

**ENSURING TIMELY ACCESS:
CHALLENGES IN VA SCHEDULING**

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BEFORE THE
SUBCOMMITTEE ON TECHNOLOGY
MODERNIZATION
OF THE
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C O N T E N T S

THURSDAY, SEPTEMBER 26, 2024

	Page
OPENING STATEMENTS	
The Honorable Matthew M. Rosendale, Sr., Chairman	1
The Honorable Sheila Cherfilus-McCormick, Ranking Member	2
WITNESSES	
PANEL I	
Ms. Cherri Waters, Executive Director, Health Portfolio, Office of Information & Technology, U.S. Department of Veterans Affairs	4
Accompanied by:	
Ms. Hillary Peabody, Acting Assistant Under Secretary for Health for Integrated Veteran Care, Veterans Health Administration, U.S. De- partment of Veterans Affairs	
Mr. Mark Hausman, M.D., Executive Director for Integrated Access, Vet- erans Health Administration, U.S. Department of Veterans Affairs	
APPENDIX	
PREPARED STATEMENTS OF WITNESSES	
Ms. Cherri Waters Prepared Statement	23
STATEMENTS FOR THE RECORD	
Questions for the Record Submitted by The Honorable Matthew M. Rosendale, U.S. House of Representatives, (MT-02)	25
U.S. Department of Veterans Affairs Response to Questions for the Record	27

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SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:07 a.m., in room 360, Cannon House Office Building, Hon. Matt Rosendale (chairman of the subcommittee) presiding.

Present: Representatives Rosendale, and Cherfilus-McCormick.

OPENING STATEMENT OF MATTHEW M. ROSENDALE, CHAIRMAN

Mr. ROSENDALE. Good morning. The subcommittee will come to order. I want to welcome our witnesses to discuss the efforts to modernize the U.S. Department of Veterans Affairs' (VA) appointment scheduling process. Ten years after the wait time scandal, it is still too difficult for veterans to get appointments in the Veterans Health Administration (VHA) or in the community. Some members of this committee have been eager to get into arguments about VHA care versus community care. I believe veterans should have all the information and the VA should respect their choices. I was charged with making sure our veterans get the care that they have earned when they want it, where they want it, period.

I can tell you, in Montana, community care is an absolute necessity, but the reality is both systems are still far too bureaucratic and difficult to navigate. It is also still too complicated for the VA employees to manage scheduling. These Information Technology (IT) systems have not been a high priority, and the projects that are consuming the lion's share of the IT budget do little to solve the problem. I am glad to see our witnesses working on the integrated scheduling solution, the clinical capacity search tool, and the clinic configuration manager to improve VHA scheduling. I question why the Department waited so long to start these projects and why some of them will take so many years to complete, but without a doubt, the goals are worthy. I expect our witnesses to stay the course and deliver these systems on schedule and on budget, which is another big problem that we have had with many of the IT programs.

Our veterans would have been much better served if the VA had not abandoned the medical appointment scheduling system, MASS in 2019. This project had implemented Epic's scheduling system and patient portal in Columbus, Ohio, and they were working well.

The VA leaders at the time made a special effort to eliminate it, paving the way for Cerner, a name that we have had come up in this committee many, many times, not under good circumstances, to duplicate the work and install an inferior system. This was a disastrous decision that we are all still paying for.

I also expect our witnesses to explain how they are going to fully implement the External Provider Scheduling (EPS) system, which includes the software of a company called WellHive. WellHive enables direct scheduling, which means VA schedulers no longer have to play phone tag for hours to hunt down open appointments with community care providers. Instead, they can see each participating community care provider's scheduling availability in real time on one screen. They can schedule the veteran's desired appointment with one call. WellHive's software has proven successful in the medical centers that have been permitted to use it. According to VA's own statistics, it has accelerated the overall community care referral and scheduling process from 26.6 to 17 days. The status quo phone tag method takes days or weeks and many phone calls before a veteran can get scheduled. I know many veterans who are watching this can certainly relate to this problem.

According to the VA's website, WellHive enables staff to schedule appointments in under 6 minutes. The medical center employees have given it rave reviews during the committee staff's oversight visits. It seems to be working, yet we continue to see VA make confusing decisions that hold the project back. Early on, there were caps on how many schedulers at each medical center could use WellHive. More recently, the company has complained that its efforts to sign up new healthcare providers are restricted. Now VA tells us that WellHive's system will be turned off in four medical centers where it was already implemented, and the planned rollout in Fiscal Year 2025 will be dramatically scaled back.

I am well aware of the VHA budget shortfall. I think the House made the right decision yesterday to get a complete explanation of the shortfall rather than to hand over a \$12 billion supplemental appropriation right away. I have no doubt that Congress will get to the bottom of the situation and prevent any veterans' care from being disrupted. That being said, it would be incredibly short sighted to cause lasting damage to this project with budget cuts that will quickly disappear everywhere else. I have serious concerns that the current leaders of the Department of Veterans Affairs might be intentionally undermining this project and making veterans' health care slower and more difficult out of political hostility to community care. I hope that is not the case.

Today we are going to dig into these decisions and the thinking behind them because veterans' appointment scheduling is too important, and the status quo is too broken to let any of the projects we are discussing today slip into failure or neglect. With that, I will yield time to Ranking Member Sheila Cherfilus-McCormick for her opening statement.

**OPENING STATEMENT OF SHEILA CHERFILUS-MCCORMICK,
RANKING MEMBER**

Ms. CHERFILUS-McCORMICK. Thank you so much, Mr. Chairman, and thank you so much to our witnesses for being here today. This

subcommittee has spent a lot of time discussing VA's transition to its new Oracle Electronic Health Record (EHR). Lost in the conversation has been the Veterans Health Administration's critical need for a new appointment scheduling solution. Appointment scheduling is the foundation of veteran access to care, the current process and the system that support it. Weeks or months to the time that the veterans wait for their critical medical appointments. This should not be the case. Instead, we should be creating solutions that provide better visibility to care. Whether it is sought at VA or in the community, veterans deserve as much.

For more than 20 years, VA has attempted to modernize or replace its scheduling IT system. It has been decades of modernization efforts with little to no success. In fact, most of the efforts have been abandoned. In just the last 10 years, we have seen four partial efforts to create this functionality for veterans, all of which have suffered from the same feeling as most of VA's IT modernization struggles—poor requirements development. In 2014, VA updated Veterans Health Information Systems and Technology Architecture (VISTA) legacy by developing a graphical user interface, or GUI, and automated some of the scheduling rules. The project, dubbed VistA scheduling enhancement (VSE) for VSA, did not address data quality issues and did not bring VA much closer to the then current state of healthcare information systems, effectively putting lipstick on a pig.

In 2015, VA has changed directions and contracted for 624 million to implement a commercial off the shelf or COTS scheduling system the medical appointment scheduling system MASS, which has later downgraded to a pilot. By all reports, including VA's own assessment, that pilot was a huge success. VA found increasing scheduling system efficiencies, improved timely access to services for veterans, increased productivity, and a substantial decrease in overtime. However, 8 months after the implementation of MASS and the signing of a contract with Cerner, now Oracle Health, VA halted the pilot.

In 2019, VA shifted again, announcing plans to implement the scheduling solution that it had purchased as part of the Cerner contract, known as the centralized scheduling solution, or CSS, but on a separate and accelerated deployment schedule from the rest of the electronic health record. The plan at the time was to have the Cerner application deployed by 2023. This plan, similar to VSE and MASS, was also abandoned. Instead, VA has spent the past 5 years developing its own software. The integrated scheduling solution, or ISS, a system that is currently being scheduled, will now take as long or even longer than planned CSS timelines and is being developed and deployed only to eventually be replaced by CSS anyway.

I still do not understand the logic behind this. It seems like a waste of time, energy, taxpayer money to be spent 5 years developing something that would presumably be replaced in the next 10 years, especially when called systems have already been tested and integrated at VA, with some success. Further, despite these efforts, the ISS is still unable to compare direct care schedules to availability in the community, something it desperately needs as community care referrals continue to rise. The exploiting community

care cost is having dire impacts on VA's budget, especially as community care is more expensive than VA direct care. If we do not find a way to balance it, there may not be a VA for future generations of veterans. While community care is a valuable resource for ensuring that veterans have access to the care they need, VA lacks the ability to prove that veterans could be seen faster in community care than they can at VA.

In fact, in a broader swath in the country, VA's access is better than that of the community. Central to the oversight of this committee provides is ensuring that veterans, whether they are seen as VA or in the community, have access to health care that is both timely and high quality. Without visibility into the community, we are not able to make these quality assurances for veterans as they deserve. I urge VA to implement a solution that allows for apples-to-apples comparisons between VA care and community care. Veterans should be able to make decisions about their healthcare with the full breadth of information available. Thank you to our witnesses and I yield back.

Mr. ROSENDALE. Thank you very much, Ranking Member Sheila Cherfilus-McCormick. I will now introduce the witnesses on our first and only panel.

First, from the Department of Veterans Affairs, we have Ms. Cherri Waters, Executive Director for the health portfolio in the Office of Information and Technology (OIT). Welcome back, Ms. Waters. From the Veterans Health Administration, we have Ms. Hillary Peabody, the Acting Assistant Under Secretary for Health for Integrated Veteran Care (IVC). Finally, we have Dr. Mark Hausman, the Executive Director for the Access Transformation in the Office of Integrated Veteran Care. If you all could please rise and raise your right hands.

Do you solemnly swear, under penalty of perjury, that the testimony you are about to provide is the truth, the whole truth and nothing but the truth? Thank you very much and let the record reflect that all witnesses have answered in the affirmative.

[Witnesses sworn.]

Mr. ROSENDALE. Ms. Waters, you are now recognized for 5 minutes to deliver the opening statement on behalf of the VA.

STATEMENT OF CHERRI WATERS

Ms. WATERS. Good morning. Chairman Rosendale, Ranking Member Cherfilus-McCormick and distinguished members of the subcommittee thank you for the opportunity to testify on the Office of Information and Technology and Veteran Health Administration's efforts to modernize the Department of Veterans Affairs scheduling systems. I am accompanied by my colleagues from VHA, Ms. Hillary Peabody, Acting Assistant Under Secretary for Integrated Veteran Care, and Dr. Mark Hausman, Executive Director for Access Transformation, IVC. I am honored to highlight the collaborative efforts that are transforming the future of veteran care.

VA's enterprise scheduling modernization effort, a joint endeavor between VHA and OIT, is a testament to our commitment to streamline and enhance VA scheduling systems. To provide the best outcomes for veterans, VA must invest in modern scheduling tools that offer near term benefits and ultimately facilitate a long-

term scheduling solution. The introduction of new functionalities through VA's modernization efforts is a significant step toward improving access to care for veterans. The ability to schedule both virtual and in person appointments, consolidate scheduling functions, and implement provider-based scheduling is pivotal in aligning VA scheduling systems with industry standards. These enhancements are designed to provide greater flexibility and efficiency in scheduling appointments, ultimately connecting veterans with the best available resources for their needs.

One of the key tools driving this effort is the Integrated Scheduling Solution, ISS, which represents a significant improvement from our legacy system VistA scheduling enhancement graphical user interface, or VSE GUI. ISS streamlines the scheduling process, offering a more integrated and intuitive platform for VA staff to schedule various appointment types across multiple sites of care. Transitioning users from VSE GUI to ISS is in progress and is expected to be fully completed by February 2025, representing a significant milestone in our journey toward a more cohesive scheduling system. We have already received significant staff praise during the initial testing and implementation. The Clinic Capacity Search Tool, CCST, and the Clinic Configuration Manager, CCM, are enhancing the scheduling experience for veterans by providing quicker access to care, reducing discrepancies and increasing efficiency.

CCST currently allows VA staff to quickly search and view telehealth appointments across multiple facilities. Starting in January 2025, we will begin rolling out enhancements to CCST that will enable staff to view appointments for both telehealth and in person visits. Furthermore, we are working on enhancements to CCM for managing the provider's appointment availability. These enhancements will enable the implementation of provider-based scheduling across VA, providing a unified view of provider availability and significantly streamlining the scheduling process. In support of community care, the External Provider Scheduling platform simplifies the process of connecting veterans with community care providers. EPS enables VA staff to directly schedule community care appointments electronically, enhancing coordination and ensuring timely access to care.

As we look toward the future, our focus remains on improving timeliness, ensuring veterans receive the best available resources, and enhancing coordination between VA and community care providers. These efforts will ultimately converge under the ISS platform, which will integrate multiple scheduling tools into a single, streamlined experience across the enterprise. This will provide veterans with faster access to care, whether through VA facilities or community providers, while simultaneously reducing the administrative burden on VA staff.

Chairman Rosendale, Ranking Member Sheila Cherfilus-McCormick, and members of the subcommittee, thank you for the opportunity to appear today. We are proud of the progress we have made and remain committed to continuing this journey of improvement for the benefit of our veterans and the dedicated staff who serve them. This concludes my testimony, and I look forward to answering your questions.

[THE PREPARED STATEMENT OF CHERRI WATERS APPEARS IN THE APPENDIX]

Mr. ROSENDALE. Thank you, Ms. Waters the written statement of Ms. Waters will be entered into the hearing record. We are now going to proceed to questioning and I will recognize myself for 5 minutes. Ms. Waters, how is the clinical capacity search tool going to make the appointment scheduling process easier and better?

Ms. WATERS. Thank you for that question, Chairman. The clinical capacity search tool will allow a staff scheduler to be able to see available appointments across multiple sites in a single unified view. Currently, this is available to see all telehealth appointments. As I mentioned in my opening testimony, in January 2025, we are rolling out the next enhancement to CCST, which will allow you to see schedules across multiple sites.

Mr. ROSENDALE. What are CCST's capabilities today, and when do you expect the system to be fully functional? Fully functional is a term that I have been using since the day I arrived in Washington, and we have not had it, experienced it anywhere in anything. That is the big part of this.

Ms. WATERS. I appreciate the question. It is very difficult when we talk about IT tools to talk about what is fully functional. One of the things that we do is we look——

Mr. ROSENDALE. Where all of the features that are being promised by the vendor are fully functional. They are working, they are available, they are ready.

Ms. WATERS. As I mentioned, the current state of CCST allows you to see available telehealth appointments across the enterprise. In January 2025, we are rolling out the next enhancement, which will allow us to see available in person appointments in that same unified view.

Mr. ROSENDALE. Will all the features then be functioning?

Ms. WATERS. Again with IT systems it is always our hope that we are continuously making incremental improvements, and we will be working with our partners in IVC.

Mr. ROSENDALE. I will take that as a no. All of the features will not be fully functional in January 2025?

Ms. WATERS. All of the features that we have defined today will be available in January 2025. That is correct. We are always looking for opportunities to enhance and improve things.

Mr. ROSENDALE. You just began rolling out the integrated scheduling solution this month. Will it improve the scheduling process and what are its initial capabilities?

Ms. WATERS. Yes, so ISS is going to vastly improve the ability to schedule appointments. ISS is initially designed as a replacement for VSE GUI, but we are already seeing incredible improvements with this tool. Examples of this include the fact that it is designed to be in a web browser, so it is got a much more modern user interface. It is not dependent on a desktop application, so it runs faster for the scheduler to be able to utilize, and it allows them to then move from one Vista system into another Vista system to schedule appointments without re-authenticating. It makes that experience much better for the user. The redesign of the system also makes it much easier for us to do enhancements to the system because it is no longer dependent on a desktop application that will sit on 600,000 desktops. We are not beholden to that as

we want to do incremental enhancements and do improvements to the project.

Mr. ROSENDALE. What will its full capabilities look like and when will those be implemented throughout VHA?

Ms. WATERS. Again, with IT systems, we are hoping to always build requirements and do enhancements to it. Right now, on our roadmap for ISS, not only do we have the ability to schedule across multiple facilities, we will be working to integrate the view from the CCST tool and to work on the ability to schedule external provider appointments or through EPS through the ISS platform.

Mr. ROSENDALE. When do you expect all of this to be implemented throughout VHA?

Ms. WATERS. I do not have that date at this point. We are still working on the requirements that we need to refine that date, but I am happy to come back and brief you on that.

Mr. ROSENDALE. Thank you. Thank you very much. Ms. Waters, why are these two systems, CCST and ISS, being developed separately, and what will it entail to eventually combine them?

Ms. WATERS. They are being developed separately at this point, it allowed us to do a much more rapid glide path to build those tools out. They use the same back-end infrastructure and architecture and refer back to the back end EAS system. It was simply for ease of convenience and the ability to rapidly deploy them that we did them separately with the full intention to combine them in the future.

Mr. ROSENDALE. Okay, thank you very much. I will yield back. I now recognize Ranking Member Sheila Cherfilus-McCormick for 5 minutes of questioning.

Ms. CHERFILUS-McCORMICK. Thank you, Mr. Chairman. Ms. Peabody. At this subcommittee's last hearing on VA's patient scheduling IT system, the witnesses discussed VA's plan to separate CSS from the rest of the Cerner suite of applications and deploying in ahead of the rest of the EHR. That plan was abandoned during the pandemic, and I am still unclear as to why. What is the VA's logic for choosing to develop another homegrown solution versus deploying the tool that the department had already purchased?

Ms. PEABODY. Thank you for that question, Ranking Member. I am actually going to hand that one to Dr. Hausman.

Dr. HAUSMAN. Thank you, Ranking Member. Yes, in Columbus, the central scheduling solution, or Cerner based scheduling solution, was implemented in August 2020, and following that implementation an evaluation was performed. Ultimately, the decision based on the evaluation was that while this can work layered on a VistA electronic health record, the cost and the disruption to clinical operations outweighed the value gained by moving forward with this strategy. Specifically, in order to implement the scheduling solution thousands of clinics had to be rebuilt and reconfigured in a way that is compatible with Cerner, which puts capacity limitations and access limitations on the medical center for weeks to months to get this done.

One other point is there is an incremental cost with licensing with this, so there would be additional expense to license the scheduling product across the enterprise. In summary, the thought was instead of having two disruptive events implementing sched-

uling, Cerner scheduling, and then later implementing the Cerner EHR, it made more sense to implement both at the same time.

Ms. CHERFILUS-McCORMICK. Are you not doing the clinic rebuild for ISS?

Dr. HAUSMAN. We are not. ISS is currently, as of this month, being deployed in its initial phases, and that deployment is going to run over the next 5 months. We are able to seamlessly integrate this version of ISS with all existing VistA clinics.

Ms. CHERFILUS-McCORMICK. What would the cost difference be between the, what would the cost difference have been before been for VA to deploy CSS versus the development of ISS?

Dr. HAUSMAN. I do not have those figures. That is something we can take back and get you an answer.

Ms. CHERFILUS-McCORMICK. What was the decision-making process for this strategy and who ultimately made that decision?

Dr. HAUSMAN. I think that is another question we will need to take back to get you the right answer.

Ms. CHERFILUS-McCORMICK. Ms. Waters, VA has a long history of IT. Modernization efforts suffering from the lack of effective project management and requirements development does not meet the VA's needs. How does the planning for a Cerner scheduling solution deployment differ from what has been going on in the past?

Ms. WATERS. I am not sure, and let me please clarify. Are you speaking to the Cerner scheduling deployment or the integrated ISS scheduling deployment?

Ms. CHERFILUS-McCORMICK. ISS.

Ms. WATERS. Thank you for that clarification and thank you for the question. One of the things that we are trying to do with ISS is adopt an incremental approach. That is again, goes back to that answer of fully deployed versus deploying a tool and then making enhancements to it. We firmly believe that when we do an incremental approach the way that we are doing, you will see a quicker rollout and adoption across the enterprise that then allows us to move the organization with each enhancement that we deploy.

Ms. CHERFILUS-McCORMICK. How does the VA plan to avoid or mitigate the risk of outcomes similar to the past failed IT projects?

Ms. WATERS. What I can say is that we are working very diligently in a collaborative effort in IT with VHA to work together. With any one of these implementations, it really requires movement in both people, process and technology. If you only move one of those things, you are likely to suffer failures.

Ms. CHERFILUS-McCORMICK. There is no plan? My time is running out, so there is no plan?

Ms. WATERS. I guess I am not sure that I understand your question.

Ms. CHERFILUS-McCORMICK. You do not have a plan to avoid and mitigate the past failures?

Ms. WATERS. Our plan to mitigate the past failures is to ensure that we are working in a collaborative format, doing incremental improvements so that we can ensure success at every step along the way. I think we are demonstrating that with our current rollouts.

Ms. CHERFILUS-McCORMICK. You have made an assessment of all the failures and now have committed to avoiding that?

Ms. WATERS. I cannot speak for what happened before me, so I cannot say that we have done an assessment of all the failures. Certainly, we do have an understanding of why we have stepped away from other solutions.

Ms. CHERFILUS-McCORMICK. Thank you. I yield back.

Mr. ROSENDALE. Thank you very much. Ms. Waters, we just touched on, and Dr. Hausman just touched on, the MASS medical appointment scheduling system Ranking Member was asking about. I do want to make sure that we get the information on the record about what the thought process was and who was responsible for the decision to end that system. That is very important. We will be looking for that information to come back to us. Dr. Hausman, could you briefly describe the steps the VA schedulers go through to schedule veterans' community care appointments without WellHive?

Dr. HAUSMAN. Yes, Mr. Chairman. It starts with a referral or a request for care, and from there we have referral coordination teams that evaluate that request to determine if a veteran is community care eligible based on access standards. Once eligibility is determined, a veteran is offered community care, the best community care option we can find, as well as the best VA option that we have. If a veteran opts into community care, then we begin the process of collecting preferences. Where geographically would you like to see your provider? What days and times tend to work best for you? Those types of things.

From that point, we begin the process of telephoning. We need to reach community provider offices to determine if they have available appointments, when those appointments are available. We, of course, target that search based on the preferences the veteran gives us. That really can be one of the areas for delay in getting veterans appointed to the community is the need to have synchronous communication through a telephone, and that could take some time.

Mr. ROSENDALE. If anybody was trying to create a flowchart just now on that process, it did not really look good. Okay. From my standpoint, because there is a long, long path before the veteran actually gets that care. Okay. Where we need to get a more direct path, if you will. How long does this process take with and without WellHive?

Dr. HAUSMAN. This last quarter, quarter three of this current fiscal year, we are scheduling veterans from the moment in time care is requested to when they are first appointed in the community in just over 21 days. If you look at a head-to-head comparison of scheduling veterans to like care using our traditional process versus WellHive, it is about a 26 day with a traditional process versus 17 days with WellHive. That is the difference. Substantial time savings and improvement in timeliness with using the EPS solution.

Mr. ROSENDALE. Okay. On average, how many community care appointments are VA staff able to schedule per day using WellHive versus the current system?

Dr. HAUSMAN. Using the WellHive software, a trained, season scheduler can schedule upwards of 20, maybe 25 appointments per day.

Mr. ROSENDALE. Without?

Dr. HAUSMAN. About eight appointments.

Mr. ROSENDALE. About eight. Okay, what are the VA schedulers saying about WellHive, either in surveys or anecdotally? What kind of feedback are you getting?

Dr. HAUSMAN. You know, the feedback for those that have used the system, which is now numbers in the hundreds, has been uniformly positive. I think the greatest challenge is having appointments available in this system. In other words—

Mr. ROSENDALE. If slots open, availability.

Dr. HAUSMAN. In the right specialties for the right type of care. That is correct.

Mr. ROSENDALE. Okay. Okay. Please explain what File Entry Date (FED) to first appointment means.

Dr. HAUSMAN. File entry date is the moment in time when care is requested by a veteran, or in the event of a primary care provider and a veteran generating a referral for specialty care. It is that moment in time that referral is generated. That is file entry date. First appointment is the moment in time when the appointment for that care is scheduled.

Mr. ROSENDALE. Okay. One of the things that I have seen in the past is that the first appointment date sometimes gets skewed because it gets canceled, and then the initial appointment for the veteran gets transferred out and transferred out, sometimes several times, so that their true first appointment may not be for many months after that. I would really like to see if there is some way that we can get more of an accurate reflection of those times as well.

Not just the first appointment date, when it is set, but when it is actually experienced, if you will. Okay. When it takes place, so that we can see the true timeframe between when they contact and when they are getting that. That initial care for healthcare. Okay, I am close enough. I will go ahead and yield time to the Ranking Member.

Ms. CHERFILUS-McCORMICK. Thank you. Ms. Waters. I cannot help but recall your response of not knowing what happened before you were there. It just makes me feel like if we do not understand the mistakes we did in the past, then we are capable of repeating it. The committee really wants to make sure that implementation going forward is not repeating the mistakes of the past. You know, hopefully we can get back and you guys can actually take a real good assessment of that, and we can make sure that we are not repeating that.

My next question is also for Ms. Peabody. What is the OIT's role in the ISS role in the ISS project?

Ms. PEABODY. Thank you for that question. I will start and then I will ask Dr. Hausman to add on, because really, it is his team and Ms. Waters teams that have been working in the trenches together on this. OIT has been a really valuable partner for us in VHA. Dr. Hausman's worked very closely in partnership with our colleagues in OIT to actually stand up a very unique governance structure where we have a working group that includes our OIT counterparts and key VHA stakeholders, and they are working hand in hand to develop that scheduling roadmap.

OIT's role, coming back to your question, is really to take the business requirements that VHA puts forward and help us design the solution and then be able to fund that. Anything to add, Dr. Hausman?

Dr. HAUSMAN. Thanks, Ms. Peabody. That is correct. A strong partnership between VHA and OIT on this project is critical. I believe we have a strong partnership in place. We set the requirements, we set the priorities. We do the testing of the initial versions of the product, the user acceptance testing. We also do the training, deployment, change management. OIT takes our requirements and our prioritizations and develops these products or enhances the products. Also, those prioritizations and requirements inform the roadmap for the timing for some of these bigger milestones that we are working toward.

Ms. CHERFILUS-McCORMICK. Is OIT's role prominent enough to support solid project management and to help prevent. Oh, Ms. Waters, is OIT's role prominent enough to support solid project management and to help prevent previous mistakes?

Ms. WATERS. Thank you for that question. Please also let me clarify that my answer when I reflected that I personally was not aware of some of those challenges and decisions that were made in the past, rest assured that there are strong teams behind me in OIT that are very aware of them and are taking them into account. I probably misspoke when I said I was not aware of them.

Let me also share that on this initiative, it is critical that we have strong PM's available and working with the team, and we have teams that are working day in and day out with Dr. Hausman and his team that are dedicated to making this effort a success.

Ms. CHERFILUS-McCORMICK. How is the requirements development for this project different from VA's previous struggles to modernize patient scheduling applications?

Ms. WATERS. Again, with this adoption that we are doing, we are doing it in a collaborative, shoulder to shoulder format, day in and day out, working with our partners to ensure that we are doing it together.

Ms. CHERFILUS-McCORMICK. Wonderful. Ms. Waters, you are leading your teams, correct?

Ms. WATERS. That is correct.

Ms. CHERFILUS-McCORMICK. As a leader of your teams, do you feel like you should be aware and do that analysis for your own knowledge to lead your team?

Ms. WATERS. Yes, of course. I also trust my teams and the leaders that I have on my teams.

Ms. CHERFILUS-McCORMICK. Thank you, Ms. Peabody. I understand that VA is rethinking a strategy for the external provider scheduling project that you are looking at, pairing back the number of sites using the EPS tool. What is the VA's goal in this reformatting effort?

Ms. PEABODY. Thank you for that question. Our goal is really to take the lessons that we have learned from the first two phases of the rollout this year and refocus our strategy to secure more success. One of the biggest challenges that we have had in rolling this out is getting enough providers enrolled on the platform so that the scheduler, when they log into the EPS system, they can actually

find a provider and they are not having to then revert back to the standard processes of looking for a provider elsewhere.

Ms. CHERFILUS-McCORMICK. How many facilities are using EPS?

Ms. PEABODY. I will tag that to Dr. Hausman.

Dr. HAUSMAN. 16 facilities are currently live on EPS.

Ms. CHERFILUS-McCORMICK. All right, thank you. I yield back.

Mr. ROSENDALE. Thank you, Dr. Hausman. I want to go back to the file entry date, first appointment issue again. With all of this advances in technology and improvements that we are making, is it true that the goal was recently changed from seven to 14 days to actually extend it out?

Dr. HAUSMAN. For community care appointments? I know there was discussion on changing that goal. I am not sure if that decision has yet been made.

Mr. ROSENDALE. If we are having improvements, Ms. Waters, and things are flowing better and we are making all these investments in the technology, that just seems counterintuitive to me that if it is working well, if we are making improvements, that we would be setting the goal out longer, doubling it, literally doubling it from seven to 14 days. Have you seen that information? Are you telling me that you have not seen and participated in discussions in that regard?

Dr. HAUSMAN. I will defer to Ms. Peabody to answer that, sir.

Ms. PEABODY. Thank you for that question. I want to clarify that these metrics, when we are talking about FED to first scheduled, that is what we call internal schedule timeliness. It is very different from wait times. Now, both of those measures are important for us to track and monitor within VHA, and we set goals around that schedule timeliness because that is really our measure for our schedulers within VHA to be able to do the piece of this that is their responsibility.

We have been exploring changing what are those goals. We had some very strong feedback and a report from the U.S. Government Accountability Office (GAO) several years ago, and we have had an open recommendation to relook at that schedule timeliness metric and to reconsider it to something that is more realistic for our facilities. We have undertaken through our access committee, a look at different options for that we have recently just brought up through the VHA governance structure.

Mr. ROSENDALE. Okay, so Ms. Peabody, you have seen this recommendation then, or consideration from the seven to 14 days?

Ms. PEABODY. Yes.

Mr. ROSENDALE. Okay. Again, counterintuitive to everybody that is sitting in this room. If we are making improvements, if we are making investments and everybody is telling us that we are making these strides toward a smoother system, why would we not be taking the goal and pushing it the other direction? This just does not make sense to me that we are talking about extending it, doubling it from seven to 14 days.

Ms. PEABODY. Thank you for that question. I would add there are some nuances and we can take it back for the record to get you the specifics of what we are looking at changing in that metric.

Mr. ROSENDALE. Why has it changed? Whether it is Dr. Hausman or Ms. Peabody, why would they change this number again, if we are making improvements?

Ms. PEABODY. We have looked at different options for changing that measure in several different ways to measure that. What is most important is that for any urgent consults, our measure continues to be that those need to be scheduled within 2 days. I looked at that measure this morning, and we are sitting at 100 percent of those. For those non urgent consults, we do want to allow our schedulers enough time to be able to make contact with the community provider and with the veteran to schedule that. We have—

Mr. ROSENDALE. Okay, working on my time here. I just do not understand. Okay. As a person who has always had his compensation based on performance, how in the world you can never expect better performance if you set the goal lower. That just is, again, it is counterintuitive. If you take the goal and you make it lower, that matrix. You are never going to improve the situation. If you set goals that are less than what you have now, standards that are lower than you have now, how are you ever going to make an improvement? It just does not work. You have a section touting external provider scheduling, aka WellHive, on your community care network page, on your information website for providers. Does the department endorse this system and encourage community care providers to sign up and use it?

Ms. PEABODY. We do encourage community care providers to sign up for our external provider scheduling platform.

Mr. ROSENDALE. Okay, what is the process to solicit and recruit providers into external provider scheduling, Ms. Peabody?

Ms. PEABODY. If I could, I would like to hand that to Dr. Hausman.

Dr. HAUSMAN. Thank you, Mr. Chairman. The process begins with selecting from our community care provider network of 1.3 million the highest potential providers with whom to engage, and engaging with them to explain the program, explain the value of the program, the importance of this program, the vision. Then from there discuss, make sure we get with the right decision-makers and discuss the process. How does a community provider system participate in this? We get into the technical requirements and then from there, if we have an agreement, we do the process of onboarding, which actually is the technical integration of their schedules into our WellHive user interface.

Mr. ROSENDALE. My time is expired. Ranking Member, I yield 5 minutes for questions.

Ms. CHERFILUS-McCORMICK. Thank you Mr. Chairman. Ms. Peabody, what do you believe is limiting provider enrollment in EPA in EPS?

Ms. PEABODY. The thank you for that question, as Dr. Hausman was just articulating, the longer piece of the onboarding is actually that technical integration, and there is a fair bit of work on the provider. The provider has to have the ability to actually know their appointment availability and to be able to pass that into our system and be able to do that technical integration with our team

that can be very lengthy and a significant investment of time for them.

At this time, we have not put in place any types of incentives or run this through our community care network contract. We have done a significant amount of market research actually through our CCN next generation contract recompetete efforts to gather some market research on how do we actually incentivize providers to do that. We have received a good amount of feedback on what that would look like. As we look further on down the road, how we will make this successful, we know that we are going to have to have some sort of carrot, if you will, for providers.

Ms. CHERFILUS-McCORMICK. Also, when we took a look at it, South Carolina was successful, whereas Orlando really struggled. One of the different factors we saw was that the staff and the providers were more involved, and so really supporting the system made a huge difference. We did not see that in Orlando. Is the VHA properly supporting their enrollment efforts?

Ms. PEABODY. Yes, we have made this a priority, and in fact, this has been an initiative that myself and Dr. Hausman have briefed several times to our governance board, which is VHA's highest governing body. We have got full support behind this. It is just important that we really step back and take some of those lessons we have learned over the last several months and pivot a little bit in that approach, because we need to do that to make it successful.

Ms. CHERFILUS-McCORMICK. The lessons that you learned from doing the analysis of these two sites, that has not been done yet, the analysis?

Ms. PEABODY. Yes, that has been done, and our refocused strategy is a direct result of that analysis.

Ms. CHERFILUS-McCORMICK. Can you tell us some of the pieces that you are plugging in to make sure that they are actually, that other clinics do not have this kind of struggle?

Ms. PEABODY. I will start and then I will ask Dr. Hausman to help fill in any gaps here since he has been leading this effort. The biggest thing that we have learned is that when we try to do this big bang approach across the entire system, it is a pretty significant level of effort for us to do that provider outreach and start integrating each of those providers. When we initially took this approach of let us just do it everywhere at the same time, we found that we got several providers here and there, and it was sort of a smattering. When the scheduler logs into the system, if there is only a handful or a few handfuls of providers, they are having to go back and forth between systems, and it is impacting the trust that they have in the data that is in that system. We feel taking that focused approach so that we can really, really do it well at a few sites and then be able to expand from there, that is going to be more successful.

Ms. CHERFILUS-McCORMICK. Thank you. Also, is VA planning on pulling the tools from any facilities?

Ms. PEABODY. Yes.

Ms. CHERFILUS-McCORMICK. What is the long-term plan for EPS?

Ms. PEABODY. Dr. Hausman, do you want to address that?

Dr. HAUSMAN. Yes, I am happy to. Thank you. We do see EPS as the enterprise solution for community care scheduling. At the end of the 2025 fiscal year, we intend to have EPS live in approximately one third of our VA medical centers. That is about 50 sites across the enterprise in focused regions. We anticipate being successful. What I mean by that is attracting and enlisting the participation of a large number of larger, higher volume community care providers into this program over the next year and then booking more appointments through EPS. Specifically, we are looking at least a tenfold increase in provider participation as well as appointments booked compared to what we are looking at this year. That is how we define success for next year. Now beyond 2025, we intend to continue to roll this out across the enterprise to the other medical centers and other Veterans Integrated Service Networks (VISN) that are not part of the 25 plan.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Mr. ROSENDALE. Thank you very much. Ms. Peabody, what is the process to solicit and recruit providers into the external provider scheduling?

Ms. PEABODY. Thank you for that question, Chairman. We have both a team within Dr. Hausman's team as well as a vendor that we have been using to support some of those onboarding efforts. We take several steps in this process. One, our team has been traveling to conferences, doing webinars, posting in our newsletters just to get the word out. Then the provider that is interested can reach out to us and our team will start that process of onboarding and walk them through that.

Mr. ROSENDALE. When you were talking earlier about focusing your attention instead of trying to do just what I will call a shotgun approach and cover the whole country focusing in, and we are going to use a rifle and a scope and we are going to zero in on some areas and concentrate the effort to try and get those providers. That is starting to make a little bit of sense to me. Is that why there is such a discrepancy in the number of participating providers in WellHive, in, say, South Carolina, which has numerous, and Montana, which has a couple of dozen.

Ms. PEABODY. Thank you for that question. Yes, I would agree with that assessment. I think in some areas, if we are able to get the affiliate or one or two of the large hospital systems, this works really well in more urban areas where you have one hospital system, you can bring that whole system in. It has been really successful. In areas like Montana, it is a little more sparse.

Mr. ROSENDALE. It is rural. That is exactly right. What is the thought process or how are you identifying where to focus those resources, okay. To go in and recruit and get these providers listed? You know, what does that list look like and what is the criteria that you are using?

Ms. PEABODY. Yes, so I will start and Dr. Hausman will definitely help make sure I do not miss anything here. We started actually by sitting down with our CCN contractors and getting some feedback from them because it is their network of providers predominantly, and so they know which providers are most likely to be open to doing this. The team actually focused which VISNs and medical centers where, you know, we would go next around some

of that feedback. We also gathered that just from our own experience. We have to consider just where is their appetite to do this. This is very leading edge kind of stuff. The private sector, you do not see a whole lot of this. We are starting to get there with more providers being willing to open up their clinic grids and do the work to integrate into some of these.

Mr. ROSENDALE. I have to stop you. The one concern that I have is that what is the input from the actual patient? What is the input from the veterans themselves? If we start basing too much of our information on these large providers, forgive me for using the term, but there is a medical industrial complex out there. They will try to completely dominate the services. As a former commissioner of securities and insurance, I can tell you that every single study that has ever been put out shows that the bigger the organization is, the bigger the administration is, the bigger the corporation, the medical corporation is, that the lower the quality of care is and the higher the cost is. I need to hear something that says we are talking to those veterans, especially in the rural communities like Montana, that maybe are not going to have access to a large facility, that we have a team that understands this and is going to go out and recruit and sign up physicians that the veterans want to access.

Ms. PEABODY. Thank you for that question, Chairman. Yes, absolutely. In fact, our team did, I am sure you are very familiar with Veterans Signals (VSignals). That is how we get the most, a big portion of our feedback from veterans. We actually rolled out a VSignal specifically for EPS, and we got some really, really impressive results. We are continuing to get that feedback from veterans as well.

Mr. ROSENDALE. Again, what would it look like to have a team if we are going to go out, and I understand we have the electronics and everything, but to actually have a team to go out and start trying to go around to these areas that not necessarily are urban, the very rural areas and start getting some, some providers to sign up.

Ms. PEABODY. Thank you for that question. We do have that in place today, and that is that separate vendor contract that is supporting us with going out and doing that onboarding. Then we are also looking at options perhaps in the future to be able to leverage our CCN contractors to help us with that.

Mr. ROSENDALE. Okay, thank you. I yield back and recognize the Ranking Member.

Ms. CHERFILUS-McCORMICK. Thank you, Ms. Peabody. As I said in my opening, I am convinced that VA must address the lack of a fully integrated scheduling solution. We are extremely concerned by the exploding community care costs. I am particularly concerned that much of the cost may be unnecessary, but VA cannot prove that, as they cannot compare access in apples-to-apples manner. What is the VA's plan to address this shortcoming?

Ms. PEABODY. Thank you for that question. VA is committed to making sure that the care that our veterans are getting in the community is clinically appropriate and that they are getting that care at the right time and place. Since I stepped into this role as the Acting Assistant Under Secretary for Health for Integrated Veteran Care in February, I actually spent some time resetting what our

mission statement is and what our three priorities are as an office. One of those three priorities is ensuring that when our veterans do go out to the community, that the care that they are getting is high value care. We would be happy to do a briefing on several of the initiatives that we are doing, but that includes making sure that we have a high performing provider network, and we are able to see where the providers that are in our network are actually highest performing and have the best quality measures and be able to give that information to our veterans. That also includes doing a more robust utilization management program in the future.

Ms. CHERFILUS-McCORMICK. Thank you. The vendor who supports the EPS, the project has this capability. It was part of the pilot program. Why did the VA choose to shut it down?

Ms. PEABODY. Thank you for that question. VHA has not chosen to shut down. In fact, based on the pilot, we did a, we gathered market research from industry to identify options for how we could procure a similar solution in the future and then moved forward with an acquisition plan to do that, which resulted in actually having the same vendor from that pilot.

Ms. CHERFILUS-McCORMICK. It seems to me that the VA is making short sighted decisions that are focusing veterans to continue waiting. Is there anything that you would recommend this committee do to help and support, make sure that there are not any feelings and that this is actually sufficient moving forward?

Ms. PEABODY. Thank you for that question. We appreciate your continued support for efforts like this one and for continuing to hold us accountable for ensuring that our veterans get the care that they have earned and deserve.

Ms. CHERFILUS-McCORMICK. Thank you. I yield back.

Mr. ROSENDALE. Thank you very much. Ms. Peabody, I understand your office has decided to make cuts to the external provider scheduling. We are going to get into the reasoning in a moment, but I want to understand what the cuts actually entail first. Is it correct that the VA medical centers in West Haven, Connecticut, Hudson Valley, New York, and Ann Arbor and Iron Mountain, Michigan currently have WellHive activated and that it will be turned off?

Ms. PEABODY. Thank you for that question. I definitely want to ask Dr. Hausman to make sure I get this right.

Dr. HAUSMAN. That is correct.

Mr. ROSENDALE. Okay. Dr. Hausman, I really do not understand this because when we were just talking about the final entry date to first appointment and the time that it is reducing, that it is making these improvements, why would this be being turned off?

Dr. HAUSMAN. We are active at 16 medical centers. We will continue to be active in 12 of those 16 medical centers moving into the next fiscal year, plus adding five additional entire VISNs into the mix. This was a decision made by our VHA governance board. I think the decision was around solving the issue of having acquired licenses this year that we simply cannot use because we do not have adequate number of community care providers yet participating in this program.

The strategy that we are putting forward and we are going to be working toward next year will allow us to focus on key areas or

markets that we think are highest potential for a lot of the considerations that Ms. Peabody already mentioned with this revised strategy, there are four medical centers, two in Michigan and the other two that you mentioned that will be paused for this next year.

Mr. ROSENDALE. Dr. Hausman, Iron Mountain, Michigan has very few community care providers signed up, but Hudson Valley, New York already has hundreds. Why did you decide to turn off both of these facilities? What message does that send to providers that WellHive already has in New York and the providers you are hoping to recruit in Michigan?

Dr. HAUSMAN. Well, we hope the message will be that we believe in this program, and we are going to be back to building and activating this program in these areas very soon. In the instance of Hudson Valley, while we do have around 300, almost 300 providers that are on board, this was the first area that we built out, and we did not focus in the way that we should have in terms of engaging providers that do higher volume of care, more veteran care, higher quality care. We built this out in a way that we learned from. Strategically, we are going to be focusing on working with providers that do higher volume of care, that are known to do high quality care, and that also have a good relationship, that we have a good relationship with, for example, academic affiliates.

Mr. ROSENDALE. Again, I just, to me, as a consumer, I hear somebody shutting down after they have opened up a system, a facility, whatever, and they are telling me how great it is, but yet they come in and say, but you are not going to have it available to you. We are going to go out and try and sell. I do not see how that is going to help efforts going forward to get other providers to sign up. I just do not.

I think it is a very, very poor marketing concept. Are you concerned that when you decide to turn, WellHive on again in Connecticut, New York and Michigan, the providers will be frustrated and suspicious about working with VA?

Dr. HAUSMAN. We appreciate that those sentiments may exist as we go to reactivate. I do believe that the messaging that we put forward, the communications that we are going to be putting forward to these community partners now, is going to be very important in how we message this decision and why we are doing this, and also the idea that we will be coming back likely in the beginning of '26. There is definitely some communication that will be taking place that will hopefully keep the relationship with these providers strong and keep them interested in participating in the future.

Mr. ROSENDALE. Even again, the future providers that you are trying to sign up, when they look and see that you are basically pulling the rug on the other providers, I cannot believe that it is going to give them a level of faith in participating. I mean, can you understand that?

Dr. HAUSMAN. I do understand that concern.

Mr. ROSENDALE. How much is the cut to the external provider scheduling project? You told the committee staff that \$20 million during a meeting, is that correct?

Dr. HAUSMAN. That is approximately our budget for this program in '25.

Mr. ROSENDALE. The system that seems to be working that is helping us schedule a better, that is providing better healthcare, is the place that we are going to have a \$20 million cut?

Dr. HAUSMAN. Approximately.

Mr. ROSENDALE. Ms. Peabody, was this cut your decision? If you did not make that decision, who did?

Ms. PEABODY. Thank you for that question. Our VHA governance board made that decision unanimous to take on——

Mr. ROSENDALE. Did you make it as a recommendation to them or did they come up with this, amongst their collaboration and their work?

Ms. PEABODY. That was IVC's recommendation. Yes.

Mr. ROSENDALE. That was your recommendation?

Ms. PEABODY. Yes, sir, that was my recommendation based on the inputs from Dr. Hausman and his team.

Mr. ROSENDALE. Okay. I will now yield 5 minutes. I think that that puts a pin on it. Then I am good. Okay. I would recognize the Ranking Member for any closing remarks that you may have. Do not have any. Okay. No closing remarks. Okay. I want to thank our witnesses for joining us today. VA scheduling process and technology directly affect veterans' healthcare. Obviously. Outdated, dysfunctional systems increase veterans wait times and may discourage them from getting care from the VA altogether.

We have to remember that most veterans also have Medicare or private insurance. As the billboards say, the Department of Veterans Affairs want veterans to choose VA. That means getting an appointment has to be user friendly. This morning, we have heard about some real accomplishments in internal scheduling and direct scheduling that are improving veterans experiences.

We also know that the VA has a troubling history of snatching defeat from the jaws of victory when it comes to technology projects. I urge the committee to continue rigorous oversight in the next Congress to prevent that from happening again. I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material. Without objection. So, ordered. This hearing is adjourned.

[Whereupon, at 10:09 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Cherri Waters

Good morning, Chairman Rosendale, Ranking Member Cherfilus-McCormick, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify on the Office of Information and Technology's (OIT) and Veterans Health Administration's (VHA) efforts to modernize the Department of Veterans Affairs' (VA's) scheduling systems. I am accompanied by my colleagues from VHA, Ms. Hillary Peabody, Acting Assistant Under Secretary for Health for Integrated Veteran Care (IVC), and Dr. Mark Hausman, Executive Director, Access Transformation, IVC.

Enterprise Scheduling Modernization: A Collaborative Effort

VHA and OIT are working together on the Enterprise Scheduling Modernization effort, which aims to streamline and enhance VA scheduling systems. The modernization of our scheduling tools is essential for ensuring Veterans receive the best and most timely care while simplifying processes for Veterans and VA staff. By consolidating and upgrading our scheduling systems, we are laying the foundation for a seamless, more efficient, and more Veteran-centered health care system.

VA's Enterprise Scheduling Modernization efforts introduce new functionalities designed to improve access to care for Veterans. These include the ability to schedule virtual and in-person appointments across VA facilities, consolidating multiple scheduling functions into a unified platform, and provider-based scheduling that integrates various appointment types into a single scheduling application. Our modernization efforts are crucial in bringing VA scheduling systems up to industry standards, enabling us to schedule any type of appointment with greater flexibility and efficiency. Our ultimate goal for these scheduling improvements is to connect Veterans with the best available resources for the most convenient and most appropriate care. To provide the best health outcomes for Veterans, VA must invest in modern scheduling tools that have near-term benefits and ultimately facilitates a long-term scheduling solution.

Key Scheduling Tools and Benefits

Integrated Scheduling Solution

The Integrated Scheduling Solution (ISS) is a staff-facing, web-based application currently used for scheduling Veteran appointments that ultimately consolidates functionalities from multiple scheduling applications into a single enterprise scheduling solution for care in VA health care facilities. ISS represents a significant leap forward from our legacy system, VistA Scheduling Enhancement Graphical User Interface (VSE GUI) by offering a more integrated, intuitive, and efficient scheduling process. We began the enterprise-wide rollout of ISS September 2024, and full implementation is expected by February 2025. Enhancements, including additional appointment types and telehealth capabilities are underway, and we anticipate retiring VSE GUI by June 2025. Ultimately, ISS will be the future single scheduling system that will house all scheduling tools and functionalities; this will allow VA staff to schedule appointments in a single platform across multiple sites of care.

Clinic Capacity Search Tool

The Clinic Capacity Search Tool (CCST) is a simplified web application providing the ability to search and view all available appointments for requested service and modality across multiple facilities. Currently, CCST enables the scheduling of telehealth appointments, providing Veterans with quicker access to care and a broader range of available options. We are enhancing CCST to include additional in-person clinical resources, and we are scheduled to begin rolling out of these new features in January 2025.

Clinic Configuration Manager

The Clinic Configuration Manager (CCM) is a web-based tool VHA administrative staff use to provide a standardized approach to managing availability with providers anywhere in VA. Fully implemented in March 2024, CCM reduces discrepancies, increases efficiency and improves scheduling.

Community Care Scheduling: External Provider Scheduling (EPS) Platform

External Provider Scheduling (EPS) is a technology platform that will be able to improve the process of scheduling Veterans with community care providers by supplying information on care availability and allowing VA staff to schedule Veterans directly into available community care provider appointment slots through a singular user interface. EPS connects VA and community care providers to streamline care navigation and coordination activities. EPS offers information on who, where, and when community care providers and services are available to support informed Veteran decision-making.

Moving Forward

VA's scheduling modernization efforts aim to improve timeliness between a Veteran's request for care and the scheduling of their appointment, ensure Veterans receive the best available resources, and enhance coordination and information sharing between VA and community care providers. Our multiple scheduling efforts strengthen the collaboration between VA, Veterans, and community care providers and will ultimately unite under our ISS platform. ISS will integrate these tools and processes to create a streamlined scheduling experience across the enterprise, which will lead to faster, more flexible care for Veterans. Our efforts enable VA staff to increase efficiency, reduce administrative burdens, and improve care delivery for Veterans in a sustainable and effective manner. Veterans will experience enhanced access to the best care more quickly, whether within VA or through community providers.

Conclusion

Chairman Rosendale, Ranking Member Cherfilus-McCormick, and Members of the Subcommittee, thank you for the opportunity to appear today. VA's modernization efforts are transforming the way we deliver care to Veterans and support VA staff and providers. We are proud of the progress we have made and remain committed to continuing this journey of improvement for the benefit of our Veterans and the dedicated staff who serve them. This concludes my testimony, and I look forward to answering your questions.

STATEMENTS FOR THE RECORD

Questions for the Record Submitted by Matthew M. Rosendale

Questions for the Record

House Committee on Veterans' Affairs
Subcommittee on Technology Modernization

"Ensuring Timely Access: Challenges in VA Scheduling"
September 26, 2024

Questions for VA

Chairman Rosendale

1. Why was the Medical Appointment Scheduling System (MASS) canceled after several years in development? Who made the decision, and what was the rationale behind it? How did this decision impact VA's progress on scheduling system modernization, and what impacts are still being felt today?
2. When is the Clinical Capacity Search Tool (CCST) expected to be fully functional?
3. What will CCST's full capabilities be, and when will those capabilities be fully implemented across VHA?
4. Please further explain the decision to change the File Entry Date timeframe from 7 days to 14 days. What was the External Provider Scheduling (EPS) project's role in this decision, if any?
5. How many VISNs and medical centers will EPS add in fiscal year 2025? Please identify them. When does VA expect to implement EPS in all VISNs and medical centers?
6. Please further explain the decision to reduce the size and scope of the EPS expansion. Is this decision the result of the health care budget shortfall or a choice VA made?
7. Within EPS, has WellHive ever proposed any discount or billing deferral for its services? If so, what was the value of the discount or deferral, and was it accepted?
8. Does the \$20 million budget cut to EPS take any WellHive discount or billing deferral into account?
9. Has there ever been a proposal to eliminate the EPS project or to remove WellHive's participation in the project?
10. Has there ever been a proposal or recommendation to replace WellHive or its software in the EPS project with another vendor?

11. How does VA plan to comply with sections 131-134 of the Cleland-Dole Act, P.L. 117-328, requiring a community care self-scheduling pilot project? If the EPS project or WellHive was eliminated, how would VA comply?
12. What plans, if any, exist to enhance communication and encourage adoption with respect to EPS among the Central Office, VISNs, facilities, and community care providers?
13. How does VA plan to mitigate the impacts of deactivating WellHive in individual medical centers, particularly Hudson Valley, New York which already has roughly 300 providers signed up?
14. VA described its rationale for scaling back the EPS program as incorporating lessons learned and addressing challenges in enrolling community care providers. Will VA offer a detailed plan and identify necessary resources to improve change management, field outreach, communications, and provider onboarding in EPS?
15. How many VA employees and contractors are assigned to or support the EPS program? How was this number determined, including with respect to other comparable projects?
16. In 2022, VA piloted the technology now being used in the External Provider Scheduling project to integrate multiple VistA instances for scheduling purposes. Please describe the outcomes of that pilot. Provide any report or evaluative documentation that exists. How many VistA instances were integrated in the pilot?
17. What is the estimated cost and schedule to conduct a pilot to demonstrate integrated scheduling, including community care and VHA care appointment availability in one direct scheduling solution?

U.S. Department of Veterans Affairs Response to Questions for the Record

**Department of Veterans Affairs (VA)
Questions for the Record
Subcommittee on Technology Modernization
Committee on Veterans' Affairs
U.S. House of Representatives
“Ensuring Timely Access: Challenges in VA Scheduling”**

September 26, 2024

Questions for the Record from Representative Matt Rosendale:

Question 1: Why was the Medical Appointment Scheduling System (MASS) canceled after several years in development? Who made the decision, and what was the rationale behind it? How did this decision impact VA's progress on scheduling system modernization, and what impacts are still being felt today?

VA Response: The Epic-based Medical Appointment Scheduling System (MASS) was piloted as a potential replacement for the Veterans Health Information Systems and Technology Architecture (VistA) scheduling application in Columbus, Ohio. MASS allowed VA to monitor demand for outpatient care and VA's capacity to provide such care. Shortly after the MASS pilot deployment, VA adopted the Cerner scheduling solution as part of the enterprise Cerner electronic health record (EHR) system acquisition. VA made this decision to facilitate stronger continuity of care as Service members transitioned from the Department of Defense to the Veterans Health Administration (VHA). VHA decided to cancel MASS based on proceeding with the Cerner (now ORACLE) EHR implementation.

VA began implementing the new Integration Scheduling Solution (ISS) in September 2024, with an anticipated completion timeline of February 2025. This system supports direct scheduling for care within VA. Since implementation started, approximately half of all VHA schedulers have been trained on the system, and it is actively utilized. VHA facilities that remain on the legacy VistA EHR will continue to use ISS until they transition to the ORACLE scheduling solution, at the time they transition from the VistA EHR to the ORACLE EHR.

Question 2: When is the Clinical Capacity Search Tool (CCST) expected to be fully functional?

VA Response: The Clinical Capacity Search Tool (CCST) is a custom tool that is being developed in phases to ensure a smooth and effective implementation. While it is currently fully functional for telehealth appointments, additional functionality, including the ability to search for face-to-face appointments across multiple facilities, was released for limited production testing on January 15, 2025, and will continue national rollout through FY25Q2.

Question 3: What will CCST's full capabilities be, and when will those capabilities be fully implemented across VHA?

VA Response: While CCST is currently fully functional for telehealth appointments, additional functionality, including the ability to search for face-to-face appointments across multiple facilities, was released for limited production testing on January 15, 2025, and will continue national rollout through FY25Q2.

Additional requirements for future enhancements to CCST include enhanced reporting capabilities and integration with ISS. The specific timeline for these enhancements will depend on various factors, including resource availability and evolving user needs.

The full scope of CCST's capabilities is still being defined. As the tool matures and user adoption grows, additional requirements may be identified and incorporated into future development plans.

Question 4: Please further explain the decision to change the File Entry Date timeframe from 7 days to 14 days. What was the External Provider Scheduling (EPS) project's role in this decision, if any?

VA Response: VHA has not finalized the change from 7 to 14 days for community care scheduling timeliness. It is considering this change after evaluating facility level data of community care scheduling timeliness (time from File Entry Date to First Scheduled) and in response to the Government Accountability Office's recommendations to consider whether the current 7-day metric is feasible. VHA remains committed to fostering a culture of accountability and continuous improvement by closely monitoring the efficiencies gained through the deployment of the External Provider Scheduling (EPS) system. Since the EPS system is in its implementation phase and not deployed enterprise-wide, it does not impact scheduling timeliness in the majority of VHA facilities or services at this time. Thus, VHA did not consider the current impact of EPS on timeliness when considering the enterprise-wide change from 7 to 14 days.

Question 5: How many VISNs and medical centers will EPS add in fiscal year 2025? Please identify them. When does VA expect to implement EPS in all VISNs and medical centers?

VA Response: Through fiscal year (FY) 2025, VHA plans to expand to all medical centers under 5 Veterans Integrated Services Networks (VISN) while continuing with 8 individual medical centers, for a total of 47 medical centers. The EPS program will continue to expand to the remaining VISNs in the subsequent year(s) based on funding availability. Please refer to the list of VA Medical Center facilities below.

VAMCs
Birmingham VA Medical Center (Birmingham, AL)
Bob Stump Department of Veterans Affairs Medical Center (Prescott, AZ)
Boise VA Medical Center (Boise, ID)

Carl T. Hayden Veterans' Administration Medical Center (Phoenix, AZ)
Carl Vinson Veterans' Administration Medical Center (Dublin, GA)
Central Alabama VA Medical Center (Montgomery, AL)
Charles George Department of Veterans Affairs Medical Center (Asheville, NC)
Charlie Norwood Department of Veterans Affairs Medical Center (Augusta, GA)
Cheyenne VA Medical Center (Cheyenne, WY)
Colonel Mary Louise Rasmuson Campus of the Alaska VA Healthcare System (Anchorage, AK)
Dallas VA Medical Center (Dallas, TX)
Durham VA Medical Center (Durham, NC)
Fayetteville VA Coastal Medical Center (Fayetteville, NC)
Fort Harrison VA Medical Center (Ft. Harrison, MT)
George E. Wahlen Department of Veterans Affairs Medical Center (Salt Lake City, UT)
Grand Junction VA Medical Center (Grand Junction, CO)
Hampton VA Medical Center (Hampton, VA)
Jack C. Montgomery Department of Veterans Affairs Medical Center (Muskogee, OK)
James E. Van Zandt VA Medical Center (Altoona, PA)
Jennifer Moreno Department of Veterans Affairs Medical Center (San Diego, CA)
Jerry L. Pettis Memorial Veterans' Hospital (Loma Linda, CA)
Jonathan M. Wainwright Memorial VA Medical Center (Walla Walla, WA)
Joseph Maxwell Cleland Atlanta VA Medical Center (Atlanta, GA)
Mann-Grandstaff VA Medical Center (Spokane, WA)
Marion VA Medical Center (Marion, IL)
Nashville VA Medical Center (Nashville, TN)
New Orleans VA Medical Center (New Orleans, LA)
Oklahoma City VA Medical Center (Oklahoma City, OK)
Omaha VA Medical Center (Omaha, NE)
Orlando VA Medical Center (Orlando, FL)
Portland VA Medical Center (Portland, OR)
Ralph H. Johnson Department of Veterans Affairs Medical Center (Charleston, SC)
Raymond G. Murphy Department of Veterans Affairs Medical Center (Albuquerque, NM)
Richmond VA Medical Center (Richmond, VA)
Robert J. Dole VA Medical Center (Wichita, KS)
Rocky Mountain Regional VA Medical Center (Aurora, CO)
Roseburg VA Medical Center (Roseburg, OR)
Salem VA Medical Center (Salem, VA)
Seattle VA Medical Center (Seattle, WA)
Sheridan VA Medical Center (Sheridan, WY)
Tibor Rubin VA Medical Center (Long Beach, CA)
Tucson VA Medical Center (Tucson, AZ)
Tuscaloosa VA Medical Center (Tuscaloosa, AL)
W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center (Salisbury, NC)

West Los Angeles VA Medical Center (Los Angeles, CA)
White City VA Medical Center (White City, OR)
Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center (Columbia, SC)

Question 6: Please further explain the decision to reduce the size and scope of the EPS expansion. Is this decision the result of the health care budget shortfall or a choice VA made?

VA Response: The EPS program did not have adequate funding to implement across the enterprise resulting in a need to bring the program to VHA Governance Board for an implementation and funding decision. The board reviewed the cost of software licensing, onboarding providers, implementation and return on investment. VHA's Governance Board decided to fund some VISNs while maintaining most of the existing sites to improve the effectiveness and efficiency of the EPS program. The decision to focus on specific regions required EPS to pause implementation at 4 existing sites while expanding to a total of 47 sites by the end of FY 2025.

Question 7: Within EPS, has WellHive ever proposed any discount or billing deferral for its services? If so, what was the value of the discount or deferral, and was it accepted?

VA Response: VA does not have a contract with WellHive for EPS licenses. The contract was awarded via the National Aeronautics and Space Administration (NASA) Solutions for Enterprise-Wide Procurement (SEWP) vehicle as a Service-Disabled Veteran-Owned Small Business set aside to an authorized reseller, V3Gate. There was a 59% discount realized from the vendor's NASA SEWP Catalogue contract pricing.

Question 8: Does the \$20 million budget cut to EPS take any WellHive discount or billing deferral into account?

VA Response: VA does not have a contract with WellHive; VA has a contract with V3Gate.

Question 9: Has there ever been a proposal to eliminate the EPS project or to remove WellHive's participation in the project?

VA Response: No. The limited success of the program over the last year led the team to reassess the implementation approach, and to consider several possible courses of action. Ultimately, our approach is to focus on fewer facilities so that we can ensure the roll out is successful and cost effective and ensures that Veterans obtain care more quickly. Furthermore, because we have found through our experience and formal market research that effective provider adoption of similar tools in industry requires a different approach (such as using incentives), VA is considering ways that we could potentially do this if the new implementation approach appears to be yielding success.

Question 10: Has there ever been a proposal or recommendation to replace WellHive or its software in the EPS project with another vendor?

VA Response: No. The current contract with V3Gate included a base year and 4 option years, which will end on September 21, 2028. As with any contract, prior to expiration or ending, VA will need to develop an acquisition strategy.

Question 11: How does VA plan to comply with sections 131-134 of the Cleland-Dole Act, P.L. 117-328, requiring a community care self-scheduling pilot project? If the EPS project or WellHive was eliminated, how would VA comply?

VA Response: VA is working with the EPS/WellHive project, under the V3Gate contract for software licensing only, to deliver the required community care self-scheduling pilot program. If EPS/WellHive were eliminated, we would review all existing products and establish alternative mechanisms to comply with this requirement. Currently, only VA schedulers have access to the provider grids using the EPS tool/software, not patients.

Question 12: What plans, if any, exist to enhance communication and encourage adoption with respect to EPS among the Central Office, VISNs, facilities, and community care providers?

VA Response: The VHA Governance Process, which includes the Scheduling Subcommittee bringing decision points to the VHA Governance Board, is used to track the EPS effort and associated major decisions. This allows VHA to ensure that Central Office and VISN level leadership understand and are involved in major decisions related to EPS.

To support implementation at VA facilities, the EPS project team regularly communicates directly with each VA facility through meetings, team chat, and a Hyper Care user support channel to provide updates of EPS efforts. At the same time, facilities provide feedback to the EPS onboarding team regarding providers or provider groups to engage for inclusion within the platform. For each provider or provider group, the provider outreach team demonstrates the EPS program and emphasizes the advantages of joining the EPS program to reduce the number of phone calls and eliminate unnecessary manual labor from the traditional method. The onboarding team continues to engage community providers and guides them through the onboarding process. Additionally, the outreach team sends weekly email updates to facility leadership on EPS usage and provider onboarding efforts. Ongoing efforts include conducting two weekly office hour sessions to encourage dialogue and providing a monthly newsletter, "EPS PulsePoints," containing success stories, insights from users, and scheduled training opportunities.

To reach CCN providers, VA provides updates in the monthly Provider Advisor publication, which reaches a network of more than 100,000 community providers. See the publications at <https://www.va.gov/COMMUNITYCARE/providers/Provider-News->

[Archive.asp](#). Based on market research, VA also continues to explore additional opportunities to enhance adoption.

Question 13: How does VA plan to mitigate the impacts of deactivating WellHive in individual medical centers, particularly Hudson Valley, New York which already has roughly 300 providers signed up?

VA Response: The community provider information from the four paused sites remains in the EPS system for future usage. There is no “deactivation” necessary to remove any of the existing providers from the system. VHA will inform these providers of the pause in EPS usage and that the traditional method for scheduling Veteran appointments will continue.

Question 14: VA described its rationale for scaling back the EPS program as incorporating lessons learned and addressing challenges in enrolling community care providers. Will VA offer a detailed plan and identify necessary resources to improve change management, field outreach, communications, and provider onboarding in EPS?

VA Response: The refocused strategy on specific regions is intended to seek market conditions favorable for the provider onboarding effort. In the initial rollout plan, provider onboarding and adoption was relatively low, which significantly limited how much impact the program had and came with very high unit costs. The new approach will allow a more targeted evaluation of whether industry is open to adopting a tool like this on a large scale. Due to the location proximity of existing provider groups, EPS onboarded more than 1,000 providers in the first 2 months of FY 2025 within the regions of the five selected VISNs. We are hopeful that continuing with the focused approach—and potentially with added incentives—we can drive provider adoption to make this program meaningful and beneficial to Veterans, while using resources effectively.

Question 15: How many VA employees and contractors are assigned to or support the EPS program? How was this number determined, including with respect to other comparable projects?

VA Response: There are approximately 32 full-time (4 VA employees, 28 contractors) and 13 part-time (8 VA employees, 5 contractors) assigned to support the EPS project. VHA determined the number based on the needs for general project management, change management, external providers onboarding effort, technical supports for VA facilities in utilizing the WellHive software, general communications, and administrative requirements. Part-time staff is used to meet demands where opportunities are identified, and technical support increased during preparation times to bring facilities to go-live with EPS.

Question 16: In 2022, VA piloted the technology now being used in the External Provider Scheduling project to integrate multiple VistA instances for scheduling purposes. Please describe the outcomes of that pilot. Provide any report or

evaluative documentation that exists. How many VistA instances were integrated in the pilot?

VA Response: During that initiative, EPS was integrated into 15 VistA instances to explore direct scheduling functionality (with VA providers) for the platform. The solution was successfully developed over 10 months, and then implemented in production and used in the VISN 8 VA Health Connect clinical contact center for 1 month. Subsequently, the integration with those instances has been eliminated as the VA Office of Information and Technology (OIT) is now working towards its current strategy to implement and enhance ISS to support direct scheduling. VA determined that maintaining ISS, as a government-developed system for direct care, was in VA's best interest while it moved to a readily available and capable external provider scheduling system to meet the immediate needs of Veterans using community care.

Question 17: What is the estimated cost and schedule to conduct a pilot to demonstrate integrated scheduling, including community care and VHA care appointment availability in one direct scheduling solution?

VA Response: VHA and OIT are collaborating to create a roadmap that will achieve scheduling integration.

OIT estimates the cost of implementing a single scheduling solution to integrate and pilot within ISS at approximately \$18 million and requires a timeline of 3.5 years. The current projection for completion is between FY 2028 and FY 2030, subject to availability of funding.

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