Improper Payments Act through their Performance and Accounting Report, and ever since 2009, they have—that program,

being the non-VA care, has been on the Improper Payments List, under par. The inaccuracies have improved, but they are still making a lot of improper payments.

Chairman ISAKSON. I thought that was a crystal clear example of why being put on this list can have a solution that can end up benefiting the VA and solving another problem, but my time is up. We are going to do a second round of questions because I want to follow up on this.

Ranking Member Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman. Thank you all for being here. I thank each of you for your service in the ways that you have provided invaluable help to this Committee, to veterans, and to the VA.

Let me begin with Dr. Draper. Your testimony is that more than 100 recommendations from the GAO have not been implemented, is that correct?

Ms. DRAPER. That is correct.

Senator BLUMENTHAL. Some of those recommendations have to do with accountability, do they not?

Ms. DRAPER. That is correct.

Senator BLUMENTHAL. Some have to do with training?

Ms. DRAPER. Mm-hmm.

Senator BLUMENTHAL. These recommendations that have not been implemented with respect to training have real life consequences, do they not?

Ms. DRAPER. Well, many of our recommendations, whether they are training or for oversight and accountability, have some real life consequences.

Senator BLUMENTHAL. For example, I noted that in your May 2011 report, you found that training of staff responsible for cleaning and reprocessing reusable medical equipment, such as endoscopes and some surgical instruments, was lacking. The failure to properly clean and reprocess these kinds of instruments can cause very severe infections, can they not?

Ms. DRAPER. That is correct.

Senator BLUMENTHAL. In fact, one of the major problems in health care in America today is infections that occur within hospitals, is that correct?

Ms. DRAPER. That is correct.

Senator BLUMENTHAL. Yet, the VA has failed to implement a number of recommendations having to do with that basic training requirement, correct?

Ms. DRAPER. That is correct, and there have been incidents in some VA facilities where that has been a problem.

Senator BLUMENTHAL. In terms of accountability and oversight, has the VA exercised sufficient discipline, taken sufficient measures to hold accountable individuals that fail to act properly?

Ms. DRAPER. One of the things we talk about and one of the areas of putting VHA on the High-Risk List relates to oversight and accountability. We found several concerns there. One was that VA tends to rely on facility self-reported data. There is no validation of that data and it is often incomplete or inaccurate. We will go into the facilities and find something totally different.

They do not always audit or provide oversight activities for making sure that facilities are in compliance with particular requirements. It is not a very rigorous oversight and accountability process.

Senator BLUMENTHAL. Has that improved?

Ms. DRAPER. We are still seeing some of the same things.

Senator BLUMENTHAL. In answer to my question, the oversight accountability process within the VA is still extremely lacking?

Ms. DRAPER. We have not seen improvements to the recommendations we made related to those categories, a lot of those recommendations still remain open.

Senator BLUMENTHAL. Those kinds of failures have real life consequences, too, do they not?

Ms. DRAPER. They do. I can give you a perfect example. When we found the oversight and accountability related to outpatient appointment scheduling you hear this a lot. You see in one VA facility, the way the processes and policies play out at the local level, and there is so much variation from each of the many VA facilities. In that particular instance, we found facilities documenting their outpatient appointment times very differently, so the wait times data are unreliable. You cannot really provide oversight on something that is unreliable.

Senator BLUMENTHAL. You cannot hold accountable people for failing to meet schedules if the scheduling data is unreliable.

Ms. DRAPER. Another thing, the information technology system, the appointments scheduling system, it is prone to user error. If someone wanted to go in and manipulate the data, it would not be hard to do.

Senator BLUMENTHAL. I am going to come back. Thank you for your answers. On the second round, I hope I will be able to come back to you.

Dr. Daigh, I have read the Veterans Health Administration VA Office of Inspector General review of alleged patient deaths, et cetera, in the Phoenix Health Care System. It is dated August 26, 2014. Your office prepared it, did they not?

Dr. DAIGH. That is correct, yes.

Senator BLUMENTHAL. Is that your final report on Phoenix?

Dr. DAIGH. There is one aspect of Phoenix that we have not reported on and that is the urology care there. We issued an interim report on that. Shortly, we will be able to publish a urology care piece.

Senator BLUMENTHAL. That is dated January 28, 2015?

Dr. DAIGH. That sounds right, sir.

Senator BLUMENTHAL. I am going to ask that they be made part of the record.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BLUMENTHAL TO JOHN D. DAIGH, JR., M.D., C.P.A., ASSISTANT INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00875-112

Interim Report

Review of Phoenix VA Health Care System's Urology Department Phoenix, AZ

January 28, 2015

Washington, DC 20420

Department of Veterans Affairs

Memorandum

Date: January 28, 2015

From: Assistant Inspector General for Healthcare Inspections, VA Office of Inspector General (OIG) (54)

Subj: Interim Report – OIG Review of Phoenix VA Health Care System's Urology Department

To: Interim Under Secretary for Health, Veterans Health Administration

During OIG's 2014 review of scheduling practices and wait times at the Phoenix VA Health Care System (PVAHCS), we found that large numbers of patients who were referred for urological evaluation and/or treatment experienced significant delays in either obtaining an appointment, scheduling follow-up, and/or receiving authorizations for non-VA urology care.[1] This prompted OIG's Office of Healthcare Inspections (OHI) to open an expanded review, specifically focusing on access to care within PVAHCS' Urology Department.

While our review is ongoing, some concerning preliminary findings require your immediate attention. These findings suggest that delays associated with the processing of referrals through the Office of Non-VA Care Coordination (NVCC) could potentially be putting patients at risk for being lost to follow-up.

In September of 2014, a list of 3,321 veterans whose care had likely been affected by the staffing shortages within the Urology Department was provided to the OIG by PVAHCS. To date, we have completed a first level review of the electronic health records (EHRs) of those patients. Our focus has been on identifying patients who were referred for evaluation to either PVAHCS' Urology Department or to a non-VA urologist via a voucher or fee basis authorization. To determine the potential impact of delayed evaluations, we reviewed follow-up documentation including clinic notes, imaging and laboratory results, and urologic procedure reports. In approximately 2,500 EHRs, we determined there was enough information to make a reasonable assessment of the impact of delayed care and/or an assessment of the quality of care a patient received.

In approximately 23 percent (759)[2] of the total cases reviewed, we frequently found approved authorizations for care, notations that authorizations were sent to contracted providers, and often scheduled dates and times of appointments with non-VA urologists. However, in these instances, we found no scanned documents verifying that patients were seen for evaluations and, if seen, what the evaluations might have revealed. This finding suggests that PVAHCS has no accurate data on the clinical status of the patients who were referred for urologic care outside of the facility. Included in this group are also

[1] OIG report *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, VA OIG Report 14-02603-267, August 26, 2014.
[2] On January 23, 2015, an OHI staff member delivered this list of 759 patient names to VHA to begin an immediate review.

patients who may have been followed routinely by the Urology Department prior to mid-2013 but, in the midst of the staffing crisis, were lost to follow-up.

During the week of January 12, 2015, OIG inspectors conducted a site visit to PVAHCS' Office for NVCC. We found:

- The office is understaffed and unable to keep up with many of the administrative tasks required to process authorizations.
- Non-VA providers are unaware of VA's policies for authorizing outside care. Frequently, vouchers are misinterpreted as authorizing only one visit. This causes delays because the non-VA provider will submit another request to NVCC or advise the patient that s/he needs to contact the facility for further authorizations. This results in the creation of a backlog of unnecessary secondary authorizations, further delaying care.
- With respect to scanning and reviewing outside clinical documents, when the services are provided by a TriWest provider, providers submit documents to the TriWest Portal. In order to access this information, a fee basis staff member must log into the TriWest Portal to print and scan these records into the EHR. Presently, only one employee is consistently assigned this task because of staffing shortages. According to staff, the office is "hundreds of records behind," so unless a provider or patient specifically requests the clinical results from the outside provider, this information may remain "unseen" (thus, unassessed) for several months.
- The facility maintains a Secondary Authorization Request List. This list is compiled from information gathered in the TriWest Portal and is used to track the requests from TriWest providers for authorization extensions as well as requests for further studies that would require additional authorization. Such requests are assigned an urgency level. At the time of the site visit, staff reported that they were six weeks behind in processing "Stat" or urgent requests.

While OIG's review of EHRs is ongoing, absent complete information being available within the medical record, an accurate assessment of care is impossible for close to 23 percent of patients who were identified as needing urological care. This finding supports that PVAHCS has no accurate data on the clinical status of these veterans as it relates to that care. This finding also suggests that potentially important recommendations and follow-up are not being addressed by the referring providers because they do not have access to the outside records.

As the facility continues to recruit and hire physicians and mid-level providers to staff its Urology Department, it is critical that staffing and administrative processes related to non-VA authorized care be properly administered.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John McCain, Jeff Flake
U.S. House of Representatives: Ann Kirkpatrick, Kyrsten Sinema

This report is available on our web site at www.va.gov/oig

Chairman ISAKSON. Without objection.

Senator BLUMENTHAL. Thank you.

Have you finished your oversight and investigation of other facilities around the country? There are, I think, 93 of them that exhibited similar deficiencies; is that correct?

Dr. DAIGH. If you are speaking, sir, of the scheduling issue that the Office of Investigations was undertaking, I believe that they are still in the process of working with Assistant United States Attorneys (AUSAs) around the country, where appropriate, to process that and——

Senator BLUMENTHAL. Did you find prosecutable offenses in the Phoenix report?

Dr. DAIGH. I am not from the Office of Investigations. If you can ask that question for the record, we can respond, or I am sure we would be willing to come up and brief you on that.

Senator BLUMENTHAL. If you could, I would appreciate it, both on the record and in a briefing.

Dr. DAIGH. Yes, sir.

Senator BLUMENTHAL. Did your report lead to disciplinary action against individuals?

Dr. DAIGH. I believe that VA has taken disciplinary action against a number of individuals. Sir, I mostly focused on the health care issues that are involved in Phoenix. When you get to the actual discipline of the leadership or you get to the actual criminal nature of it, that turns out to be an Office of Investigations feature, so I would need to talk with them or——

Senator BLUMENTHAL. I will be submitting questions for the record that I hope the VA will provide responses in addressing to this Committee.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Hirono.

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

Senator HIRONO. I thought you were going to go to one of the gentlemen.

Chairman ISAKSON. Ladies first.

Senator HIRONO. Oh, thank you. [Laughter.]

Thank you very much.

There are 100 or so recommendations that have not been implemented, so this is for Dr. Clancy. Have you all prioritized the recommendations as to which ones you would want to tackle first?

Dr. CLANCY. Yes. I think there was a suggestion or inference made that we are ignoring them and I really would like to state for the record that we are not ignoring them.

Senator HIRONO. Yes.

Dr. CLANCY. I do not know if that has been that way in the past. I can only say what we are doing right now.

Some of the recommendations that are very, very thoughtful reflect systemic improvements we would need to make to make durable changes, which is why, frankly, many of these, or most of these recommendations are so valuable to us, but they do take time to implement.

Senator HIRONO. Yes, I understand that. My question was, again, of these 100 recommendations, have you established priorities or——

Dr. CLANCY. Yes, we have.

Senator HIRONO. What were the factors that went into establishing those priorities? Let us say, of the 100 recommendations, what would your top ten priorities be and what were the factors that led to those being the top ten?

Dr. CLANCY. These are prioritized by how quickly can the problem be fixed and what are the highest risks to patients, and then coming after that are things that are also important but take time to implement across a very large health care system.

Senator HIRONO. Is that list of priorities something you can share with the Committee?

Dr. CLANCY. We can get you that for the record, yes.

Senator HIRONO. Getting back to the Chairman's question, though, with regard to the testimony that he referred to where there are these huge overpayments as well as underpayments, that sounds like something that should be addressed pretty fast.

Dr. CLANCY. That is something that we have been working on for a while, and the consolidation of our payments for care in the community that came about as a result of this law has made this visible in a far more transparent way and we are working through those business processes right now. Some of this has to do with the fact that individual facilities, as Dr. Daigh noted, were doing it their own way.

Senator HIRONO. Yes.

Dr. CLANCY. We have found, for example, that some facilities actually do not know how to estimate or how to use the tools that have been provided to estimate what a test or appointment or service in the community is likely to cost, and we are right in the midst of working through that right now.

Senator HIRONO. So, clarifying your processes so that all your individual VA health centers, et cetera, are not doing their own thing, is that high on your list of priorities so that——

Dr. CLANCY. Very, very high. Yes.

Senator HIRONO. OK.

Dr. CLANCY. That is both a governance as well as a business process issue.

Senator HIRONO. Good. I think part of it was that there was a desire that it should not be a one-size-fits-all, that there is a desire that different communities may want to approach the health care needs of their veterans in ways that would be best for them. But, this led to a very piecemeal, hard to account kind of a system.

Dr. CLANCY. I think it is fair to say that when the networks were set up about 20 years ago, they were designed as laboratories of innovation.

Senator HIRONO. Yes.

Dr. CLANCY. I think that was the phrase that was used a lot, and——

Senator HIRONO. It sounded good.

Dr. CLANCY [continuing]. That is exactly what we got.

Senator HIRONO. Yes.

Dr. CLANCY. The flip side of that was a lot of inconsistency. I think we all recognize that health care in your State is different than health care in Georgia or Connecticut or other States for a whole lot of reasons. We need to have most of our core processes be consistent wherever veterans seek our assistance.

Senator HIRONO. I realize that this is a vast, vast health care system and it is going to take a while to address the various changes, and this is why I am so interested in what kind of priorities you have established. Is the homeless veterans issue a high priority?

Dr. CLANCY. That is a high priority for us. We have three overarching priorities this year. One is homelessness, because we are hoping to get as close as possible to functional zero by the end of this year.

Second is access, whether that is access within our system or access to care in the community and getting that in a timely way.

The third is veteran experience, that it is easy for veterans to navigate.

Senator HIRONO. Getting back to the homeless situation, you have a national call center for homeless veterans and the OIG identified there were systemic problems with the call center leading to some 40,000 missed opportunities where the center did not refer calls to VA medical facilities or closed referrals without ensuring that the homeless veterans were receiving the services. Is this on your list of——

Dr. CLANCY. Yes.

Senator HIRONO [continuing]. Priorities to change?

Dr. CLANCY. Yes. In fact, we have separated the homeless call center from the veterans' crisis line. Do you have your board? I just wanted to make a very brief Public Service Announcement about the crisis line because it is so important. I do not think a week goes by when I am not referring veterans directly to that line, and I am astonished by how rapidly they reach out and find the veterans and get them the help that they need.

For a variety of reasons, both to make sure that the homeless calls were answered, but also to make sure that the crisis line was not getting overloaded with other calls——

Senator HIRONO. OK.

Dr. CLANCY [continuing]. Forgive my brief Public Service Announcement.

Senator HIRONO. I would be happy to put that information in my own veterans' newsletter.

Dr. CLANCY. We will get you a link. We will be happy to do that.

Senator HIRONO. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. You are going to get enough criticism. You ought to be allowed to brag a little bit in the hearing. We appreciate what you are doing. The hotline is a great service to our veterans and it does a great job.

Dr. CLANCY. Thank you.

Chairman ISAKSON. Senator Sullivan.

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and I want to start by just commenting on the work of the Committee. I want to compliment Chairman Isakson and Ranking Member Blumenthal. You know, one of the things that, at least in my short time in the Congress, this is a committee that is very bipartisan in terms of its approach, in terms of what we are trying to achieve. I think that that stems from the leadership on both sides of the aisle, certainly, but also stems from the mission that we all recognize is so important, to take care of our veterans and that I know all of you recognize.

Sometimes these committees, you can have an opportunity for people to come here and kind of pound you on something like this. I think the better approach is probably to just figure out what the heck is going on.

Dr. Clancy, when I looked at your testimony, I was a bit troubled. The Secretary mentioned that he is fine to be on the list. He certainly wants to improve. But, your testimony seems to lack a focus. It is four pages, double spaced. It talks a lot about MyVA, which is a promising initiative, but I do not think that is the road to getting off the list.

Let me just ask a couple of questions, and in some ways, they are a follow-up of Senator Hirono's questions, which is how seriously is the VA, VHA, taking the issue that you are on this list? It is not a good list to be on. More importantly, she asked about priorities. You gave kind of broad priorities. What are the priorities to actually address the issues that got you on the list?

Dr. CLANCY. We are taking this very, very seriously. Frankly, what I find personally most valuable, as do my colleagues, about being on the High-Risk List is getting at the root causes of how did we get here.

Senator SULLIVAN. Right.

Dr. CLANCY. There are two ways to look at problems. One is very specific problems that have been very clearly laid out for us in the past, and that is ongoing work.

The second is to say, what is wrong with this picture and how did we get here, and that is a key part of realignment that we are doing internally within VHA. I would agree with you, I do not think the written statement was as well written as it could have been, and for that, I offer apologies. We would be happy, actually, to amend it for the record if that were an opportunity.

Senator SULLIVAN. I think it is important. When you were just asked on priorities, you talked about homelessness, access, veterans' experience. I think I, certainly, am one who is going to be very focused on helping work with the VA to achieve those. But, it does not go back to the more specific issues——

Dr. CLANCY. Correct.

Senator SULLIVAN [continuing]. That put you on the list in the first place. What are the priorities that you are going to undertake to address the issues that were laid out in the GAO listing of your agency?

Dr. CLANCY. Our priorities are a serious leadership commitment that we are moving beyond, if you have seen one VA, you have seen one VA. Yes, there are local differences. The buildings look a little

bit different. But, the core processes have to be very consistent and standardized. It is very easy for me to say this. Making it happen and executing to that is going to take some time.

Capacity and the resources and, frankly, being clear to the Congress about what we need to build the capacity to meet veterans' needs is very high on our list. That is why you have heard from the Secretary——

Senator SULLIVAN. Yes.

Dr. CLANCY [continuing]. From me and others about what we need for hiring, what we need for space, and so forth. We recognize that there is also a backlog.

Oversight and accountability is critically important. We have a lot of the pieces in place and I would submit that they have been too fragmented and need to be better integrated to rise to the challenges before us.

Frankly, being transparent with the public and trying to get to a place where we are reliable, so we are posting how we are doing on wait times every 2 weeks for the public to see. We are also posting our results on a comprehensive system of metrics, which is how it is done in hospitals, outpatient care, efficiency, and so forth. But, that is available for the public to see every quarter.

Senator SULLIVAN. Right.

Dr. CLANCY. I will take Ms. Draper's comment about self-reported data very, very seriously. We have also built some trigger tools so that when our people who work with the data centrally are seeing very funny signals, they actually let the facility know in real time. They do not wait for them to go look for this report. They actually send them an e-mail to say, we are seeing some funky things going on here and you need to investigate what is going on with the scheduling.

These are early, and, I would argue, fundamental and important steps, but that is the building block on which we are moving forward.

Senator SULLIVAN. Thank you.

Thank you, Mr. Chairman, and I will have some additional questions for the record the panel can——

Dr. CLANCY. That would be great. I do need to tell you, Little Rock has actually made tremendous progress and I am very proud of that, so, since we are your homestate.

Senator SULLIVAN. Well, I am actually from Alaska, so—

Dr. CLANCY. Oh, I apologize. I got you confused. [Laughter.]

Senator SULLIVAN. Maybe I will——

Dr. CLANCY. I will save that for Senator Boozman.

Senator SULLIVAN. At least you did not confuse me for Senator Tillis, which happens a lot. [Laughter.]

Thank you very much for your kind words.

Dr. CLANCY. Well, if you see me hiding under the table, you know why.

Senator SULLIVAN. That is OK.

Chairman ISAKSON. Thank you, Senator Sullivan.

Senator Manchin.

HON. JOE MANCHIN, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, and thank you all for being here.

It seems like we are just piling on now. All of us have problems. I will give you a specific one and it is in Beckley, WV. I think you all just heard about that. This has been going on for quite some time and I will go through the specifics.

It seems like that we are all having problems understanding why no one is being held accountable or actions have not been taken against the responsible parties. It is just ongoing with the one in Beckley, as I said. The Office of Special Counsel substantiated allegations of switching antipsychotic drugs based solely on cost. They know they are doing it. The doctors are saying, prescribe the drug. They make a decision at the executive level. It is pushed down to the pharmacist. They dispense an alternate drug that is much cheaper because they say they do not have the money to pay. This has been going on, and it the only one we have had this report, but for so long.

I guess I would just ask, Dr. Clancy, what does VA have in place to resolve these problems or make sure they do not continue, and why would anyone let it go on?

Dr. CLANCY. As you know, and I think your staff spoke with staff from our Office of Medical Inspector earlier today——

Senator MANCHIN. Right.

Dr. CLANCY [continuing]. What you have just described is exactly correct. It turns out that some of the proven therapies for psychosis actually are sometimes better than the newer, more expensive ones, but what was absolutely not supposed to happen was a mandate, and veterans who were doing well on one of the newer treatments were not supposed to be switched arbitrarily——

Senator MANCHIN. They never got it——

Dr. CLANCY. Right. No, that is exactly right——

Senator MANCHIN [continuing]. Because it was all based on cost.

Dr. CLANCY. Right, and that was the wrong thing to do and we are going to be taking corrective actions to make sure that that does not happen and that there is a physician on the Pharmacy and Therapy Committee at Beckley, which has not been the case.

Senator MANCHIN. We seem to jump out of the fire into the frying pan. It keeps going on, back and forth, the problems that we are running into. We had another clinic, a satellite of the Beckley clinic, that was closed, and we are trying to make sure we get services down in the rural part of the State in Greenbrier County.

Dr. CLANCY. Yes.

Senator MANCHIN. I think we have worked with you on that, or are trying to work with you to try to get some help down in there.

But, we, you know, if there is incompetency at any level, it seems like VA has a hard time getting rid of that, and I do not know why your system is so protective versus the military. Heck, they can get rid of people easier than you all can, I think.

Dr. CLANCY. I do not actually know how that works. What I know in health care is that many people believe that you want to be careful about keeping punitive disciplinary actions separate from people reporting problems that they see, because if people are

afraid that if they report problems, they might be punished, they will not report them.

Senator MANCHIN. Let me go to the——

Dr. CLANCY. I do not know if I am being clear.

Senator MANCHIN. I——

Dr. CLANCY. We will be taking appropriate disciplinary action.

Senator MANCHIN. We will get together, I guess. We have a problem there. You and I will talk, maybe personally, on this.

Dr. CLANCY. Great.

Senator MANCHIN. Dr. Daigh, on prescription drug concerns, in West Virginia, it is the number 1 killer in my State. These are drugs out of the medicine cabinet and they are just being abused. That is an important issue for not just me, but for, I think, every Senator here in every part of America that is plagued by the epidemic of drug abuse and addiction. Of course, you know the VA patients are no different. We have a lot of our veterans returning and they are getting over-drugged as soon as they get there. They complain to us and they cannot get the proper treatments or the proper evaluation to get the proper treatment they need. They are having problems with that.

I guess I would just ask, is this one of your most pressing issues, that you are getting a lot of complaints on this? Do you see this in your investigation?

Dr. DAIGH. I would say that the management of patients who require or take narcotics in excess of what seems reasonable is probably one of the most important issues the VA struggles with right now. They are not the Lone Ranger. I think the country struggles with that problem.

Senator MANCHIN. If we had a piece of legislation that said you had to use an alternative before you could prescribe opiates——

Dr. DAIGH. I think about things in this way, sir. I think there are people who have pain. You have a toothache. You need treatment.

Senator MANCHIN. Sure.

Dr. DAIGH. I think, though, that we need to come up with a way to prevent that patient who starts taking narcotic for a good reason but then ends up abusing it for some reason. I think that for the population——

Senator MANCHIN. We know they are very addictive and people are getting hooked overnight. It seems like we are giving oxycontin for anything. You have got a headache, take an oxycontin.

Dr. DAIGH. I agree entirely with what you are saying. I think that there are several ways to get there. One way to think about it is to try to make sure that more people do not become addicted to a narcotic and focus your effort on trying to keep that from happening through the many things that I know you said before that are——

Senator MANCHIN. I would like to get with you on this issue.

Dr. DAIGH. Yes, sir.

Senator MANCHIN. Mr. Chairman, if I may indulge, just one second, if I could. Could you all, any of you want to just answer very quickly, do you believe that we can give veterans better care through the private providers than what we are giving now through the VA, or just as good, if not better?

Dr. DAIGH. My personal view is it depends on what the situation is. For example——

Senator MANCHIN. I am just saying, we know all the problems we are having. No, no. I am just saying within the VA system. The culture, whether it is procurement, whether it is building a hospital, whether it is doing whatever, do you not think the taxpayers' dollars would be spent better if we got our veterans channeled for thequickest amount ofcare and thebest care,whereverthat may be?

Dr. DAIGH. Yes.

Senator MANCHIN. Thank you.

Dr. DAIGH. My answer is yes, and I think sometimes that will be the VA.

Senator MANCHIN. Thank you.

Chairman ISAKSON. Thanks, Senator Manchin.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman, and I want to thank all the panelists for being here.

I have to give a shout out for one of my VAs again. I was down at the VA on Saturday back in Salisbury, and once again, they were doing great stuff, a lot of them on their personal time hosting an event for a Purple Heart recipient. We left there and went over to the town hall, which is a best practice for providing care to many seniors.

To expand, Dr. Daigh, on your point, there is no doubt that many of the veterans who need care want care in a VA facility. The question is, can we provision it properly and can we make sure that it is done in the most efficient and effective way possible?

I am not going to ask you any questions on all the shiny objects, reported by the GAO. I am glad to know that the VA has hit a list that really raises attention and, hopefully, marshaling of resources to fix problems. I think it is good. It is no different than a 300,000-person national company running in the United States where all of the sudden the bond raters or the stock investors put you on a watch list and get ready to tell people to sell your stock short because you are a failing entity. That is the reality. We have a lot of problems with the VA.

We should not lose sight of the fact that most of the solutions to the VA are good things that are going on in the VA, and a part of what we have to do on this Committee is recognize we are sort of a board of directors and we need to perform our fiduciary responsibility to the veterans who need the care by making sure that we do not become a disabler, which we could potentially do, by not really focusing on how do we get to a systematic process that identifies the high priority items, the short-term, as Dr. Clancy said, the short-term things you can fix because they are relatively straightforward and relatively low cost and high impact.

Then, the intermediate and long-term initiatives that we have to get implemented. We need an enterprise transformation strategy for the VA, which Secretary McDonald and I spoke about and I am thrilled to know, although I hope they have not fully read the GAO report—Dr. Shulkin and Laverne Council—because if they did, they may be scared to death and not want to be confirmed. I am

looking forward to the confirmation hearing. They are very talented people who, I think, if they come in, they can be a part of the solution.

We have to step back, and instead of having these hearings—and I know that it takes a lot of time for you all to prepare for this, and I know it takes your eye off the ball of the things that you want to do in your enterprise. What we need to do is get to a point where we have a hearing where we are talking about an inventory of the problems.

I had a lengthy discussion with Laverne Council on IT issues. There is gold on the floor for improving the IT shop in the VA, for improving performance, and freeing up resources for other things to do in the VA. We have to get that done. It is not hard. It gets done every day in the private sector though seldom in the U.S. Government.

We have to get away from this mentality that variation—variation is oftentimes rationalized and almost never justified. There is a standard best practice and process for IT and provisioning of care. I am not talking about the care provided to patients. There may need to be some variations at that atomic level. All these other things, anybody who is in the VA who is responsible for it should not have a job. They should know that that was an irresponsible management decision. They should have had programs in place or recommended to their top management programs that make sense, which they have not done.

I believe you all are part of the solution, and I think the GAO and other people that are looking at this are a very important part of the solution. But, we have to get to a point to where the Secretary and the senior executives develop a plan, so instead of us coming and chasing the shiny objects and then having people run down and report on progress of that shiny object, potentially at the expense of more important, higher-priority things, we have to start looking at this on a holistic basis and then decompose it into very specific action threats where we can actually start producing results.

One thing I would urge the Secretary to consider is a different way of going about these programs. I think that some of the Members on this Committee, with the Chairman's indulgence, need to be embedded in that enterprise planning strategy. We need to have people here who are not just coming here because it is interesting. On the one hand, we are boards of director members, and then on the other hand, we are the general managers of our little VA plants in each of our States. We hear things that are going on in the State, so all of the sudden, we are hammering you on the specific things in our State. That is not a sustainable approach to addressing these enterprise problems.

We need to get to a point where we are talking about the strategy and less about all of these examples that need to be fixed; and if they do get fixed, that may satisfy us for this Committee meeting, but they are not going to satisfy us for the long term and do what we need to do for the veterans.

That was probably more of a speech than questions, but, Mr. Chairman, the only thing I would really ask the Secretary to consider, and some of these nominees that are coming in is, let us sit

down and come up with a different approach, something that really has not been done on an enterprise basis, and in my estimation, in any area of government. Prioritize this, set specific—and capital improvement is another one. We talked about Denver.

Let us talk about this enterprise and let us look at each one of these enterprises, put them on a heat map, find out which ones we should be tackling and how we prioritize the others ones, so what we are doing in future Committee meetings is talking about time to benefit and whether or not you made your goals, and hold people accountable—reward them for having achieved success and hold them accountable for having failed to.

I think, if we do that, we will get away from this discussion that has been going on for years without substantial improvement and get to a truly transformed organization that will include VA facilities, hard working people in Fayetteville, Durham, Salisbury, Asheville, and all over this country, will include the best practices that are already embedded at a lot of those facilities.

I am sorry I went over.

Chairman ISAKSON. We will go to Senator Tester in just a second. I want to make two comments.

First of all, I appreciate calling our attention to the confirmations. For the record, Dr. Clancy, those confirmations will be on May 5. The reason they were not last week is because we did not have the answers to all the questions that had been submitted and we cannot do a final markup until we do, so I appreciate your attention to that.

Second, Sen. Tillis, I thought it was one of your better speeches. [Laughter.]

I always do this. I may forward good ideas, but Dr. Clancy, do you have someone in the veterans health services that is the operational point person for responses to things like GAO and IG reports?

Dr. CLANCY. Yes, we do.

Chairman ISAKSON. Who is that person?

Dr. CLANCY. A physician named Dr. Karen Rasmussen. She is here with me today.

Chairman ISAKSON. Where is Karen Rasmussen? Hi, Dr. Rasmussen. How are you? I want to volunteer Senator Tillis and you to do a little project for me, if you would. I thought what you just said was an outstanding template to begin to get a game plan for responding and dealing with the recommendations of the IG and the Department. If you would work with Karen to see if there is a way that your idea can mesh with what they are doing in the VA, because I have got a feeling the VA does things the way they think they are supposed to do them because that is the way it has always been done. What you talked about is a different way of doing things, and maybe there is a combination between those two that would serve well. I do not want to force you to honor your speeches, but if you would be willing to do that and Karen would be willing, I think.

Senator TILLIS. Mr. Chair, I would ask, with your indulgence, that you consider maybe having a Member from the other side join in, because I honestly would like for this to become a point where people on this body have confidence in your overarching enterprise

transformation strategy so we remove ourselves from chasing the latest issue of the day, which is important, but we become advocates for building credibility around a strategy that has specific timeline goals and measurable results. I think it would be worthwhile to have a couple of us take a look at that and I would be honored to help.

Chairman ISAKSON. I am going to ask Ranking Member Blumenthal if he will supply us with a volunteer and let us know who that volunteer is. It does not have to be right this minute, because I pulled this totally off the top of my head, but——

Senator BLUMENTHAL. We will definitely provide you with a volunteer.

Chairman ISAKSON. I want to thank Senator Tillis in advance for doing so and thank Dr. Rasmussen for being willing to take on that task, too. Thank you very much.

Senator Tester, I apologize for taking some of your time. I apologize for interrupting.

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

Senator TESTER. No problem, Mr. Chairman. Thank you very much; and not for the record, I think that is the best speech you ever gave, Senator Sullivan. The best. [Laughter.]

Senator TILLIS. I will tell Senator Sullivan you said that. [Laughter.]

Senator TESTER. We had a recent hearing in front of the VA Appropriations Mil Con, VA Appropriations Subcommittee, and I believe, if I heard it correctly, the Secretary said that he requested that the VA be put on the High-Risk List. I may be wrong on that, but I thought that was the case.

Dr. CLANCY. He did say that, yes.

Senator TESTER. In the midst of all this, we had $1.4 billion cut out of the House VA appropriations bill, which I know we will deal with it in our own way over here that would result in less veterans getting care, more specifically, about $690 million cut to medical care means 70,000 fewer veterans would receive the health care they need. Veto threats have been made. The National Commander said the VA cannot fulfill its mission without proper funding, but the House, for whatever reason, now wants to ration care, eliminate infrastructure projects, stop improving upon the programs and services the VA was created to provide.

Dr. Clancy, is it fair to say that if the Senate took up the VA funding bill as it has now been voted out of subcommittee that it would be very difficult to get removed from the High-Risk List?

Dr. CLANCY. Yes, I think that is fair to say. It would certainly slow our progress. The Secretary has been strongly committed to being as open and transparent with all of you in terms of what are our requirements to meet veterans' needs and that is actually what we submitted in the administration's request. I will leave it at that.

Senator TESTER. Thank you. I think the facts are that we have got Iraq and Afghanistan going on, but the Vietnam veterans are the ones who need the attention right now, and rightfully so, and we thank them for their service, too. Part of that thank you is making sure they get the health care they need when they need that health care.

I want to talk about some of those facilities. It is absolutely clear that we need to bolster our medical workforce. It is just not debatable. But, with that comes an increase in facilities and space to accommodate that. It is kind of the chicken and the egg kind of a thing. It has to happen almost simultaneously or you are not going to get the bang for the buck nor the services you expect.

When I took the Secretary to Missoula, Montana here last month, he saw some of that local demand. We saw a clinic that has exceeded its capacity. The veterans in that region are growing 24 percent just in the next 6 months. He had said that there would be a green light to expand that facility. I do not know if you know or not. Is that true?

Dr. CLANCY. I would have to check on that and get back with you.

Senator TESTER. OK. Well——

Dr. CLANCY. I think you had also talked about potential partnerships with the—I just forgot the name——

Senator TESTER. We talked about partnerships with the Billings clinic——

Dr. CLANCY. Thank you. Yes——

Senator TESTER [continuing]. For mental health care professionals, too——

Dr. CLANCY. Yes. Yes.

Senator TESTER [continuing]. That is also very, very important. But, what——

Dr. CLANCY. I know Dr. Walter [phonetic] would be happy to pursue that.

Senator TESTER. Here is what I would point out to you. We are going to expand a facility that is probably going to have to be replaced in a year or two——

Dr. CLANCY. Yes.

Senator TESTER [continuing]. I understand you have got to walk before you can run, but the truth is that I appreciate the expansion, but ultimately, they are going to have a new building, and, boy, the quicker we could do that, we could maybe do away with some of the other expenditures, if you know what I mean.

Dr. CLANCY. We will get back to you on that.

Senator TESTER. All right. Thank you.

The Chairman talked about VA leadership, which is critically important. I want to talk about that partnership with the Billings clinic for psychiatry at the University of Washington. Are you guys in the process of formalizing that partnership? Has any more been done than just talk?

Dr. CLANCY. Not yet, but Dr. Walter is on my list. I have worked with him in a number of national medical organizations and would be happy to follow up with him.

Senator TESTER. He is very, very good, but even more importantly—and I do not think there is a Senator that sits around this table or maybe even serves in the U.S. Senate that will not tell you that we need more mental health care professionals——

Dr. CLANCY. Right.

Senator TESTER. Whether you are in New York State, in the busiest part of New York City, or whether you are in Saco, MT, we

need them. Quite frankly, I think this is an opportunity to address the rural aspect.

Dr. CLANCY. Yes.

Senator TESTER. If you can follow up on that, that would be good. I will tell you that I am sure that folks on this Committee, myself included, will do what we can do to help you meet mental health care needs out there, that also the whole country is short of.

Dr. CLANCY. Right. I should just note our appreciation for the resources in the Choice Act and also in the Clay Hunt Act for attracting and helping with debt reduction and so forth. I think that we also need to move upstream to encourage more students to go into these fields and that that is clearly going to be the next frontier for us.

Senator TESTER. I appreciate the Senator's proactivity on trying to recruit early.

Chairman ISAKSON. Thank you, Senator Tester.

Senator Rounds, followed by Senator Boozman.

Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman.

Earlier today, Chairman Isakson and I sent a letter to the Secretary of the VA with concerns on reimbursement changes to home health care and hospice care providers. I have also heard from a number of other groups on untimely payments from the VA. Late payments hurt veterans because providers are reluctant to take on VA patients if they do not get paid in a timely basis. How does the VA plan to address this particular issue? Are you aware of the issue? Possibility that maybe flexibility within your budgeting process could help provide for some more timely payments, and has the GAO made more than one mention or just the one mention in 2014 in terms of any recommendations on this particular issue?

Dr. CLANCY. I am acutely aware of this issue. I get a lot of e-mails and correspondence, as does the Secretary. And, I would guess that we have never been the swiftest payer. I think that is putting a lot of providers in a bind right now because they are feeling a lot of pressure from both the Federal Government as well as private payers trying to get to value-based payments and so forth. They have less flexibility and they are now feeling like they are really in a box.

Because of the consolidation of our central business office and our payments, our biggest challenge right now is making sure that we get the business processes right. We are in the midst of doing that. A number of our networks have shown some improvements. VISN 23, which your State is part of, is one of our better networks, which is not to say flawless, in terms of payments. Others are further behind.

We are keeping, literally, a weekly eye on this and will not rest until more providers are getting paid in a timely fashion, because you are completely right. Some veterans say they go to providers on the outside and are told, I will see you this time, but next time, Ido not know.That is very,very high onour list of priorities right now.

Senator ROUNDS. I think maybe that goes back, as the Chairman had suggested, back to what Senator Tillis had proposed here in terms of the operations side of things.

I am just curious. It looks to me like in a lot of cases we find some very good people that are working within a system which, for lack of a better term, is simply archaic. It is a very large organization, and what I am curious about is if we talked about an organizational chart, one in which ideas can flow up and down and direction and focus moves in both directions, do you have an accurate organizational chart that is available to you that you have had a chance to look through to see where it gets from you down to a doctor, let us say, at the VA in Sioux Falls, South Dakota?

Dr. CLANCY. I think you have just articulated one of our biggest challenges, for sure. I have organizational charts. I think our bigger challenge is less the boxes on the chart—although we are taking a very hard look at that and will look forward to doing more of that with Dr. Shulkin and so forth—but it is more what I would say is the physiology. How do the processes work?

I know that there is phenomenal work going on at a lot of our local VAs. Salisbury would be one. They are everywhere. We do not actually get to learn enough from them, and I do not think that we have created the space in the past where if a policy is issued from headquarters and people do not have the resources or capacity to do it that they have got the space to say: great idea, except it will not work here. That is the alignment that we are working very, very hard on now, which, frankly, is why the recommendations in the High-Risk Report are useful to us, because they very clearly articulate root causes that we can use as sort of a compass moving forward.

Senator ROUNDS. One of the employees in the Sioux Falls location tried to chart it, and as near as they could determine, from a physician trying to get to the top would have 13 layers to literally work their way through. It seems to me that that may be part of the challenge that you face. You can have a lot of very hard working individuals, but they are working in a system which today you would not find in most business proposals. Is that a fair statement?

Dr. CLANCY. That is a very fair statement, and I will say, literally, from day one, when Secretary McDonald was confirmed, you know, I think it took him probably a few weeks to put his personal cell phone online and on CNN and so forth, and has modeled for all of us trying to break up that kind of hierarchial filtering, if you will, of information, both up and down the chain. I communicate with the field every week. I get a lot of e-mails back, which is symbolically important. It is not the same thing as having clearer processes for it, which is what we are working on now.

Senator ROUNDS. Mr. Chairman, there is just one thought, and that is this. I think when the Chairman and the Ranking Member both indicated at the very first meeting that while we are going to ask some really tough questions, our goal is to see that you succeed.

Dr. CLANCY. I appreciate that immensely. Thank you.

Senator ROUNDS. We still feel that way and we want to see it happen. But, based on what we saw just in Denver and the challenges you have got there——

Dr. CLANCY. Huge.

Senator ROUNDS [continuing]. The issues are very significant, and perhaps part of what we need to do, as some of you who have walked into some pretty deep water with lots of gators, maybe it is time that we not only start draining the swamp, but maybe we pull a few of those gators out and move them in a different direction, as well. Thank you.

Dr. CLANCY. Thank you.

Senator ROUNDS. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Rounds. Good analogy, by the way.

Senator Boozman.

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

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you all so much for being here. We are glad that things are going better in Little Rock.

Dr. CLANCY. I will never make that mistake again.

Senator BOOZMAN. I bet. [Laughter.]

Dr. CLANCY. I am going to send Senator Sullivan a note, but——

Senator BOOZMAN. No——

Dr. CLANCY [continuing]. But things are better in Little Rock.

Senator BLUMENTHAL. You have helped to lighten our meeting significantly. Thank you for——

[Laughter.]

Senator BOOZMAN. Thank you very much. In the GAO report, one of the reasons that VHA ended up on the High-Risk List is because of ambiguous policies and inconsistent processes, which is interesting. I think all of us feel like we need to bring to all of you the things that we are hearing out in the field; and one of the complaints that I hear most often is that VA has no standardized processes for reimbursing claims. You are kind of hearing the same thing over and over.

It is really difficult if you are in an area where you are across borders and across VISNs or however we designate things now, but you will have one method of handling things in Memphis. You will have another in Jackson, MS. You will have another in Little Rock. It really does get confusing. So, that is something I think we really need to look at and I would appreciate it if you would look at standardizing those kind of things.

Again, these are things that do not cost money. These are things that will save you time and save the practitioners.

The other problem is that, I think, practitioners get hung up. I am sure it is true in the VA, with VA practitioners, like if you are on the phone for 2 hours trying to figure out what is going on, trying to figure out where a claim is at. Is there a way to, perhaps using some sort of identification, taxpayer number or whatever, to do that electronically, where you could get in a situation where you could go online and figure out where you are at as far as——

Dr. CLANCY. First, we are trying——

Senator BOOZMAN [continuing]. Medical claims?

Dr. CLANCY [continuing]. We are working very hard now to standardize these processes, and I think you are all aware that we have about five different paths to helping veterans get care in the

community, which is a little bit part of the problem. It is not the sole problem. Some of the original problem is not having standard processes at every facility.

It is further complicated by the fact that we have got the resources offered by Choice, which is terrific, the PC3 contract, Project ARCH in some areas, traditional non-VA care, and some other agreements with our affiliates and so forth. It is a pretty messy puzzle, not a script you would write from scratch.

I think that we are going to look forward to working with all of you to look for opportunities to streamline that, because in the end, if you have got five different ways to do something built into the process before you even start getting with claims, you are more likely to increase the probability of error. It is almost a law.

We are working very hard on standardizing how we pay those claims right now. That is not going to be fixed immediately, but I have got some of our very best people on this, and as I noted earlier, we have our senior leaders in D.C. this week. We were working about this into the evening last night. It is a huge challenge with us.

We embrace the opportunities to do the best by veterans when we see them in our system, but also to take advantage of local capabilities. We need to have business processes that support it and that is not what we have had. So, I will leave it at that.

Senator BOOZMAN. No, and I appreciate that, and it is difficult. Another thing that we hear is that, and I think Senator Rounds mentioned it in the sense of you have policies, you have directives, and sometimes you have situations where perhaps employees feel like that that is not appropriate there and kind of go around. And, the other side of that is we want people to have local control, which I understand is really difficult.

With whistleblowers we have a situation now that reports of retaliation and things like that. Can you all address that and talk to us a little bit about what is going on in that regard. Certainly, you want people to come forward without the problem of retaliation.

Dr. CLANCY. Yes. I will say that the Secretary has been incredibly crystal clear from day one, and Sloan Gibson before him, when he was Acting Secretary, that retaliation will not be tolerated.

I will go further and say there is no health care organization in this country or anywhere in the world that can actually provide safe care without whistleblowers. Now, I am using a small "w" here, OK. But, if people are not coming forward and saying, we have a problem, I am seeing a problem, there is a leak over here. In fact, if people are not actively looking for error all the time, you will never get to care that is reliable and safe.

Nuclear industries run like this, right. They are constantly looking for, where are we going to have a problem and anticipating them ahead of time. That is where we have got to get to.

In that context, whistleblowers are heroes, which is why some of our executives have actually gone to ceremonies celebrating them and so forth.

I think we are not retaliating and we are cooperating fully with investigations of those who have been accused of retaliating. I know that Senator Blumenthal had a lot of questions about this.

Some of these investigations are still ongoing. But, appropriate discipline can be taken, I can assure you.

Senator BOOZMAN. Can I, with your permission, just to follow up with that.

Dr. CLANCY. Sure.

Senator BOOZMAN. In the bill that we passed, we gave you the ability to retaliate against people that were not acting appropriately, in the sense of giving you the ability to get rid of people that were not working out. Do we need to—that was at the top. I know Senator Rubio and Congressman Miller have introduced bills to make it such that a lower level, that you have more flexibility in that regard, again, those people that are not working out. Do you support that, so that we can deal with some of the problems like retaliation?

Dr. CLANCY. We have discussed this with the Secretary and so forth. We are very uncomfortable with anything that would single out VA as opposed to other Federal departments because it might impair our ability to recruit.

I think that we welcome the flexibility that you gave us when you passed the Choice Act because it does not eliminate due process but encourages to speed up the process. Due process does take some time. Again, that balance between if people feel like if they wave their hands and raise their hands, excuse me, and say, we have got a problem, that they do not need to fear being punished. That is the balance that we are—it is very dynamic and that is what we are struggling for.

So, I know that some people who work in VHA do not feel that safe right now at the senior leader level. I am not sure that making that more widely available would necessarily be helpful.

Senator BOOZMAN. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

Senator Blumenthal had a follow-up question.

Senator BLUMENTHAL. You just mentioned, Dr. Clancy, that there will be disciplinary measures. When will there be——

Dr. CLANCY. We are waiting for the results of investigations to conclude. I know, for example, in Phoenix that there are multiple investigations going on right now. By design, many of these are being done by the Office of the Inspector General. We are waiting to hear from them. I cannot give you a specific timeline except to say that when we get those results, we will act as swiftly as we can.

Senator BLUMENTHAL. Dr. Daigh, when will the investigations be done?

Dr. DAIGH. I think the best answer I can give you, sir, is that there is a process in place to work through AUSAs and to move forward according to the rules that we normally deal with for criminal complaint.

Senator BLUMENTHAL. By AUSAs, you mean——

Dr. DAIGH. Assistant U.S.——

Senator BLUMENTHAL [continuing]. Assistant U.S. Attorneys.

Dr. DAIGH. That is correct, sir. But, I——

Senator BLUMENTHAL. But, they do not prepare reports.

Dr. DAIGH. I believe that we take our reports to them to seek whether or not they will attempt to prosecute an individual.

I think it best that the investigators get back to you in a written response.

Senator BLUMENTHAL. Have those reports been submitted to the AUSAs?

Dr. DAIGH. I cannot speak to all of them, but I know that some have. I am aware that some have, yes.

Senator BLUMENTHAL. Well, let me again ask you what the timeline is for their consideration. How long have those investigations been ongoing?

Dr. DAIGH. Sir, I will have to get back with you for the record. I simply do not work in that area non-stop. I will say that at every staff meeting we have within the Inspector General's office, we get an update on numbers of how many reports are where, and I know that there are a number of them with AUSAs.

Senator BLUMENTHAL. I really do appreciate your offer to provide me with information, but, quite bluntly, the American people deserve this information, not just Members of Congress in a private briefing setting or in a written response. The American people deserve to know who will be held accountable, why the investigations have not been completed, what is going to be done to expedite them. Justice needs to be sure, swift and sure, especially when it comes to danger of people's lives. Both you and Dr. Draper have indicated that lives were at risk and maybe even lost as a result of potential wrongdoing in Phoenix and in 1992 or 1993, other situations around the United States.

So far, we have been discussing only Phoenix, and the reports, investigations there are not even complete yet. Am I correct?

Dr. DAIGH. I am uncertain exactly about the investigations——

Senator BLUMENTHAL. Dr. Clancy is nodding her head, which, I think, is——

Dr. DAIGH. I believe her, but I am not certain on that fact. But, sir, I believe that all of us want this to be done as far as we can. There is no——

Senator BLUMENTHAL. I am sure you do want it to be done as quickly as possible. We all want it to be done as quickly as possible. The question is when it will be done.

Let me just ask one last question. There have been various proposals to take a billion dollars from money that was allocated to the accessibility and Choice program in order to pay for completion of the Denver medical facility. My belief is that taking this billion dollars from the Choice program would make it far more difficult and unlikely for the VA to be removed from the High-Risk List. Does anybody disagree?

Let me interrupt myself to call on Dr. Daigh.

Dr. DAIGH. Sir, the only thing I can say is I am not sure that we have studied that question, so I——

Senator BLUMENTHAL. You are not disagreeing, then.

Dr. DAIGH. I am not disagreeing.

Senator BLUMENTHAL. Does anyone disagree? Dr. Draper.

Ms. DRAPER. Well, I will say we have specific criteria for removal from the High-Risk List; and we do have, in response to Senator Tillis, I think, a good framework for how agencies address getting off the High-Risk List.

Senator BLUMENTHAL. Well, let me put the question a different way. Detracting from the objectives of the Choice program by diverting a billion dollars will make it far more difficult and unlikely that the VA will meet those criteria, is that correct? Dr. Clancy.

Dr. CLANCY. If I could just provide some specific details. The Choice resources are sort of two big buckets, right. One is the $10 billion for the actual purchasing care in the community and the other is $5 billion really focused on enhancing our capacity.

Most of our facilities, when asked about their acute needs, actually front-loaded their requests from that $5 billion for construction. Most were not for new facilities, but mostly for non-recurring maintenance, renovation, and so forth, which goes on all the time in the hospital and health care industry, right. The proposal is that a portion of that would be slowed down. It would not inherently affect our capacity in terms of increasing space and hiring people who need to see patients.

I take your point, but I want to say that——

Senator BLUMENTHAL. Dr. Clancy——

Dr. CLANCY [continuing]. We have a very strong commitment to get off this High-Risk List, but at the same time, I think Denver, the facility there, and what is the right thing to do for veterans and the public is also pretty imperative.

Senator BLUMENTHAL. Would it not affect the quality of care?

Dr. CLANCY. In most instances, slowing down the construction, renovation, and so forth would not necessarily impact the quality of care.

Senator BLUMENTHAL. Not necessarily, but I can tell you in the instances where I know and I have talked to my colleagues——

Dr. CLANCY. Yes.

Senator BLUMENTHAL [continuing]. It would have an impact on quality of care. We are talking about in the Westhaven facility in New Haven——

Dr. CLANCY. Yes. Mm-hmm.

Senator BLUMENTHAL [continuing]. Primary care.

Dr. CLANCY. Yes.

Senator BLUMENTHAL. I would like to know from you, and you do not have to do it now——

Dr. CLANCY. OK.

Senator BLUMENTHAL [continuing]. You can provide it in written form——

Dr. CLANCY. I will give you an informed, thoughtful response.

Senator BLUMENTHAL. Thank you.

I want to thank all the witnesses for your very informative and helpful comments today.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Ranking Member Blumenthal.

I would just end by saying this, that I think within these recommendations and findings of GAO and the Inspector General, there are savings and there are funds that could be used to pay for things that the VA needs to pay for without us just adding onto the burden. I think Senator Blumenthal makes an outstanding point, and I told Sloan Gibson in Denver that when the recommendation comes to the Committee as to how we pay for the billion-dollar overrun, if there is not contribution from within the

operational budget of the VA itself, I do not know how we are ever going to get any money done to do it whatsoever. I hope as they look to build that, they will find those funds internally to the extent possible without damaging the VA.

With that said, I want to thank all our people for testifying. Thank you for being here, and I thank Senator Tillis for volunteering to be my Committee Chairman, and Karen, thank you for being so willing to be voluntarily volunteered for a task.

This meeting stands adjourned.

[Whereupon, at 3:58 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Question 1. A number of factors are considered in evaluating whether any Federal department, agency, or program should be placed on the High Risk List. Please describe the procedures, process, and people involved in the Government Accountability Office to determine whether a Federal program is placed on the List.

Response. Many individuals within GAO with expertise in various Federal policy areas, including the Comptroller General, are involved in the process of evaluating whether specific programs or functions should be included on the High Risk List. Affected agencies and departments are not solicited for their agreement to be placed on the list, nor do they ask to be placed on the list. Rather, the decision to add areas to the High Risk List is a determination made solely by GAO based on comprehensive analyses and quality assurance reviews.

To determine which Federal Government programs and functions should be included on the High Risk list, we use our guidance document, *Determining Performance and Accountability Challenges and High Risks*.[1] In making this determination, we consider:

- whether the program or function is of national significance or is key to performance and accountability;
- qualitative factors, such as whether the risk involves public health or safety, service delivery, national security, national defense, economic growth, or privacy or citizens' rights; or, could result in significantly impaired service, program failure, injury or loss of life, or significantly reduced economy, efficiency, or effectiveness;
- the exposure to loss in monetary or other quantitative terms—at a minimum, $1 billion must be at risk in areas such as the value of major assets being impaired; revenue sources not being realized; major agency assets being lost, stolen, damaged, wasted, or underutilized; potential for, or evidence of improper payments; and presence of contingencies or potential liabilities; and,
- corrective measures planned or under way to resolve a material control weakness and the status and potential effectiveness of these actions—if effective solutions will not be completed in the near term and resolve the root causes of the problem, we determine that the program or function is high risk.

The process for determining whether VA health care should be designated high risk began months before GAO issued its 2015 high risk series update. In making the determination to add VA health care to the High Risk List in 2015, a number of specific factors were considered. In recent years, we have made numerous recommendations that aim to address weaknesses in VA's management of its health care system—more than 100 of which have yet to be fully implemented. After analyzing the findings of GAO's work on VA health care completed over the past five years, we categorized our concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of the health care the department provides into five broad areas: (1) ambiguous policies and inconsistent processes, (2) inadequate oversight and accountability, (3) information technology challenges, (4) inadequate training for VA staff, and (5) unclear resource needs and allocation priorities.

Once the determination was made to add VA health care to its High Risk List, GAO briefed the relevant Congressional committees of jurisdiction. Just prior to the publication of the 2015 High Risk List, GAO officials met with and informed VA officials—including the VA Secretary and Under Secretary for Health—that VA health care was being added to the list.

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[1] GAO, *Determining Performance and Accountability Challenges and High Risks*, GAO–01–159SP (Washington, DC: November 2000).

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DAN SULLIVAN TO DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Question 1. Dr. Draper, the VA and the VHA are getting beaten up a lot in the media and in Congress. While a lot of aggressive oversight is justified, a group of people can only take so much of this type of oversight before they become timid and simply check the box to not get in trouble. This is not the type of culture we want at the VA. What suggestions do you have to improve the culture at the VHA and the VA as a whole?

Question 2. Dr. Draper, what suggestions do you have to actually encourage innovation and new ideas?

Question 4. Dr. Draper, how can we create excellence at the VA?

Response. We provide a combined response to questions 1, 2 and 4, as all three questions deal with VA organization, performance, and opportunities for improvement.

VHA's mission states, "Honor America's veterans by providing exceptional health care that improves their health and well-being." However, risks to the timeliness, cost- effectiveness, quality, and safety of veterans' health care, along with other persistent weaknesses identified by GAO, VA's Office of the Inspector General, and others in recent years have not only raised concerns about VA's management and oversight of its health care system, but also increased awareness of the magnitude and pervasiveness of the issues. Over the past few years there have been numerous reports of VAMCs failing to provide timely care, including specialty care, and in some cases, the delays have reportedly resulted in harm to veterans.[2]

In addition to its responsibility to those veterans it serves, VA also has a fiduciary responsibility to the American people to ensure that taxpayer dollars are spent properly. Congress has provided steady increases in VA's annual health care budget with amounts increasing from $23.0 billion to $55.5 billion between fiscal years 2002 and 2013. Additionally, the Veterans Access, Choice, and Accountability Act of 2014 provides $15 billion in new funding for, among other things, the use of non-VA clinicians to provide care for those veterans faced with access challenges, including those related to lengthy travel distances and long wait times.

To address these issues and help improve the department's culture, encourage innovation, and create excellence, I suggest VA consider the following resources. First, GAO's five criteria for removal from the High Risk List provide an excellent framework for performance improvement, while also addressing the relevant high-risk issues for VA. The following are the five criteria for removal:

- *Leadership commitment.* Agency leadership has demonstrated strong commitment and support.
- *Capacity.* Agency has the capacity (i.e., people and resources) to resolve the risk(s).
- *Action plan.* Agency has developed a corrective action plan that defines the root cause(s), identifies solutions, and provides for substantially completing corrective measures, including steps necessary to implement solutions we recommended.
- *Monitoring.* Agency has instituted a program to monitor and independently validate the effectiveness and sustainability of corrective measures.
- *Demonstrated progress.* Agency has demonstrated progress in implementing corrective measures and in resolving the high-risk area.

Second, VA could seek to learn from the experiences of other agencies and program areas that have been successfully removed from, or are making progress toward removal from GAO's High Risk List. For example, the National Academy of Public Administration recently sponsored a discussion on the opportunities and challenges of being on GAO's High Risk List, by a panel of participants representing agencies and programs that have been included on, or have been removed from the list. At the discussion, one official said the agency she represented used a portfolio management system to prioritize risks for leaders, which helped the program to be removed from the High Risk List. Another agency official with programs currently on the High Risk List said his office was planning to launch an exchange program to gather ideas by giving employees experiences in other offices.

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[2] See, for example, Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina*, Report No. 12–04631–313. (Washington D.C.: September 6, 2013), and Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Consultation Mismanagement and Care Delays Spokane VA Medical Center Spokane, Washington*, Report No. 12–01731–284. (Washington D.C.: September 25, 2012).

Third, VA could consult organizational performance literature and research, which commonly identify several key characteristics of highly effective, excellent, and innovative organizations. These include the following:

- Well defined and compelling mission, purpose, and expected results
- Clear and visible commitment to excellence
- Customer/client-centric
- Efficient and effective infrastructure, systems and processes
- Effective management of resources, including attracting and retaining a highly qualified workforce
- Empowered workforce, including open, trusting, and multi-directional communications
- Flexible and adaptable in an ever changing environment
- Emphasis on continuous learning

Finally, a number of programs are available to assist organizations in achieving performance excellence. One such program is the Baldrige Performance Excellence Program, which is administered by the Department of Commerce's National Institute of Standards and Technology, in conjunction with the private sector. The Baldrige Criteria for Performance Excellence—used by organizations around the country, including health care organizations—provide a framework and tool to assess organizational strengths and weaknesses, to identify opportunities for improvement, and to create a plan for moving forward.[3] According to the Baldrige Program, "performance excellence refers to an integrated approach to organizational performance management that results in: (1) delivery of ever-improving value to customers and stakeholders, contributing to organizational sustainability; (2) improvement in overall organizational effectiveness and capabilities; and, (3) organizational and personal learning." In addition to the Baldridge Program, other entities, such as the Institute for Healthcare Improvement and the Joint Commission, also offer programs that focus on health care organizations' performance improvement.

Question 3. Dr. Draper, what authorities can Congress give you to help these innovations and ideas cut through the existing VA and VHA bureaucracies?

Response. GAO has adequate audit authority to continue to provide robust oversight of VA. To help ensure VA takes the necessary actions to improve health care for the Nation's veterans, congressional attention and oversight is critical. In the spring and summer of 2014, congressional committees held more than 20 hearings to address identified weaknesses in the VA health care system. Sustained congressional attention to these issues will help ensure that VA continues to make progress in improving the delivery of health care services to veterans. This includes continued congressional oversight of VA's progress made on implementing recommendations made by GAO, VA's Office of the Inspector General, and others. As part of this ongoing oversight, it would also be beneficial for Congress, as well as GAO, to receive periodic updates (e.g., quarterly) from VA on its progress in addressing the five areas of concern that led to its health care system being placed on the High Risk List.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO CAROLYN M. CLANCY, M.D., INTERIM UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Clancy, during your testimony we discussed the issue of delayed construction and maintenance projects and their potential negative effects on quality of care. While you stated that delaying improvement projects would not necessarily have an impact on quality of care, I am concerned that delaying necessary improvement and maintenance for Veterans Health Administration facilities would have long-term effects on the level of care that is delivered to veterans, and the ultimate costs to maintain the facility. For instance, the Administration has recently suggested delaying an improvement project for the primary care clinic at the West Haven VAMC. I have visited that facility many times and I am convinced that veterans, and particularly women veterans, need a new primary care clinic that meets their health care needs.

a. Can you please tell me how VA plans to ensure that delays in construction and maintenance projects do not negatively affect patient care?

Response. The West Haven project was submitted and approved through VA's FY 2014 Strategic Capital Investment Planning (SCIP) process. This project was de-

[3] See for example, http://www.nist.gov/baldrige/about/performance—excellence.cfm.

layed due to scope changes. The design contract for the project is scheduled to be awarded this month.

VA will ensure that delays in construction and maintenance projects do not adversely affect patient care by utilizing the many capabilities at our disposal, such as; expanded hours, telehealth, and care in the community. These capabilities will allow us the flexibility we need to ensure that Veterans receive the quality and timely care that they rightfully deserve.

b. Are there any specific actions VA will take to alleviate any identified gaps in care?

Response. VA continually looks for gaps in care by tracking and closely monitoring facility and network capacity. In response to the recent crisis of Veteran access, senior leaders from across the department gather daily to focus on improving Veterans' access to care, thereby alleviating gaps in care. We have concentrated on key drivers of access, including increasing medical center staffing by 11,000, adding space, boosting care during extended hours and weekends by 10 percent and increasing staff productivity. This focus on capacity creates organizational opportunities to leverage choice and virtual care. We currently have ongoing pilots and programs, such as My Health*e*Vet, to operationalize these plans and create opportunities to identify potential gaps in a Veterans care.

c. Please tell me what steps VA plans to take to minimize the impact of delayed minor construction and nonrecurring maintenance on the condition of its facilities?

Response. If any minor construction or NRM projects that were originally to be funded through Section 801 of the Choice Act are delayed, VA will work to restore funds for the delayed project(s) in either fiscal year (FY) 2016 or FY 2017. In an effort to mitigate the impact to Veterans due to the potentially delayed projects, VA will work to ensure that access is provided through other avenues within VA and also within the community.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO STEPHEN W. WARREN, EXECUTIVE IN CHARGE AND CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Does the VA currently have an interoperable pharmacy data transaction system that is interoperable with the Department of Defense?

Response. DOD and VA do have interoperability for pharmacy data and currently exchange pharmacy data on Veterans. Both departments store or map the data to nationally accepted standards. This enables each to interpret and compute the other's data without risk of ambiguity.

VA does not yet have the capability to send prescriptions to DOD for dispensing or to receive prescriptions from DOD.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DAN SULLIVAN TO CAROLYN M. CLANCY, M.D., INTERIM UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

SERIOUSNESS OF THE LIST AND IT'S NOT JUST ABOUT GETTING OFF THE LIST

Question 1. How seriously is the VA and VHA taking being on the GAO's High Risk List?

Response. VA takes its inclusion on the GAO High Risk List extremely seriously and recognizes that we have a distinct opportunity to address these challenges across the system. This will require us to seek collaboration opportunities throughout the Department and in the community. We are committed to instituting long term durable solutions and sustained improvement in the high risk areas identified. As we implement corrective measures, we will provide GAO with documentation of our progress. Additionally, we will seek input from GAO and OIG to ensure that our actions are meeting the intent of their recommendations. We look forward to substantial improvement and completing the recommendations which they have identified.

Question 2. What specifically should the VHA do to not just get off this list, but to make the VHA a healthcare solution that Veterans want?

Response. VHA has established a *Blueprint for Excellence* that offers a detailed vision for the evolution of health care services provided by VHA. The Blueprint provides guidance for the alignment of resources to transform VHA from being provider-centric to Veteran-centric; with specific strategies that offer a pathway to address GAO's five high risk areas. Addressing these strategies is a fundamental part

of VHA Senior Leaders performance plans. The *Blueprint for Excellence* will allow for Health Care that simultaneously address improving the performance of VHA healthcare, developing a positive service culture, transitioning from "sick care" to "health care" in the broadest sense, and developing agile business systems and management processes that are efficient, transparent and accountable.

The *Blueprint for Excellence* aligns with several of the GAO high risk areas by emphasizing what VHA must do to become the system that Veterans deserve, and secondarily helping VA get off the GAO High Risk list:

- Improving performance,
- promoting a positive culture of service,
- Advancing healthcare innovation for Veterans and the country, and
- Increasing operational effectiveness and accountability.

VHA has developed specific actions to get off the High Risk List, using the *Blueprint for Excellence* as the vehicle. Regarding national policy and processes, VHA is integrating our policy and operational leaders across business lines, such as primary care, surgical care and mental health, which will align policy development with implementation. Health care is a dynamic industry, and our policies must be flexible enough to accommodate evolving standards for clinical care and clinical judgment. We will continue to improve our processes and implementation of policies to address GAO and OIG findings, and ensure VHA provides timely high quality care to all Veterans.

With respect to oversight and accountability, VHA restructured the Office of the Medical Inspector (OMI) into an integral element of VHA's oversight and compliance program. Responsible for assessing the quality of VA health care through site-specific investigations and system-wide assessments, OMI reports directly to the Under Secretary for Health. OMI's policies and procedures were revised to ensure that health care quality and patient safety remain a primary and constant focus.

Concerning information technology, VA is modernizing our Electronic Health Record (EHR), VistA, which is the most widely used EHR in the United States. VA is also developing a new web based Enterprise Health Management Platform, or eHMP. We will continue to share health care data on millions of Servicemembers and Veterans with the Department of Defense and our community partners in compliance with all relevant privacy laws.

Human capital training is critical to ensure Veterans receive safe care. Our frontline providers need to have effective training on VHA's national policies and procedures. They must also be capable of using VHA's tools for monitoring health care delivery. We need our training to empower employees and make it easy for every employee to do the right thing every time.

Concerning resource needs and allocation priorities, VHA is moving forward with implementing an enterprise-wide planning, programming, budget and execution program that will ensure our medical care planning and prioritization drives our budget request and execution. Using this program, we will be able to prioritize resource needs and budget for effective implementation of national policies and procedures, including budgeting for training and human capital.

EXPORT TELEMEDICINE FROM ALASKA TO THE U.S.

Question 3. Dr. Clancy, Alaska is home to the highest per capita population of veterans in the country. As of August 2014, Alaska had nearly 75,000 veterans, nearly one-tenth of our population. Alaska also is about two and half times the size of Texas, with over 663,000 sq. miles of area. Because of the amount of area in Alaska, my state leads the Nation in telemedicine and telehealth delivery, ensuring that Alaskan, wherever they are, receive the best quality and most cost-effective treatment possible. In fact, one area where Alaska is breaking the mold where many native veterans who live in bush Alaska no longer have to take multiple days off to fly into Anchorage to see their doctor and can instead VTC with their doctor from their local health clinic. While I troubled by GAO's Report which cite a 9-year, $127 million failed attempt to upgrade the VA's scheduling software and an longstanding failure to integrate Electronic Health Records for VA and the Department of Defense, I like to see the glass a half full. In this case, a half full glass is that there is a lot of room for improvement with the right investments and a culture that is willing to think outside the box. Alaska's exports many things to the U.S. are famous, including oil., salmon, and minerals. Dr. Clancy, how can the VHA take what is being done in Alaskan telemedicine and telehealth and export it to the Lower 48?

Response. VHA strives to continually look across all systems for best practices. Fortunately the Alaska VA system has been a source of inspiration across the VHA system in regards to telehealth and telemedicine. We must use the examples from

the Alaska VA system to focus on providing care when and how the Veteran needs it.

VHA is recognized as a world leader in the development and use of telehealth. More than 717,000 Veterans accessed VHA care through telehealth in fiscal year (FY) 2014, 45 percent of these Veterans live in rural or highly rural areas. The FY 2014 total for Veterans using telehealth represented an 18% growth from the year before. Telehealth services provide access to health care in more than 45 different specialty areas, including areas in which VHA has particular expertise that may not be available from the local community health care provider.

The Alaska VA Healthcare System based in Anchorage has progressive clinical and executive leadership who maximize the use of telehealth to meet the specialized needs of our Veterans in Alaska. For example, Alaska's Veterans access VHA care through Teledermatology, Teleretinal imaging for annual screening for diabetic retinopathy eye disease, Home Telehealth for monitoring and management of chronic conditions like diabetes, chronic obstructive pulmonary disease, and congestive heart failure. Veterans in Alaska use clinical video telehealth to access their Primary Care Providers based in Colorado and Florida, and Patient Aligned Care Teams (PACT) based in Idaho at the Boise Primary Care Hub. The PACT multidisciplinary teams include social workers, clinical pharmacists, mental health and primary care providers. All of the Alaska VA Healthcare System's Community-Based Outpatient Clinics (CBOC), located in in Kenai, Fairbanks, and the Mat-Su clinic in Wasilla, offer telehealth services. In some instances Veterans in the CBOC use telehealth to access care from providers at the main Medical Center, and sometimes they access care from providers at another CBOC. Last fiscal year in Alaska more than 1,800 Veterans accessed VHA care through telehealth, and more than 330 Veterans benefited from Home Telehealth. VA's Alaska Healthcare System is able to share its most successful telehealth strategies with the other 150 VA medical centers and 800 CBOCs across the country. These best practices are conveyed through the 15 year old VHA Telehealth Community which uses multiple methods to share information including weekly Program Manager conference calls, monthly National Forums, quarterly newsletters, and annual conferences.

The ability to collaborate with the Native Healthcare Systems, local community resources, and DOD has led to success in providing access to Alaska's Veterans. The use of telemedicine within Alaska and with VA facilities in other states has provided access to Veterans in multiple communities located across the vast Alaskan terrain. These relationships are crucial to ensure the health care needs of Alaska's Veterans are met.

In 2011, a policy decision from VA Central Office required the Alaska VA to provide healthcare services within the state whenever available rather than transferring Veterans to VA facilities in Seattle or Portland for care. Each Veteran was given the option for local care in the private sector, or referral to other VA facilities. Only rarely have Veterans chosen to travel to Seattle or Portland VA for care. The Alaska VA Healthcare System has a strong program in place to coordinate private sector care. Additional staff were added to ensure coordination of care and that Veterans' needs were being met. For example, with the increase in oncology care being provided in state, the Alaska VA established an oncology team to ensure the requirements for care purchased in the community was well defined and accomplished.

In August 2013, the Alaska VA began purchasing primary care in the community. This was due to high turnover and the inability to hire new providers despite the use of recruitment incentives. The shortage of primary care providers led to increased wait times for Veterans. Working with community providers and Native Healthcare Organizations, the Alaska VA was able to obtain primary care services for those Veterans who had been waiting the longest for care. As new Veterans applied for care, the Alaska VA continued to use these community providers to obtain timely primary care. Also, through 26 sharing agreements, care for Native and Non-Native Alaska Veterans living in rural Alaska was purchased across the state. Tanana Chief Conference in Fairbanks and South Central Foundation in Mat Su Valley have the largest number of Veterans receiving primary care at their facilities. In addition, VA entered into contracts with multiple private sector healthcare organizations in order to meet the access requirements of Veterans. Staff members were assigned to function as liaisons with specific community providers. Positive feedback has been received from Veterans referred to these organizations. There is ongoing communication across multiple levels of the Alaska VA -from Executive leadership to frontline staff. Extensive care coordination between VA and these community healthcare organizations is required and a continual VA presence to ensure continuity of care and issue resolution. That continuity is provided through VHA's Integrated Care Service. Due to the large number of Veterans referred to South

Central Foundation (SCF) in the Mat Su Valley, several VA employees are assigned to work with SCF to ensure consults are managed efficiently and appropriate medical record information is exchanged. To ensure ongoing communication, planning and conflict resolution is critical for the Alaska VA Chief of Staff and the Chief of the Chief of Integrated Care Services. These relationships have developed over several years of frequent interactions, face-to-face dialog and understanding of cultural sensitivities.

Another important component of the Alaska VA Healthcare System's success is the establishment of a robust rural outreach team made up of administrative and clinical staff. This group has ongoing contact with rural communities including tribal leaders, healthcare organizations, community elders and Veterans. Over 200 volunteers have been trained as Tribal Veteran Representatives and function as liaisons between VA, Veterans, and rural health organizations.

The Alaska VA also has a sharing agreement with the 673rd DOD/VA Joint Venture hospital in Anchorage for emergency care, urgent care, and inpatient care to include Intensive Care unit. By using the military resources as a right of first refusal for specialty care, the sharing of health care resources provides VA a cost effective resource for specialty care needs.

In addition, teleprimary care providers located in Boise, ID; Bay Pines, Florida; and Denver, Colorado are used to provide care for Anchorage Veterans. This augments care and serves as a bridge during provider shortages. Veterans receiving teleprimary care have expressed high levels of satisfaction with the care received.

ALASKAN WAIT TIME SUCCESS AND TRANSLATING FURTHER

Question 4. Dr. Clancy, in figures recently compiled by the Associated Press showing a snapshot of in time wait time information for 940 VA hospitals and outpatient clinics nationwide, the shows that "an average of less than 1 percent of completed appointments at the Anchorage outpatient clinic—0.90 percent—involved delays of at least 31 days from the veteran's preferred appointment date during that period. In fact, averages were lower at facilities in Wasilla, Fairbanks and Kenai." Nationally, about 2.8 percent of completed appointments involved delays of more than 30 days. In sum, Alaska has less than 1% of veterans waiting over 30 days when over 20% of the state's population lives in rural areas, many of which are hundreds of miles from VA facilities. Can the VHA use some of what is being done in the Alaska VA system and use it as a model to help other areas of the U.S.? What specific lessons can be learned from Alaska?

Response. A primary strength of the Alaska VA Healthcare System is its success in establishing strong relationships with community providers. Through these relationships VA is able to provide accessible, timely, coordinated, and high quality care for Veterans. VA community providers include DOD and the Native Healthcare Organizations, as well as multiple community providers and smaller health care systems across the state. The ability of the Alaska VA System to use purchased care is based upon the knowledge that relationship-building and open communication are the key to instill a common mission and shared vision among all providers and stakeholders. To strengthen relationships in the community, the Alaska VA Healthcare System will assign specifically trained VA staff to work with the provider's health care facility, thereby encouraging frequent face-to-face contact and close communication. Open dialog engenders mutual trust and empathy, promoting a shared mission with a focus on ICARE values, which then can be better actualized by community providers as well by the health care team at the VA facility. This "one standard of care for all Veterans" concept is an expectation of all community providers of the Alaska VA Healthcare System and promotes excellent access, continuity, and care coordination. Positive feedback has been received from Veterans, whether receiving care in the community or at their VA facility. Seamless integration of care between VA and community providers, facilitated by a strong foundation of trust and a sense of shared mission, enables the Alaska VA to provide the needed care for Veterans efficiently and effectively.

The Alaska VA's approach has important implications for VA care at sites in other states. A close and transparent network between the VA and surrounding community health care providers can improve access, continuity, care coordination and overall quality of care. VA and community health care networks can be best created through proactive efforts to facilitate close communication and relationship building. VHA anticipates and welcomes a future of close cooperation between VA and community health care programs. The goal is to develop a network of coordinated, integrated health-related services that provide seamless care for all Veterans.

Question 5. Dr. Clancy, what suggestions do you have to help create a culture at the VA that rewards this type of achievement—even incentivizes it—so that the VA

and VHA do not end on the GAO's high risk list AND more importantly, so that our veterans get the care they have earned?

Response. In order for VHA to be successful we must ensure that Veteran outcomes are always our priority; In order to do this, we must look for a uniform platform with local components that celebrates innovation across the organization. This is accomplished through the Secretaries "*MyVA*" initiative. As a part of "*MyVA*" we have begun to actively solicit employees to provide process improvement ideas and to take an active role in improving the Veteran Experience. We already have begun to examine how to expand Lean Concepts system wide which will help foster idea formation across the organization.

CULTURE CHANGE AT THE VA

Question 6. VA and the VHA are getting beaten up a lot in the media and in Congress. While a lot of this aggressive oversight is justified, a group of people can only take so much of this type of oversight before they become timid and simply check the box to not get in trouble. That is not the type of culture we want at the VA.

What suggestions do you have to improve the culture at the VHA and the VA as a whole?

Response. The *Blueprint for Excellence* lays the framework for improvement of the culture of VA, and provides a positive vision for employees. Recent shortcomings of VHA performance highlight the importance of reconnecting leadership and staff to VA's mission and the expressed values of the organization, as a basis for cultural transformation. In addition to creating a positive and "Veterans-first" culture of service in VA, this vision seeks to improve Veteran services by building an environment of continuous learning, facilitated by responsible risk-taking and balanced by personal integrity and constructive, sustainable accountability. Such an environment reinforces a culture of doing right by the Veteran every time.

Question 7. What suggestions to do you have actually encourage innovation and new ideas?

Response. The Secretary has emphasized that the best ideas come from those who are closest to the problem. This led to the development of the "*MyVA*" initiative. This initiative will reorient VA around Veterans' needs and empower employees to assist by delivering excellent customer service to improve the Veteran's experience. "*MyVA*" actually works to identify best practices to amplify issues and develop solutions. We must combat non-productive activity and waste, such as production defects, overproduction, waiting, underutilization of talent, excess motion, and extra processing. Supported by senior managers and leaders, front-line workers through mid-level management staff will be recruited to identify opportunities for innovation throughout their work areas. The "*MyVA*" brings together all members of the organization focused on continued learning and working to ensure state-of-the-art care for our nations Veterans.

VA leadership has been instructed to continue to seek feedback and ideas from Veterans, employees, community partners and stakeholders through the use of town hall forums. In addition, we have instituted the "*MyVA* Idea House;" an intranet web tool, where employees from across VA can submit ideas online to improve services, streamline processes and solve issues for Veterans and their families.

Question 8. What authorities can Congress give you to help these innovations and ideas cut through the existing VA and VHA bureaucracies?

Response. Congress has been extremely helpful as we continue to work to transform VA's organizational culture and become the VA that our Veterans want and deserve. We look forward to working with Congress to help us fill needed personnel shortages across our system. Also, by helping us to get the message out that VA has a laudable mission and is a great place to work.

Question 9. How can we create excellence at the VA?

Response. We can create excellence in the VA by continually looking for ways to improve our system and by putting the Veterans Experience principal in all we do.

We must recruit and retain the best and brightest and give them the tools necessary to provide the very best care possible to our nations Veterans who have earned it. We also must seek to learn from mistakes and prevent reoccurrence.

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