

**OVERSIGHT HEARING ON DATA MANIPULATION
AND ACCESS TO VA HEALTH
CARE: TESTIMONY FROM GAO, IG AND VA**

HEARING

BEFORE THE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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OVERSIGHT HEARING ON DATA MANIPULATION AND ACCESS TO VA HEALTH CARE: TESTIMONY FROM GAO, IG AND VA

Monday, June 9, 2014

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

The committee met, pursuant to notice, at 7:30 p.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Flores, Denham, Runyan, Benishek, Huelsamp, Coffman, Wenstrup, Cook, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, O'Rourke, and Walz.

Also present: Representative Johnson of Ohio.

The CHAIRMAN. Good evening everybody. If I could get your attention for just a minute. We had set aside time for a business meeting tonight to talk about a subpoena that we thought we were going to need to issue. We asked for some information from the Department almost a year and a half ago. Miraculously, it appeared today, so that negates the need for us to move forward with a subpoena on that particular issue, so we will not be having the business meeting that we originally had noticed and talked to everybody here on the committee, and I appreciate it.

Good evening everybody. I want to welcome you again to tonight's hearing, entitled "Oversight Hearing on Data Manipulation and Access to VA Health Care: Testimony from GAO, IG, and from VA." And tonight we are going to address ongoing issues of systematic wait times, manipulation that occurs throughout the Veterans Health Administration and negatively impacts the veterans that we serve and the health care that they should be provided.

VA wait times and scheduling issues have been the subject of numerous investigations by the committee for many years. We have many outstanding requests for information and have held hearings to address the problems within VA that have led to veterans waiting so long for needed care. The VA's Office of Inspector General has also repeatedly warned the VA about its substandard scheduling practices. From as early as 2005, in numerous reports, VA OIG has noted that medical facilities did not have effective electronic waiting list procedures; their outpatient scheduling procedures needed improvement nationwide; their data was often unreli-

able; and they overstated their success regarding patient wait times.

In December of 2012, GAO found that VAs reported wait times remained unreliable. VHA's policy continued to be implemented inconsistently across VA. Schedulers, in fact, lacked proper training and VHA's appointment scheduling system was outdated and inefficient. Despite these repeated warnings that have come from Congress, from the GAO, and even from VA's own investigative body, issues with patient wait times and scheduling remain a pervasive problem today. Last year, this committee requested that GAO conduct a separate investigation to confirm the extent of problems throughout the VHA regarding ongoing issues with patient wait times and consult delays. GAO will testify as to its findings here tonight.

Recently, the committee received whistleblower complaints regarding the Phoenix VA healthcare system that explained how the facility was keeping numerous wait lists to give the impression that its wait times were much shorter than they actually were. One of the secret wait lists at the facility, sources found, that as many as 40 patients may have died while they were awaiting care. After the committee was able to confirm these allegations, we made the issue public during our April 9th, 2014, hearing. At that hearing, I asked that the VA OIG look into those allegations which prompted its investigation.

The interim results of that investigation were released on May 28th of 2014. In that report, the OIG substantiated a number of problems at the Phoenix VAMC but also noted how it has opened or has planned to open investigations into 42 different VA medical facilities. The OIG found that at Phoenix, at least 1,700 patients who were waiting for a primary care appointment were not on the electronic wait list, meaning that these veterans may never receive such an appointment.

Additionally, OIG found that the Phoenix leadership considerably underestimated new patient wait times, which it noted is its metric used to consider bonuses and salary increases for VA employees. VA OIG also stated that inappropriate scheduling practices like those found in Phoenix are systemic across the Veterans Health Administration.

Finally, we were notified earlier last week that VA would provide the findings of its internal audit of appointment wait times by last Friday. VA provided us with those findings earlier this afternoon. Tonight, I look forward to hearing what VA has to say about its audit, how it plans to repair the damage it has caused by tampering with veterans' access to care.

PREPARED STATEMENT OF THE HON. JEFF MILLER, Chairman

Good evening.

I would like to welcome everyone to tonight's hearing entitled, "Oversight Hearing on Data Manipulation and Access to VA Healthcare: Testimony from GAO, IG and VA."

Tonight, we will address ongoing issues of systemic wait time manipulation that occurs throughout the Veterans Health Administration and negatively impacts care provided to veterans.

VA wait times and scheduling issues have been the subject of numerous investigations by the Committee for many years. We have many outstanding requests for information and have held hearings to address the problems within VA that have led to Veterans waiting so long for needed care.

The VA's office of Inspector General has also repeatedly warned VA about its substandard scheduling practices. From as early as 2005, in numerous reports, VA OIG has noted that medical facilities did not have effective electronic waiting list procedures, their outpatient scheduling procedures needed improvement nationwide, their data was often unreliable, and they overstated their success regarding patient wait times.

In December 2012, GAO found that VA's reported wait times remained unreliable, VHA's policy continued to be implemented inconsistently across v-a, schedulers lacked proper training, and VHA's appointment scheduling system was outdated and inefficient. Despite these repeated warnings that have come from Congress, GAO, and even from VA's own investigative body, issues with patient wait times and scheduling remain a pervasive problem today.

Last year, this committee requested that GAO conduct a separate investigation to confirm the extent of problems throughout the VHA regarding ongoing issues with patient wait times and consult delays. GAO will testify as to its findings tonight.

Recently, the Committee received whistleblower complaints regarding the Phoenix VA Health Care System that explained how the facility was keeping numerous wait lists to give the impression that its wait times were much shorter than they actually were. On one of the secret wait lists at the facility, sources found that as many as forty patients may have died waiting for care. After the Committee was able to confirm these allegations, we made the issue public during our April 9, 2014, hearing. At that hearing, I asked that the VA OIG look into those allegations, which prompted its investigation.

The interim results of that VA OIG investigation were released on May 28, 2014. In the report, the OIG substantiated a number of problems at the Phoenix VAMC, but also noted how it has opened or has planned to open investigations into forty-two different VA medical facilities. The OIG found that at Phoenix, at least 1,700 patients who were waiting for a primary care appointment were not on the Electronic Wait List, meaning that these Veterans may never receive such an appointment.

Additionally, OIG found that the Phoenix leadership considerably understated new patient wait times, which it noted is a metric used to consider bonuses and salary increases for VA employees.

VA OIG also stated that inappropriate scheduling practices, like those found in Phoenix, are systemic across the VHA.

Finally, we were notified earlier last week that VA would provide the findings of its internal audit of appointment wait times by last Friday. VA provided us with those findings earlier this afternoon.

Tonight, I look forward to hearing what VA has to say about its audit and how it plans to repair the damage it has caused by tampering with Veterans' access to care. With that, I now recognize Ranking Member Michaud for his opening statement.

OPENING STATEMENT OF MIKE MICHAUD, Ranking Minority Member

Mr. Michaud. Thank you very much, Mr. Chairman, for having this hearing this evening. There is nothing more important than the welfare of the men and women who have served this country with honor and distinction. I am pleased our committee is continuing to move quickly and in a bipartisan manner to investigate the many serious shortcomings within the VA, especially those regarding access to health care. Now is the time for us to identify the problem so we can move forward and implement changes. That means working together on oversight and legislative solutions. It also means having very frank conversation with veterans about their personal experiences so we know what we're—how we can improve the system.

Over the years, this committee has identified and helped fix many of the problems within the VA, but the VA is clearly facing a crisis, a crisis that is now being addressed by the media and our increased oversight efforts. In this environment, it is especially important that we are fair in our oversight and measured in our responses, but above all, we must never fall short of doing what we need to ensure that veterans have access to the healthcare system that they've earned and deserve.

It is important for us to work together to achieve the VA we envisioned. We must work together across the aisle and across branches of government to fix these problems and ensure that the VA is caring for our veterans. When we work together, this committee works best. We know that the work that we must put forward—forward, that we must ensure that the VA is receiving the necessary assistance and resources that they need to do what they have to.

As I see it, there is critical questions that should be asked by this committee, questions that get to the root causes of the problems, questions related to the broad strategic changes needed at VA, changes in the leadership climate, encouragement with other agencies, like DOD and HHS, increased utilization of the private sector, and long-term resource planning. We need to ask the hard question: What should the Department look like in the future?

These are not easy questions, nor do they have easy, simple answers, but today, more than ever, we must ask these questions and come up with these answers. I believe thoughtful, measured, sound policy is needed today more than ever. The answers need to be comprehensive, and when necessary, nuanced. For example, when holding leaders accountable, we need to not only focus on career senior executive members but also the doctors and nurses who oc-

cupy administrative or executive leadership positions. As I mentioned earlier, H.R. 433–4399 closes the gap in the current package of legislation being considered by the House and the Senate.

Mr. Chairman, I've always been proud of the bipartisan nature in which this committee has operated. My hope is that we'll continue that spirit working together to help identify the problems and working towards a solution. No single individual has a monopoly on the answers, and no single individual or institution has all the answers. The work ahead of us will be hard, and it will require all of us to work together in that regard, the Veterans Service Organizations, the Department, this committee, the Senate and the White House.

And Mr. Chairman, I want to thank you once again for your robust advocacy for our veterans in holding all these hearings that we're having for the oversight, and it's my hope that when the committee asks for information from the Department of Veterans Affairs, that they provide that information in a timely manner so we'll not have to issue subpoena to get the information that we need so we can do our oversight hearing. That's our responsibility, and we expect the Department to help us do our oversight hearing as well.

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

The CHAIRMAN. I thank you very much for your comments this evening.

PREPARED STATEMENT OF THE HON. MIKE MICHAUD

* Thank you, Mr. Chairman.

* Nothing is more important than the welfare of the men and women who have served their country with honor and distinction.

* I'm pleased our committee is continuing to move quickly, and in a bipartisan manner, to investigate the many serious shortcomings within the VA, especially those regarding access to health care.

* Now is the time for us to identify the problems so that we can move forward and implement changes. That means working together on oversight and legislative solutions. It also means having very frank conversations with veterans about their personal experiences so we know what is working and what must be improved.

* Over the years, this committee has identified and helped fix many problems within the VA over the years. But, the VA is clearly facing a crisis, a crisis that is now being addressed by the media, and our increased oversight efforts.

* In this environment, it is especially important that we are fair in our oversight and measured in our responses. But, above all, we must never fall short of doing what we need to do to ensure that veterans have access to their health care system.

* It is important for us to work together to achieve the VA we envision. We must work together, across the aisle and across the branches of government, to fix these problems and ensure the VA is caring for our veterans.

* When we work together this committee works best. And now, that work must put us on a path to ensuring that the VA is receiv-

ing the necessary assistance and resources, and that we are, in turn, providing the necessary oversight.

* As I see it there are critical questions that should be asked by this Committee. Questions that get at the root cause of the problems. Questions relate to the broad, strategic changes needed at VA - changes in leadership climate, engagement with other agencies like DoD and HHS, increased utilization of the private sector, and long-term resource planning. We need to ask the hard question - what should the Department look like in the future?

* These are not easy questions, nor do they have easy, simple answers. But today, more than ever, we must ask these questions and come up with these answers. I believe thoughtful, measured, sound policy is needed today, more than ever.

* The answers need to be comprehensive, and, when necessary, nuanced. For example, when holding leaders accountable, we need to not just focus on career Senior Executive Service members, but also the doctors and nurses who occupy administrative or executive leadership positions. My bill, HR 4399 closes that gap in the current packages of legislation being considered by the House and Senate.

* Mr. Chairman, I have always been proud of the bipartisan nature in which this committee operates.

* My hope is that this spirit continues. Working together, we can help identify the problems and work toward solutions.

* No single individual has a monopoly of concern over our veterans. And no single individual or institution has all the answers. The work ahead of us will be hard. It will require us all to lend a hand as we work toward identifying and fixing the problems the VA faces.

* With that Mr. Chairman, I look forward to a robust conversation today with our witnesses⁰⁹not only about the problems, but about potential solution. I thank all the witnesses for being here today.

* I yield back.

The CHAIRMAN. I would ask that all members would waive their opening statements as customary in the committee. I would invite now the witnesses to please come to the witness table, and as you're coming forward, I will introduce you.

Tonight we're going to hear from Dr. Debra Draper, Director of Health Care for the Government Accountability Office; Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations of the Department of Veterans Affairs; Richard Griffin, acting inspector general of the Department of Veterans Affairs. Mr. Griffin is accompanied by Ms. Linda Halliday, assistant inspector general for audits and evaluations for the Department of Veterans Affairs. I would ask the witnesses, if you would, to please stand, raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Thank you very much. Please be seated.

All of your complete written statements will be entered into the hearing record. Thank you for being here tonight.

And Dr. Draper, you are now recognized for 5 minutes.

STATEMENT OF DEBRA A. DRAPER, PH.D.

Ms. Draper. Chairman Miller, Ranking Member Michaud, and members of the committee, I appreciate the opportunity to be here today to discuss the ongoing difficulties that veterans are experiencing in obtaining needed medical care. In 2000 and 2001, we reported problems with wait times and medical appointment scheduling in VA medical facilities. In 2012, we again reported problems, including the unreliability of outpatient medical appointment wait times and the inconsistent implementation of VA scheduling policy, which impacted the timely delivery of care. We are currently conducting work examining VA's management of outpatient specialty care consults, a type of medical appointment, and have again identified problems that may hinder veterans' timely access to care.

Across our body of work on access to VA health care, several common themes have emerged. These include weak and ambiguous policies and processes, which result in significant variation, confusion, and increased risk of undesirable practices at the local level; software systems that do not facilitate good practices; inadequate training; unclear staffing needs and allocation priorities; and inadequate oversight, which relies largely on facility self-certification without independent verification; and the use of unreliable data for monitoring.

My comments today focus mainly on preliminary observations from our ongoing work examining VA's management of specialty care consults. We found most of the 150 consults we reviewed were not managed in accordance with VA's timeliness guidelines. Specifically, we found one in five consult requests were not triaged within the 7-day guideline. We also found 38 percent of the consults were completed but not within the 90-day guideline; 19 percent were completed within 90 days, but the provider failed to properly close out the consult in the electronic system; and the remaining 43 percent were closed without the veterans being seen.

VA medical center officials told us that increased demand for services, patient no-shows, and canceled appointments are among factors that lead to delays and impact their ability to meet VA's 90-day consult completion guideline. During the course of our review, we also identified one consult in which the veteran experienced delays and died prior to obtaining needed care. I want to walk through the timeline of events for this particular case.

In September 2013, the veteran was diagnosed with two aneurysms. In October, the medical center scheduled the veteran for surgery in November, but the surgery was subsequently canceled due to staffing issues. In December, the medical center approved non-VA care and referred the veteran to a local hospital for surgery. In late December, after the veteran followed up with the VA medical center, it was discovered that the non-VA provider had lost the veteran's information, which the medical center then resubmitted. In February 2014, the veteran died prior to the planned surgery at the non-VA provider.

This particular case is insightful for a number of reasons, including that while non-VA care may expand capacity, there are also some potential pitfalls. For example, non-VA care requires prior approval, which may delay care. More coordination is needed between

the VA medical center, the veteran, and the non-VA provider, and wait times for non-VA care are not tracked by VA.

Our findings relative to our ongoing work include variation in how medical centers have implemented new business rules for specialty care consults which limits the usefulness of the data for monitoring and overseeing consults system-wide; and an overall lack of oversight of the process, including no independent verification of medical centers' actions.

And so demand for VA health care continues to escalate. It is imperative that VA address this access to care problems. Since 2005, the number of patients served by VA has increased nearly 20 percent, and the number of annual outpatient medical appointments has increased approximately 45 percent. In light of this, the failure of VA to address its access to care problems will considerably worsen an already untenable situation.

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

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

United States Government Accountability Office



Testimony
Before the Committee on Veterans'
Affairs, House of Representatives

For Release on Delivery
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VA HEALTH CARE

Ongoing and Past Work Identified Access, Oversight, and Data Problems That Hinder Veterans' Ability to Obtain Timely Outpatient Medical Care

Statement of Debra A. Draper
Director, Health Care

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

I am pleased to be here today as you examine ongoing concerns related to the Department of Veterans Affairs' (VA) delivery of health care to our nation's veterans. In recent years, VA's Veterans Health Administration (VHA) has faced a growing demand for providing outpatient medical appointments. From fiscal years 2005 through 2012, the number of annual outpatient medical appointments VHA provided increased by approximately 45 percent, from 58 million to 84 million.¹ VHA provided this care through its primary and specialty care outpatient clinics, which are managed by VA's 151 medical centers (VAMC).² Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, problems with VHA's scheduling and management of outpatient medical appointments may contribute to delays in care, or care not being provided at all. 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.³

Nonetheless, VHA has reported continued improvements in achieving timely access to medical appointments. For example, in fiscal year 2011, VA reported that VHA completed 89 percent of medical appointments for new patients within its goal; in fiscal year 2012, VA reported that VHA completed 90 percent of primary and specialty care new patient

¹In addition, the number of patients VHA served increased from fiscal years 2005 to 2012 by approximately 19 percent, from 5.3 million to 6.3 million patients.

²Outpatient clinics offer services to patients that do not require a hospital stay. Primary care addresses patients' routine health needs, and specialty care is focused on a specific specialty service such as cardiology or gastroenterology.

³See, for example, Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dom 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).

appointments within the goal.⁴ However, in December 2012, we reported that VHA's medical appointment wait times were unreliable and VHA's inadequate oversight of the outpatient medical appointment scheduling processes contributed to VHA's problems with scheduling timely medical appointments.⁵ More recently, a report by VA's Office of Inspector General, as well as hearings on VA's delivery of medical care have discussed delays in care and improper scheduling practices resulting in lengthy wait times at VA facilities, and in some cases, care not being provided at all. Additionally, VA has initiated a system-wide audit to identify the scope and magnitude of these issues. Initial results of the audit confirmed questionable scheduling practices and other problems at many VA facilities.⁶

The problems that have been identified include VA's scheduling and delivery of outpatient specialty care. When a physician or other provider determines that a veteran needs outpatient specialty care, the provider refers the veteran to a specialist for a clinical consult—a request for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure such as a colonoscopy. VAMCs request, review, and manage consults using VHA's clinical consult process and electronic consult system, which retains information about each consult request and is part of VHA's Veterans Health Information Systems and Technology Architecture (Vista).⁷ VHA's timeliness guideline is that consults should be completed within 90 days of being requested.⁸

⁴In fiscal year 2012, VHA's appointment wait time goal for primary and specialty care appointments was 14 days from the patient's or provider's desired appointment date. According to VHA's scheduling policy, the desired appointment date, referred to as the "desired date," is the date on which the patient or provider wants the patient to be seen.

⁵GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012).

⁶U.S. Department of Veterans Affairs, *Access Audit Results Summary: Phase One Access Audit from 12 May 2014 – 16 May 2014*, accessed June 3, 2014, <http://www.blogs.va.gov/VAntage/wp-content/uploads/2014/05/VHA-Access-Audit-Phase-1-Findings-Report-ExSum-05-30-2014.pdf>.

⁷Vista is the single integrated health information system used throughout VHA in all of its health care settings. It contains patients' electronic health records.

⁸VHA officials noted that although VHA's guideline is for consults to be completed within 90 days; consults for urgent needs are completed sooner.

Appointments resulting from outpatient consults, like other outpatient medical appointments, are subject to VHA's scheduling policy.⁹ This policy is designed to help VAMCs meet their commitment to scheduling medical appointments with no undue waits or delays for patients. It establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. Additionally, it includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement. For example, the policy requires schedulers to record appointments in VHA's VistA medical appointment scheduling system.

Ideally, the consult system would contain timely and reliable information on the status and outcomes of consults, and would provide VHA information it needs to help effectively manage the process. In 2012, however, VHA found that system-wide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. VHA found that approximately 2 million consults were unresolved in its system for more than 90 days. Additionally, VHA determined that the data were inadequate to identify whether care had been provided for these consults, or provided in a timely manner. In response, in May 2013, VHA launched the Consult Management Business Rules Initiative (referred to as "consult business rules") to standardize aspects of the consult process, with the goal of developing consistent and reliable data on consults across all VAMCs.

My statement today will draw from our ongoing work examining the management of outpatient specialty care consult processes at five selected VAMCs, and our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times data and scheduling oversight.¹⁰ In particular, this statement updates information provided in our April 9, 2014 testimony before the Committee regarding (1) the extent to which VHA's process for conducting outpatient consults at five selected VAMCs ensured veterans timely access to specialty care,

⁹VHA medical appointment scheduling policy is documented in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010). We refer to the directive as "VHA's scheduling policy" from this point forward.

¹⁰GAO-13-130.

(2) the extent to which VHA monitors and oversees consults to ensure veterans are receiving outpatient specialty care in accordance with its timeliness standards; and (3) key findings and recommendations from our December 2012 report, as well as the progress VHA has made in implementing those recommendations.¹¹

For our ongoing outpatient specialty care consults work,¹² we have reviewed documents and interviewed VHA central office officials about VHA's policies and guidance for VAMCs to send, receive, and complete consults, and VHA's procedures for VAMCs to schedule outpatient medical appointments, which include those for specialty care. We also have reviewed documents and interviewed VHA central office officials about their efforts to oversee VAMCs' implementation of VHA's consult policies, including VHA's Consult Management Business Rules Initiative, launched in May 2013. Additionally, we have interviewed officials from five VAMCs selected for variation in volume of outpatient consults, complexity,¹³ and location. These five VAMCs were located in Augusta, Maine; Denver, Colorado; Gainesville, Florida; Oklahoma City, Oklahoma; and Palo Alto, California. For each VAMC included in our ongoing work, we have interviewed leadership about how VHA's consult policies and any local policies or procedures for managing consults are implemented at their facility. We also have interviewed specialty care service chiefs, administrative staff, and providers of three high-volume specialty services—cardiology, gastroenterology, and physical therapy. Further, we have interviewed officials at the five regional Veterans Integrated Service Networks (VISN) responsible for overseeing consults for the VAMCs included in our review.¹⁴

¹¹GAO, *VA Health Care: Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans*, GAO-14-509T (Washington, D.C.: Apr. 9, 2014).

¹²The scope of our work is limited to outpatient consults; however, providers may also request consults for inpatient care and administrative needs, among other things.

¹³VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

¹⁴VHA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area.

Additionally, for each of the five medical centers, we have reviewed the history of actions taken on a random sample of 30 outpatient consults (10 from each of the three specialties included in our review) that were requested during the period April 1, 2013, through September 30, 2013, that either took more than 90 days to complete or had been in process for more than 90 days. We also asked VHA to identify those consults that were requested during this time period for veterans who are now deceased. We randomly selected 50 of these consults (10 from each VAMC included in our review) to determine the extent to which these veterans may have experienced any delays in care. The preliminary findings from our ongoing review of outpatient consults are not generalizable across all VAMCs.

For our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times and scheduling oversight,¹⁵ we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times and interviewed VHA central office officials responsible for developing them.¹⁶ We also visited 23 high-volume outpatient clinics at four VAMCs selected for variation in size, complexity, and location; these four VAMCs were located in Dayton, Ohio; Fort Harrison, Montana; Los Angeles, California; and Washington, D.C. At each VAMC we interviewed leadership and other officials about how they managed and improved medical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with scheduling policy, and problems staff experienced in scheduling timely medical appointments. We examined each VAMC's and clinic's implementation of elements of VHA's scheduling policy and obtained documentation of scheduler training completion. In addition, we interviewed schedulers from 19 of the 23 clinics visited, and also reviewed patient complaints about telephone responsiveness, which is integral to timely medical appointment scheduling. We interviewed the directors and relevant staff of the four regional VISNs for the VAMCs we visited. We also interviewed VHA central office officials and officials at the VAMCs we visited about selected initiatives to improve veterans' access to timely medical appointments. Additionally, in April and June 2014, we reviewed documentation and interviewed officials from VHA's central office about

¹⁵GAO-13-130.

¹⁶We did not include mental health appointments in the scope of our work, because this issue was already being reviewed by VA's Office of Inspector General.

the extent to which they have addressed the recommendations we made in the 2012 report.¹⁷

The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We are not making recommendations on VHA's consult process at this time because some of this work is ongoing.

We shared information we used to prepare this statement with VA. After reviewing this information, VA provided us with technical comments, which we incorporated as appropriate.

Background

When providers at VAMCs determine that a veteran needs outpatient specialty care, they request and manage consults using VHA's clinical consult process. Clinical consults include requests by physicians or other providers for both clinical consultations and procedures. A clinical consultation is a request seeking an opinion, advice, or expertise regarding evaluation or management of a patient's specific clinical concern, whereas a procedure is a request for a specialty procedure such as a colonoscopy. Clinical consults are typically requested by a veteran's primary care provider using VHA's electronic consult system. The consult process is governed by VHA's national consult policy.¹⁸ The policy requires VAMCs to manage consults using a national electronic consult system,¹⁹ and requires VAMC staff to provide timely and appropriate care to veterans.

Once a provider sends a request, VHA requires specialty care providers to review it within 7 days and determine whether to accept the consult. If the specialty care provider accepts the consult—determines the consult is

¹⁷GAO-14-509T.

¹⁸VHA Directive 2008-056, VHA Consult Policy (Sept. 16, 2008).

¹⁹The electronic consult system retains information about each consult request and is part of VHA's Vista.

needed and is appropriate—an appointment is to be made for the patient to receive the consultation or procedure.²⁰ In some cases, a provider may discontinue a consult for reasons such as the care is not needed, the patient refuses care, or the patient is deceased.²¹ In other cases the specialty care provider may determine that additional information is needed, and will send the consult back to the requesting provider, who can resubmit the consult with the needed information. Once the appointment is held, VHA's policy requires the specialty care provider to appropriately document the results of the consult, which would then close out the consult as completed in the electronic system.²² VHA's current guideline is that consults should be completed within 90 days of the request. If an appointment is not held, staff are to document why they were unable to complete the consult.

According to VHA's consult policy, VHA central office officials have oversight responsibility for the consult process, including the measurement and monitoring of ongoing performance.²³ In 2012, VHA created a database to capture all consults system-wide and, after reviewing these data, determined that the data were inadequate for monitoring purposes. One issue identified was the lack of standard processes and uses of the electronic consult system across VHA. For example, in addition to requesting consults for clinical concerns, the system also was being used to request and manage a variety of administrative tasks, such as requesting patient travel to appointments. Additionally, VHA could not accurately determine whether patients actually received the care they needed, or if they received the care in a timely fashion. According to VHA officials, approximately 2 million consults (both clinical and administrative consults) were unresolved for more than 90 days. Subsequently, VA's Under Secretary for Health convened a task force to address these and other issues regarding VHA's

²⁰Some consults, referred to as "e-consults," do not require an in-person appointment with the patient and may be addressed electronically through the consult system.

²¹When a provider discontinues a consult, action on the consult is stopped, and a new consult request must be initiated by the requesting provider for the veteran to obtain the specialty care—whether that care is for a clinical consultation or procedure.

²²The results of consults are documented in the consult system, and are contained in the patient's electronic health record.

²³The policy also requires VISN leadership to oversee the consult processes for VAMCs in their networks.

consult system, among other things. In response to the task force recommendations, in May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs. This initiative required VAMCs to complete four specific tasks between July 1, 2013, and May 1, 2014:

- Review and properly assign codes to consistently record consult requests in the consult system;²⁴
- Assign distinct identifiers in the electronic consult system to differentiate between clinical and administrative consults;
- Develop and implement strategies for requesting and managing requests for consults that are not needed within 90 days—known as “future care” consults;²⁵ and
- Conduct a clinical review as warranted, and as appropriate, close all unresolved consults—those open more than 90 days.

At the time of our December 2012 review, VHA measured outpatient medical appointment wait times as the number of days elapsed from the patient's or provider's desired date, as recorded in the VistA scheduling system by VAMCs' schedulers. In fiscal year 2012, VHA had a goal of completing new and established patient specialty care appointments within 14 days of the desired date. VHA established this goal based on its performance reported in previous years.²⁶ To facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance measures—in its budget submissions and

²⁴These codes identify the type of care requested in the consult (e.g., dermatology or cardiology) and are used by VHA to run reports that assist with managing its services.

²⁵According to VHA guidance, the consult system should only be used for services needed within 90 days. VAMCs were given the option to track future care consults either by developing markers so they could be identified in the consult system, or using existing mechanisms outside of the consult system such as electronic wait lists. The electronic wait list is a component of the VistA scheduling system designed for recording, tracking, and reporting veterans waiting for medical appointments.

²⁶In 1995, VHA established a goal of scheduling primary and specialty care medical appointments within 30 days to ensure veterans' timely access to care. VA's reported wait times for fiscal year 2010 showed that nearly all primary and specialty care medical appointments were scheduled within 30 days of desired date. In fiscal year 2011, VHA shortened the wait time goal to 14 days for both primary and specialty care medical appointments.

performance reports to Congress and stakeholders.²⁷ The performance measures, like wait time goals, have changed over time.

Officials at VHA's central office, VISNs, and VAMCs all have oversight responsibilities for the implementation of VHA's scheduling policy. For example, each VAMC director, or designee, is responsible for ensuring that clinics' scheduling of medical appointments complies with VHA's scheduling policy and for ensuring that all staff who can schedule medical appointments in the VistA scheduling system have completed the required VHA scheduler training.²⁸ In addition to the scheduling policy, VHA has a separate directive that establishes policy on the provision of telephone service related to clinical care, including facilitating telephone access for medical appointment management.

²⁷VA prepares a congressional budget justification that provides details supporting the policy and funding decisions in the President's budget request submitted to Congress prior to the beginning of each fiscal year. The budget justification articulates what VA plans to achieve with the resources requested; it includes performance measures by program area. VA also publishes an annual performance report—the performance and accountability report—which contains performance targets and results achieved compared with those targets in the previous year.

²⁸Specifically, VAMCs are required to maintain a list of all staff who can schedule medical appointments in the VistA scheduling system and VAMC directors are required to ensure successful completion of required training by all staff on the list. Schedulers are not to be allowed to schedule medical appointments in the VistA scheduling system without proof of their successful completion of this training.

GAO's Ongoing Work Indicates That Veterans Did Not Always Receive Outpatient Specialty Care in Accordance with VHA Timeliness Standards, and in Some Cases, Did Not Receive Care at All

Our ongoing work has identified examples of delays in veterans receiving requested outpatient specialty care at the five VAMCs we reviewed. We found consults that were not processed in accordance with VHA timeliness guidelines—for example, consults were not reviewed within 7 days, or completed within 90 days. We also found consults for which veterans did not receive the requested outpatient specialty care, and those for which the requested specialty care was provided, but were not properly closed in the consult system.

VHA requires specialty care providers to review consults within 7 days and determine whether to accept the consult. Of the 150 consults we reviewed, the consult records indicated that VAMCs did not meet the 7-day requirement for 31 consults (21 percent). For one VAMC, nearly half the consults were not reviewed and triaged within 7 days. Officials at this VAMC cited a shortage of providers needed to review and triage the consults in a timely manner.

Our ongoing work also has identified that for the majority of the 150 consults we reviewed, VAMCs did not meet VHA's timeliness guideline that care be provided and consults completed within 90 days. We found that veterans received care for 86 of the 150 consults we reviewed (57 percent), but in only 28 of the consults (19 percent) veterans received care within 90 days of the date the consult was requested. For the remaining 64 consults (43 percent), the patients did not receive the requested care. Specific examples of consults that were not completed in 90 days, or were closed without the patients being seen, include:

- For 3 of 10 gastroenterology consults we reviewed for one VAMC, we found that between 140 and 210 days elapsed from the dates the consults were requested to when the patients received care. For the consult that took 210 days, an appointment was not available within 90 days and the patient was placed on a waiting list before having a screening colonoscopy.
- For 4 of the 10 physical therapy consults we reviewed for one VAMC, we found that between 108 and 152 days elapsed, with no apparent actions taken to schedule an appointment for the veteran. The patients' files indicated that due to resource constraints, the clinic was not accepting consults for non-service-connected physical therapy

evaluations.²⁹ In 1 of these cases, several months passed before the veteran was referred to non-VA care, and he was seen 252 days after the initial consult request. In the other 3 cases, the physical therapy clinic sent the consults back to the requesting provider, and the veterans did not receive care for that consult.

- For all 10 of the cardiology consults we reviewed for one VAMC, we found that staff initially scheduled patients for appointments between 33 and 90 days after the request, but medical files indicated that patients either cancelled or did not show for their initial appointments. In several instances patients cancelled multiple times. In 4 of the cases VAMC staff closed the consults without the patients being seen; in the other 6 cases VAMC staff rescheduled the appointments for times that exceeded the 90-day timeframe.³⁰

VAMC officials cited increased demand for services, patient no-shows, and cancelled appointments, among the factors that hinder their ability to meet VHA's guideline for completing consults within 90 days. Several VAMC officials also noted a growing demand for both gastroenterology procedures, such as colonoscopies, as well as consultations for physical therapy evaluations, combined with a difficulty in hiring and retaining specialists for these two clinical areas, as causes of periodic backlogs in providing these services. Officials at these facilities indicated that they try to mitigate backlogs by referring veterans to non-VA providers for care.

While officials indicated that use of non-VA care can help mitigate backlogs, several officials indicated that non-VA care requires more coordination between the VAMC, the patient, and the non-VA provider; can require additional approvals for the care; and also may delay obtaining the results of medical appointments or procedures. In addition, wait times are generally not tracked for non-VA care. As such, officials acknowledged that this strategy does not always prevent delays in veterans receiving timely care or in completing consults.

²⁹A non-service-connected disability is an injury or illness that was not incurred or aggravated during active military service.

³⁰As we previously reported, scheduling practices at some VAMCs could result in miscommunication with patients and cause them not to make medical appointments. In addition, outdated or incorrect patient contact information may also affect patient no-shows and cancelled appointments. See GAO-13-130.

Our ongoing review also has identified one consult for which the patient experienced delays in obtaining non-VA care and died prior to obtaining needed care. In this case, the patient needed endovascular surgery to repair two aneurysms – abdominal aortic and an iliac. According to the patient's medical record, the timeline of events surrounding this consult was as follows:

- September 2013 – Patient was diagnosed with two aneurysms.
- October 2013 – VAMC scheduled patient for surgery in November, but subsequently cancelled the scheduled surgery due to staffing issues.³¹
- December 2013 – VAMC approved non-VA care and referred the patient to a local hospital for surgery.
- Late December 2013 – After the patient followed up with the VAMC, it was discovered that the non-VA provider lost the patient's information. The VAMC resubmitted the patient's information to the non-VA provider.
- February 2014 – The consult was closed because the patient died prior to the surgery scheduled by the non-VA provider.³²

According to VAMC officials, they conducted an investigation of this case. They found that the non-VA provider planned to perform the surgery on February 14, 2014, but the patient died the previous day. Additionally, they stated that according to the coroner, the patient died of cardiac disease and hypertension and that the aneurysms remained intact.

Furthermore, our ongoing work shows that for nearly all of the consults where care had been provided within 90 days, an extended amount of time elapsed before specialty care providers completed them in the consult system.³³ Specifically, for 28 of the 29 consults, even though care was provided, the consult remained open in the system, making it appear as though the requested care was not provided within 90 days. For one

³¹Officials indicated that in October 2013, the VAMC temporarily suspended the endovascular surgeon that conducts these surgeries.

³²We have referred this case to VA's Office of Inspector General for further review.

³³According to VAMC officials, in order to successfully complete a consult, the specialty care provider must select a specific note title that links the results to the consult.

VAMC, we found that for all 10 cardiology consults we reviewed, specialty care providers did not properly document the results of the consults in order to close them in the system. In some cases, it took over 100 days from the time care was provided until the consults were completed in the system.

Officials from several VAMCs told us that often specialty care providers do not choose the correct notes needed to document that the consults are complete. Officials attributed this ongoing issue in part to the use of residents, who rotate in and out of specialty care clinics after a few months and lack experience with completing consults. Officials from one VAMC told us that this requires VAMC leadership to continually train new residents on how to properly complete consults. To ensure that specialty care providers consistently choose the correct notes, this VAMC activated a prompt in its consult system asking each provider if the note the provider is entering is in response to a consult. Officials stated that this has resulted in providers more frequently choosing the correct note title to complete consults.

Limitations in VHA's Implementation of the Consult Business Rules Impedes Its Ability to Assess Delays in Care

Our ongoing work has identified variation in how the five VAMCs in our review have implemented key aspects of VHA's business rules, which limits the usefulness of the data in monitoring and overseeing consults system-wide. As previously noted, VHA's business rules were designed to standardize aspects of the consult process, thus creating consistency in VAMCs' management of consults. However, we have found variation in how VAMCs are implementing certain tasks required by the business rules. For example, VAMCs have developed different strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days.

One task of the consult business rules required VAMCs to develop and implement strategies for requesting and managing requests for future care consults.³⁴ Based on our ongoing work, we have identified that VAMCs are adopting various strategies when implementing this task,³⁵

³⁴VHA provided VAMCs with options for managing future care consults—namely that they could develop markers to identify them in the consult system, or use existing mechanisms outside of the consult system such as electronic wait lists.

³⁵Information on the strategies used by VAMCs to implement this consult business rule task was included in our April 2014 testimony. See GAO-14-509T.

such as piloting an electronic system for providers to manage future care consults outside of the consult system and entering the consult regardless of whether the care was needed beyond 90 days.³⁶ However, during the course of our ongoing work, several VAMCs told us they are changing their strategies for requesting and managing future care consults. For example, officials from a VAMC that was piloting an electronic system stated that, after evaluating the pilot, they decided not to use this approach, and are instead planning to implement markers to identify future care consults. These consults will appear in the consult data, but will be identified as future care consults and remain appropriately open until care is provided. Officials from two other VAMCs that were entering consults regardless of whether the care was needed beyond 90 days told us they are no longer doing this. According to officials, instead they are implementing a separate electronic system to track needed future care outside of the consult system, and these future care needs will not appear in consult data until they are entered in the consult system closer to the date the care is needed. Based on our discussions with VHA officials, it is not clear the extent to which they are aware of the various strategies that VAMCs are using to comply with this task. According to VHA officials, they have not conducted a system-wide review of the future care strategies and did not have detailed information on the various strategies specific VAMCs have implemented.

Overall, our ongoing work indicates that oversight of the implementation of VHA's consult business rules has been limited and has not included independent verification of VAMC actions. VAMCs were required to self-certify completion of each of the four tasks outlined in the business rules. VISNs were not required to independently verify that VAMCs appropriately completed the tasks. Without independent verification, however, VHA cannot be assured that VAMCs implemented the tasks correctly.

Furthermore, our ongoing work shows that VHA did not require that VAMCs document how they addressed unresolved consults that were open greater than 90 days, and none of the five VAMCs in our ongoing review were able to provide us with specific documentation in this regard.

³⁶Two VAMCs included in our review reported entering the consults regardless of whether the care was needed beyond 90 days. One of these VAMCs further stated that providers discontinued consults for future care appointments when the 90-day threshold was reached.

VHA officials estimated that as of June 2014, about 278,000 consults (both clinical and administrative consults) remained unresolved system-wide. VAMC officials noted several reasons that consults were either completed or discontinued in this process of addressing unresolved consults, including improper recording of consult notes, patient cancellations, and patient deaths. At one of the VAMCs we reviewed, a specialty care clinic discontinued 18 consults the same day that a task for addressing unresolved consults was due. Three of these 18 consults were part of our random sample, and ongoing review has found no indication that a clinical review was conducted prior to the consults being discontinued. Ultimately, the lack of independent verification and documentation of how VAMCs addressed these unresolved consults may have resulted in VHA consult data that inaccurately reflected whether patients received the care needed or received it in a timely manner.

Although VHA's consult business rules were intended to create consistency in VAMCs' consult data, our preliminary work has identified variation in managing key aspects of the consult process that are not addressed by the business rules. For example, there are no detailed system-wide VHA policies on how to handle patient no-shows and cancelled appointments, particularly when patients repeatedly miss appointments, which may make VAMCs' consult data difficult to assess.³⁷ For example, if a patient cancels multiple specialty care appointments, the associated consult would remain open and could inappropriately suggest delays in care. To manage this type of situation, one VAMC developed a local consult policy referred to as the "1-1-30" rule. The rule states that a patient must receive at least 1 letter and 1 phone call, and be granted 30 days to contact the VAMC to schedule a specialty care appointment.³⁸ If the patient fails to do so within this time frame, the specialty care provider may discontinue the consult. According to VAMC officials, several of the consults we reviewed would have been discontinued before reaching the 90-day threshold if the 1-1-30 rule had

³⁷As we previously reported, scheduling practices at some VAMCs could result in miscommunication with patients and cause them not to make medical appointments. In addition, outdated or incorrect patient contact information may also affect patient no-shows and cancelled appointments. See GAO-13-130.

³⁸According to VAMC officials, the 1-1-30 rule provides a minimum standard for specialty care providers to follow in scheduling patient appointments.

been in place at the time.³⁹ Furthermore, all of the VAMCs included in our ongoing review had some type of policy addressing patient no-shows and cancelled appointments, each of which varied in its requirements.⁴⁰ VHA officials indicated that they allow each VAMC to develop their own approach to addressing patient no-shows and cancelled appointments. Without a standard policy across VHA addressing patient no-shows and cancelled appointments, however, VHA consult data may reflect numerous variations of how VAMCs handle patient no-shows and cancelled appointments.

Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, and VA Has Initiated Actions to Address Related GAO Recommendations

In December 2012, we reported that VHA's reported outpatient medical appointment wait times were unreliable and that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely outpatient medical appointments. Specifically, we found that VHA's reported wait times were unreliable because of problems with recording the appointment desired date in the scheduling system. Since, at the time of our 2012 review, VHA measured medical appointment wait times as the number of days elapsed from the desired date, the reliability of reported wait time performance was dependent on the consistency with which VAMC schedulers recorded the desired date in the VistA scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. Some schedulers at VAMCs that we visited did not record the desired date correctly. For example, the desired date was recorded based on appointment availability, which would have resulted in a reported wait time that was shorter than the patient actually experienced.

At each of the four VAMCs in our 2012 review, we also found inconsistent implementation of VHA's scheduling policy, which impeded scheduling of

³⁹The VAMC issued its updated consult policy, which included the 1-1-30 rule, in December 2013 after our request for consults data.

⁴⁰One of the VAMCs allowed for a maximum number of two no-shows for all specialty appointments, with consideration given to the patient's medical needs. Another VAMC allowed for two no-shows for all specialty care appointments before a consult could be discontinued, but provided no limit for patient cancellations. Two other VAMCs' policies stated that specialty providers should reassess the patient's needs after one no-show and may or may not reschedule the appointment. Finally, the remaining VAMC's policy did not include a limit to the number of no shows allowed for specialty appointments.

timely medical appointments. For example, we found the electronic wait list was not always used to track new patients that needed medical appointments as required by VHA scheduling policy, putting these patients at risk for delays in care. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. At that time, VAMCs also described other problems with scheduling timely medical appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler and provider staffing, and issues with telephone access. For example, officials at all VAMCs we visited in 2012 reported that high call volumes and a lack of staff dedicated to answering the telephones affected their ability to schedule timely medical appointments.

VA concurred with the four recommendations included in our December 2012 report and has reported continuing actions to address them.

- First, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to improve the reliability of its outpatient medical appointment wait time measures. In response, VHA officials stated that they implemented more reliable measures of patient wait times for primary and specialty care. In fiscal years 2013 and 2014, primary and specialty care appointments for new patients have been measured using time stamps from the VistA scheduling system to report the time elapsed between the date the appointment was created—instead of the desired date—and the date the appointment was completed. VHA officials stated that they made the change from using desired date to creation date based on a study that showed a significant association between new patient wait times using the date the appointment was created and self-reported patient satisfaction with the timeliness of VHA appointments.⁴¹ VA, in its FY 2013 Performance and Accountability Report, reported that VHA completed 40 percent of new patient specialty care appointments within 14 days of the date the appointment was created in fiscal year 2013; in contrast, VHA completed 90 percent of new patient specialty care appointments within 14 days of the desired date in fiscal year

⁴¹Prentice, Julia C., Michael L. Davies, and Steven D. Pizer, "Which Outpatient Wait-Time Measures Are Related to Patient Satisfaction?" *American Journal of Medical Quality*, (Aug. 12, 2013), accessed June 4, 2014, <http://ajmq.sagepub.com/content/early/2013/07/31/1062860613494750.abstract>.

2012. VHA also modified its measurement of wait times for established patients, keeping the appointment desired date as the starting point, and using the date of the pending scheduled appointment, instead of the date of the completed appointment, as the end date for both primary and specialty care. VHA officials stated that they decided to use the pending appointment date instead of the completed appointment date because the pending appointment date does not include the time accrued by patient no-shows and cancelled appointments. In a June 5, 2014 statement from the Acting Secretary, VA indicated that it is removing measures related to the 14-day performance goal from VISN and VAMC directors' performance contracts.

- Second, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure VAMCs consistently implement VHA's scheduling policy and ensure that all staff complete required training. In response, VHA officials stated that the department was in the process of revising the VHA scheduling policy to include changes, such as the new methodology for measuring wait times, and improvements and standardization of the use of the electronic wait list. In March 2013, VHA distributed guidance, via memo, to VAMCs describing this information and also offered webinars to VHA staff on eight dates in April and May of 2013. In June 2014, VHA officials told us that they were in the process of further revising the scheduling policy, in part to reflect findings from VA's system-wide access audit, and planned to issue a memo regarding new scheduling procedures at a future date. To assist VISNs and VAMCs in the task of verifying that all staff have completed required scheduler training, VHA has developed a database that will allow a VAMC to identify all staff that have scheduled appointments and the volume of appointments scheduled by each; VAMC staff can then compare this information to the list of staff that have completed the required training. However, as of June 2014, VHA officials have not established a target date for when this database would be made available for use by VAMCs.
- Third, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources. VHA officials stated that they are continuing to work on identifying the best methodology to carry out this recommendation, but stated that the database that tracks the volume of appointments scheduled by individual staff also may prove to be a viable tool to assess staffing needs and the allocation of resources. As of June 2014, VHA officials stated that they are continuing to address this

recommendation including through internal and external discussions taking place in May and June 2014 regarding VHA scheduling policy.

- Finally, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure that VAMCs provide oversight of telephone access, and implement best practices to improve telephone access for clinical care. In response, VHA required each VISN director to require VAMCs to assess their current telephone service against the VHA telephone improvement guide and to electronically post an improvement plan with quarterly updates. VAMCs are required to routinely update progress on the improvement plan. VHA officials cited improvement in telephone response and call abandonment rates since VAMCs were required to implement improvement plans. Additionally, VHA officials said that the department has contracted with an outside vendor to assess VHA's telephone infrastructure and business process and was reviewing the findings from the first vendor report in June 2014.

Although VA has initiated actions to address our recommendations, we believe that continued work is needed to ensure these actions are fully implemented in a timely fashion. Our findings regarding incorrect use of the desired date in the scheduling system and the electronic wait list are consistent with VHA's recent findings from its system-wide access audit, indicating continued system-wide problems that could be addressed, in part, by implementing our recommendations. Furthermore, it is important that VA assess the extent to which these actions are achieving improvements in medical appointment wait times and scheduling oversight as intended. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

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

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The CHAIRMAN. Mr. Matkovsky, you are now recognized for 5 minutes, and I understand you don't have prepared comments, but you are prepared to make some comments.

Mr. Matkovsky. That is correct, sir.

The CHAIRMAN. You are recognized for 5 minutes.

ORAL STATEMENT OF PHILIP MATKOVSKY

Mr. Matkovsky. Good evening, Chairman Miller, Ranking Member Michaud, and members of the committee. No veteran should have to wait unreasonable time for their care. They have earned this care, Americans—America's veterans deserve better. Secretary Shinseki and Acting Secretary Gibson have stated that we now know that within some of our healthcare facilities there are systemic and totally unacceptable lack of integrity. This is a breach of trust. It is irresponsible. It is indefensible, and it is unacceptable.

I apologize to our veterans, their families, and their loved ones, Members of the Congress, Veteran Service Organizations, our employees, and the American people. After this committee raised the issues in Phoenix at the VA healthcare system in mid April, Secretary Shinseki directed a nationwide audit. I will be talking about that audit tonight and answering some detailed questions.

This audit visited over 700 locations, involved over 400 of our national and field staff at the senior executive level, senior manager level, and frankly, line management level. We interviewed over 3,700 frontline staff members. We saw this as the opportunity, the opportunity for us to set a reset, to sweep away and establish a clear-eyed assessment of our actual performance, not our reported performance, and to establish a system-wide understanding of the change we needed to realize in our agency.

We released our results this morning on all VA medical centers, all CBOCs, most mid and small CBOCs, and these results from this audit confirm the OIG interim report, our May 3rd initial release, and frankly, the GAO studies. I am here to answer questions about this audit and other concerns.

Our audit revealed a number of things: Number one, we have hardworking staff on the front line, who work at a high-stress complicated environment with, quite frankly, completely outdated technology. The most frequent challenges cited by our staff are, frankly, a lack of appointment slots into which to schedule veterans. They have a difficulty understanding our policies, and they rely on an antiquated system that requires numerous workarounds by well-intentioned staff. I have to admit that unfortunately we found that our staff were—had received instructions to enter a date other than the date a veteran wanted to be seen. We know there is an integrity issue here among some of our leaders. We can and will address this issue.

I want to make a comment about reprisals against employees. Acting Secretary Gibson had mentioned this that it is not tolerated in our system. We need our staff at all levels but, most importantly, at the point of care. We need them to tell us how to improve our system to be able to deliver care better for veterans, and they

must feel safe to identify problems, and they must feel empowered to find solutions.

Acting Secretary Gibson has announced immediate actions. We will expand and create new veteran satisfaction surveys for patient care. We will begin with veterans and their perspectives. We are holding senior leaders accountable. All of our senior leaders in the field over the next 30 days are expected to inspect their practices in their facilities and to be personally accountable for the integrity of those practices.

We removed the 14-day scheduling goal from employee performance plans. We are increasing the transparency in the reporting of our data, and we will be releasing our access and timeliness data bimonthly from here on out.

Acting Secretary Gibson also announced an independent external audit of the integrity of our scheduling metrics. We are deploying a team to Phoenix to fix all aspects, not just their scheduling and access management practices, and we are formalizing a process for those high performing sites in both quality access and integrity to be able to provide guidance and leadership to our staff and facilities at facilities that require support. We have directed staff to Phoenix to hire additional staff, to bring in temporary clinical staff, to bring in mobile medical units that are currently on the ground, to increase local contracts to include for primary care, and we are removing leadership where appropriate.

We are going to—we have, I'm sorry, suspended all SES performance awards for fiscal year 2014 for VHA, and we are freezing hiring for VISN and VACO staff so that we may focus our HR hiring efforts on bringing on needed clinical engineering and administrative staff to the field.

Secretary Gibson will travel to a series of VA facilities over the next few weeks to meet with veterans, their families, employees, and to identify obstacles to timely quality health care. Secretary Gibson has said that we must restore America's trust in VA healthcare system, and we must restore that one veteran at a time. Our dedicated workforce, over a third of whom are veterans, are engaged.

Mr. Chairman, thank you for your dedication to and your care for our Nation's veterans.

STATEMENT OF RICHARD GRIFFIN

Mr. Griffin. Chairman Miller, Ranking Member Michaud, and members of the committee, thank you for the opportunity to testify tonight to discuss the interim results of the Office of Inspector General's work related to delays in care at the Phoenix healthcare system. I'm accompanied by Ms. Linda Halliday, assistant inspector general for audits and evaluation.

The issue of manipulation of wait lists is not new to VA, and since 2005, the OIG has issued 18 reports that identified at both the national and local level deficiencies in scheduling resulting in lengthy wait times and a negative impact on patient care. We are using our combined expertise in audit, healthcare inspections and criminal investigators to conduct a comprehensive review requiring an in-depth examination of many sources of information, necessi-

tating access to records and personnel both within and external to VA.

We are charged with reviewing the merits of many allegations and determining whether sufficient factual evidence exists to hold VA or specific individuals accountable on the basis of criminal, civil, or administrative laws and regulations. Veterans who utilize the VA healthcare system deserve quality care and timely care. Therefore, it's necessary that information relied upon to make mission critical management decisions regarding demand for vital health care services must be based on reliable and complete data throughout VA's health care networks.

To date, we have ongoing or scheduled work at 69 VA medical facilities and have identified instances of manipulation of VA data that distort the legitimacy of reported waiting times. When sufficient credible evidence is identified supporting a potential violation of criminal law, we are coordinating our efforts with the Department of Justice. Our work to date has substantiated serious conditions at the Phoenix healthcare system. We identified about 1,400 veterans who did not have a primary care appointment but were appropriately listed on the Phoenix electronic wait list. However, we identified an additional 1,700 veterans who were waiting for a primary care appointment but were not on the electronic wait list.

We reviewed a statistical sample of 226 Phoenix appointments for primary care in fiscal year 2013. VA national data, which was reported by Phoenix, showed these 226 veterans waited, on average, 24 days for their first primary care appointment, and only 43 percent waited more than 14 days. However, our review showed that those 226 veterans in our sample waited on average 115 days for their first primary care appointment with approximately 84 percent waiting more than 14 days.

We did not report the results of our ongoing clinical reviews in our interim report as to whether any delay in scheduling a primary care appointment resulted in a delivery or a delay in diagnosis or treatment, particularly for those veterans who died awaiting care. The assessments needed to draw any conclusions require analysis of VA and non-VA medical records, death certificates, and autopsy results. We've made request to appropriate state agencies and have subpoenaed—subpoenas to obtain non-VA medical reports. All of these records will require a detailed review by our clinical teams.

While we make recommendations to the VA in our final report, we made four recommendations to the VA Secretary for immediate implementation to ensure veterans receive appropriate care. We will address the sufficiency of VA's implementation of these recommendations in our final report.

Our recommendations include taking immediate action to review and provide appropriate health care to the 1,700 veterans identified not listed on the waiting list at Phoenix and to take the same action at all facilities in the VA system.

Mr. Chairman, this concludes my statement, and Ms. Halliday and I will be pleased to answer any questions.

The CHAIRMAN. Thank you very much, Mr. Griffin, for your testimony.

PREPARED STATEMENT OF RICHARD GRIFFIN

Chairman Miller, Ranking Member Michaud, and Members of the Committee, thank you for the opportunity to testify today to discuss the interim results of the Office of Inspector General's (OIG) work related to the delays in care at the Phoenix Health Care System (HCS).¹ I am accompanied by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations.

Background

We initiated this review in response to allegations first reported to the OIG Hotline and expanded at the request of the VA Secretary and the Chairman of the House Veterans' Affairs Committee (HVAC) following an HVAC hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. I want to stress that while our work is not complete, we have substantiated that significant delays in access to care negatively impacted the quality of care at this medical facility.

The issues of manipulation of wait lists is not new to VA and since 2005, the OIG has issued 18 reports that identified, at both the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care. As required by the Inspector General Act of 1978, each of the reports listed was issued to the VA Secretary and Congress and is publicly available on the OIG website. These reports are identified as an appendix to this statement.

Due to the multitude and broad range of issues, we are conducting a comprehensive review requiring an in-depth examination of many sources of information necessitating access to records and personnel, both within and external to VA. We are using our combined expertise in audit, healthcare inspections, and criminal investigations, along with our institutional knowledge of VA programs and operations and legal authority to conduct a review of this nature and scope.

A detailed assessment of the information obtained from Phoenix HCS' medical records and its business practices requires a full understanding of VA's current and historical policies and procedures as well as the current practices, facts, and circumstances relating to these serious allegations. We have and will continue to conduct comprehensive interviews of numerous individuals to evaluate the many allegations, determine their validity, and if appropriate, assign individual accountability. Despite the number of allegations, each individual allegation is nothing more than an allegation. We are charged with reviewing the merits of these allegations and determining whether sufficient, credible factual evidence exists to meet the standards required by applicable laws and regulations to hold VA or specific individuals accountable on the basis of criminal, civil, or administrative law and regulations.

In late April, the OIG assembled a multidisciplinary team comprised of board-certified physicians, special agents, auditors, and healthcare inspectors from across the country to address numerous allegations at Phoenix and other VA medical facilities. Since the Phoenix HCS story broke in the national media, we have received allegations of similar issues regarding manipulated waiting times at other Veteran Health Administration (VHA) medical facilities

through the OIG Hotline, from members of Congress, VA employees, veterans and their families, and the media.

In response, we have opened reviews at other VHA medical facilities to determine whether scheduling practices were in use that did not comply with VHA's scheduling policies and procedures. Clearly, there are national implications associated with inappropriate and non-compliant scheduling practices, including the impact on patient care and a lack of data integrity. Veterans who utilize the VA health care system deserve quality care in a timely manner. Therefore, it is necessary that information relied upon to make mission-critical management decisions regarding the demand for vital health care services must be based on reliable and complete data throughout VA's health care networks.

Our review in Phoenix has focused on two fundamental questions:

- (1) Did the facility's electronic wait list (EWL) purposely omit the names of veterans waiting for care and, if so, at whose direction?
- (2) Were the deaths of any of these veterans related to delays in care?

To address the allegations received thus far and remain prepared to address new allegations at medical facilities throughout VA, we are deploying Rapid Response Teams. We are not providing VA medical facilities advance notice of our visits to reduce the risk of destruction of evidence, manipulation of data, and coaching staff on how to respond to our interview questions. To date, we have ongoing or scheduled work at 56 VA medical facilities and have identified instances of manipulation of VA data that distort the legitimacy of reported waiting times. When sufficient credible evidence is identified supporting a potential violation of criminal and/or civil law, we have contacted and are coordinating our efforts with the Department of Justice.

Our review at the Phoenix HCS includes the following actions:

- * Interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers, management staff, and whistleblowers who have stepped forward to report allegations of wrongdoing.

- * Collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.

- * Obtaining and reviewing VA and non-VA medical records of patients whose death occurred while on a waiting list, or is alleged to be related to a delay in care.

- * Reviewing performance standards, ratings, and awards of senior facility staff.

- * Reviewing past and new complaints to the OIG Hotline on delays in care, as well as those complaints shared with us by members of Congress or reported by the media.

- * Reviewing other documents and reports relevant to these allegations, including administrative boards of investigations or reports of reviews conducted by VHA's Office of the Medical Inspector.

- * Reviewing over 550,000 email messages and documents, extracted from over 50 gigabytes of collected email, and imaging and

reviewing 10 encrypted computers and/or devices, and over 140,000 network files.

Results To Date Regarding Phoenix HCS Allegations

Our work to date has substantiated serious conditions at the Phoenix HCS. We identified about 1,400 veterans who did not have a primary care appointment but were appropriately included on the Phoenix HCS' EWL. However, we identified an additional 1,700 veterans who were waiting for a primary care appointment but were not on the EWL. Until that happens, the reported wait time for these veterans has not started. Most importantly, these veterans were and continue to be at risk of being forgotten or lost in Phoenix HCS's convoluted scheduling process. As a result, these veterans may never obtain a requested or required clinical appointment. A direct consequence of not appropriately placing veterans on the EWL is that the Phoenix HCS leadership significantly understated the time new patients waited for their primary care appointment in their FY 2013 performance appraisal accomplishments, which is one of the factors considered for awards and salary increases.

We reviewed a statistical sample of 226 Phoenix HCS appointments for primary care in FY 2013. VA national data, which was reported by Phoenix HCS, showed these 226 veterans waited on average 24 days for their first primary care appointment and only 43 percent waited more than 14 days. However, our review showed that those 226 veterans in our sample waited on average 115 days for their first primary care appointment with approximately 84 percent waiting more than 14 days. At this time, we believe that most of the waiting time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created. However, we found that in at least 25 percent of the 226 appointments reviewed evidence in veterans' medical records indicates that these veterans received some level of care in the Phoenix HCS, such as treatment in the emergency room, walk in clinics, or mental health clinics.

Our reviews have identified multiple types of scheduling practices that are not in compliance with VHA policy. Since the multiple lists we found were something other than the official EWL, these additional lists may be the basis for allegations of creating "secret" wait lists. We did not report the results of our clinical reviews in our interim report on whether any delay in scheduling a primary care appointment resulted in a delay in diagnosis or treatment, particularly for those veterans who died while on a waiting list. The assessments needed to draw any conclusions require analysis of VA and non-VA medical records, death certificates, and autopsy results. We have made requests to appropriate state agencies and have issued subpoenas to obtain non-VA medical records. All of these records will require a detailed review by our clinical teams.

Lastly, while conducting our work at the Phoenix HCS our onsite OIG staff and OIG Hotline received numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. We are assessing the validity of these complaints and

if true, the impact to the facility senior leadership's ability to make effective improvements to patients' access to care.

Recommendations

While we will make recommendations to the VA Secretary in our final report, we made four recommendations to the VA Secretary for his immediate implementation to ensure that veterans receive appropriate care. We will address the sufficiency of the VA Secretary's implementation of these recommendations in our final report. We recommended that:

(1) The VA Secretary take immediate action to review and provide appropriate health care to the 1,700 veterans we identified as not being on any existing wait list.

(2) The VA Secretary review all existing wait lists at the Phoenix Health Care System to identify veterans who may be at greatest risk because of a delay in the delivery of health care (for example, those veterans who would be new patients to a specialty clinic) and provide the appropriate medical care.

(3) The VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition.

(4) The VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility's electronic waiting list.

We have provided VA with the list of the 1,700 veterans we identified as not being on any wait list so that VA can mitigate any further access delays to health care services, and deliver higher quality of health care.

Conclusion

Our work continues in Phoenix on the many allegations related to that facility. Our work also is ongoing in many other locations. Our reviews at this growing number of VA medical facilities have thus far provided insight into the current extent of these inappropriate scheduling issues throughout the VA health care system and have confirmed that inappropriate scheduling practices are systemic throughout VHA. One challenge in these reviews is to determine whether these practices exist currently or were used in the past and subsequently corrected by VA managers. We will work diligently to complete our work and publish the results in August.

Mr. Chairman, that concludes my statement, and Ms. Halliday and I would be pleased to answer any questions that you or the Committee may have.

OIG Oversight Reports on VA Patient Wait Times

1. Audit of the Veterans Health Administration's Outpatient Scheduling Procedures (7/8/2005)

2. Audit of the Veterans Health Administration's Outpatient Waiting Times (9/10/2007)

3. Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3 (5/19/2008)

4. Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments (12/4/2008)

5. Healthcare Inspection09Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma (2/2/2009)

6. Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program (8/3/2009)

7. Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center (8/17/2010)

8. Healthcare Inspection09Delays in Cancer Care West Palm Beach VA Medical Center West Palm Beach, Florida (6/29/2011)

9. Healthcare Inspection09Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia (7/12/2011)

10. Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System (11/8/2011)

11. Healthcare Inspection09Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas (1/6/2012)

12. Review of Veterans' Access to Mental Health Care (4/23/2012)

13. Healthcare Inspection09Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas (8/22/2012)

14. Healthcare Inspection09Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington (9/25/2012)

15. Healthcare Inspection09Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas (10/23/2012)

16. Audit of VHA's Physician Staffing Levels for Specialty Care Services (12/27/2012)

17. Healthcare Inspection09Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia (4/17/2013)

18. Healthcare Inspection09Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina (9/6/2013)

1 Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System (May 28, 2014).

The CHAIRMAN. Members, we will all do a round of questions at 5 minutes apiece, and we will do a second round, I'm sure, after the first round.

Dr. Draper, in your comments, you said that 43 percent of the consults you reviewed were closed without the veterans being seen. Can you give me an explanation as to why the care wasn't provided?

Ms. Draper. There are various reasons. One is patient no shows, canceled appointments, and this is canceled either by the patient or the medical center, and we also found instances of, you know, some records we couldn't tell. We looked at it, and there was no documentation as to why the consults were closed.

The CHAIRMAN. Mr. Matkovsky, how does VA schedule appointments? Is it through a telephone call to the veteran, or is it by a letter?

Mr. Matkovsky. It is typically through a telephone call with the veteran. The veteran may call us. We may call the veteran. We will notify the veteran on a recall reminder process, which does involve a letter, sir.

The CHAIRMAN. That's interesting because I've heard numerous veterans tell me that they receive letters telling them when their appointment will be and whether—not asking whether or not they can attend that particular appointment, so I'm a little confused.

Mr. Matkovsky. Sir, I've heard that as well. That is not appropriate. That increases our rate of no-shows. It is not veteran-centric. We need to change that. We should be having a conversation with the veteran asking him or her when they want to be seen and then scheduling around their requirement.

The CHAIRMAN. VA has consistently stated that the alternate list or secret list in Phoenix that was being used to populate the electronic wait list was destroyed immediately after the EWL was populated. So, my question is, was there any independent verification in fact that every veteran on the alternate wait list was successfully transferred to the EWL or can you provide any documentation or assurance to us that no veteran was left off the alternate wait list?

Mr. Matkovsky. I have had a team on the ground, sir, reviewing their practices and their scheduling processes. I have a report that's only their first draft report. I'll get a final report from them, and I'll be able to dig a little bit deeper. At this point in time, I don't have any reason to believe that any veterans were left off the final EWL count, but I will wait for the final report, sir.

The CHAIRMAN. Can you tell the committee who at the central office, if anybody, knew or instructed or coached anybody how to manipulate wait times?

Mr. Matkovsky. I do not know if anyone had done that, sir, and not in my direct experience.

The CHAIRMAN. So you don't know whether they have or they haven't?

Mr. Matkovsky. I certainly hope they have not, sir. That would run counter to our policy.

The CHAIRMAN. I hope they've not either.

Mr. Matkovsky. I certainly hope not.

The CHAIRMAN. In a brief in May of 2009, Dr. Mike Davies, the national director of Systems Redesign indicated there were 49,743 veterans waiting for care as of September 15th of 2008. Now, more than 5 years later, VA's audit shows and has been reported in the media, that it has risen to 57,000 veterans waiting more than 90 days for their first appointment and an additional 64,000 veterans that appear to have fallen through the cracks. How can this be?

Mr. Matkovsky. The correct use of the electronic wait list is number that's 57,000, sir. We use the electronic wait list if we are unable to schedule a veteran who is receiving their first specialty care consult within 90 days. The correct use of that is to ensure that we can work a veteran into an appointment sooner. The 57,000 number is a much more conservative number. The known direct clinical care is only 40,000. We have to get eyes on the EWL. We have to manage it. We have to make sure there are frontline staff

and medical centers are actively working that list, getting veterans from awaiting for an appointment into an appointment.

As for the 64,000, that was new enrollee appointment request list. Mr. Griffin had told us that that was one of the recommendations, that if we could find that in Phoenix, that we should look across the entire country because we had a team review the new enrollee appointment request list, we identified every single veteran from the beginning of the period of enrollment who may have at one point in time requested an appointment at a given facility where they provided their enrollment data. If we could not verify that they had an appointment, we went ahead and added them to the list so that we can begin contacting them tomorrow.

The CHAIRMAN. Mr. Griffin, one final question before I yield to the ranking member. Have you found evidence of criminal activity in your assessment?

Mr. Griffin. We have found indications of some supervisors directing some of the methodologies to change the times. We have been in discussion with the Department of Justice concerning those and whether or not in the opinion of the Department of Justice they rise to the level of criminal prosecution is still to be determined in most instances.

The CHAIRMAN. I appreciate you talking with the Department of Justice. The committee has written a letter to them also asking that they open an investigation. We haven't heard anything from them to date other than the fact that they got our letter, but I appreciate it.

Mr. Michaud.

Mr. Michaud. Thank you very much, Mr. Chairman.

Dr. Draper, in follow up on a question the chairman asked about the VA closed consultants due to no-shows, what percentage were no-shows versus the VA canceling?

Ms. Draper. Well, for the 150 cases that we looked at, we found that more than half either had a no-show or a canceled appointment, so that's a large percentage of the consults. So it's a big problem for VA. We saw the policies at the local level vary as to how local facilities handle no-shows and canceled appointments.

Mr. Michaud. Okay. Thank you.

Mr. Matkovsky, GAO reports that wait times are generally not tracked for non-VA care. Why don't you track wait times for non-VA care?

Mr. Matkovsky. Historically, sir, we have not, Congressman Michaud. We have two initiatives, both of them in full deployment at this point. The first one is for non-VA care coordination. Effectively, what is occurring now, is when we refer a veteran to care in the community if we cannot provide it, it creates an appointment inside a clinic that allows us to monitor that and watch that appointment. We are now collecting timeliness data on that.

We also have a nationwide contract called "Patient-Centered Care in the Community." That contract has a performance requirement from our two contractors that they both schedule and see veterans within 30 days of the referral from us. We think those two approaches will help us in the long run, ensure coordination and management of non-VA care. Dr. Draper also alluded the requirement to manage the coordination of that care. It's not enough just

to refer care into the community. We do need to follow through as well, ensure that the veteran's needs are met, that that non-VA provider is respectfully working with the veteran, her or his family to get into care.

Mr. Michaud. Thank you. The GAO also reports that there is a consistent problem across the VHA with policy and procedures for handling no-shows and canceled appointments. I'm aware that VA—that you are working on an update to this scheduling policy. When do you anticipate this revised policy to be released, and will it address the no-show consistently throughout the VA system and canceled appointments?

Mr. Matkovsky. I expect it will, sir. We had a team last week reviewing the existing policy we have today and to determine whether or not we should rescind that policy and replace it with a clear declarative set of instructions for schedulers in the frontline, we expect to take that action. We will replace that policy with a revised policy that allows us to have much more concrete sets of instructions on how to schedule, specific instructions for what to do for staff if we're scheduling within 90 days, what to do on day 91 to actually offer that specific instruction and tie that policy to training.

A lot of our current policy mixes two concepts, scheduling and practice management, and we're going to have to make sure that we have a clear scheduling policy and a clear practice management policy. Management of no-shows can be handled by contacted veterans, working with veterans to ensure that they're reminded of their appointment, frankly, making sure we talk to veterans and their families when we schedule their appointment. When we do those things, we can reduce our no-shows.

Mr. Michaud. Great. Can you explain to what extent exercising non-VA care requires additional approvals?

Mr. Matkovsky. Yes, sir. In some of our medical centers, they require approval at the chief of staff level to use non-VA medical care. As part of accelerating care, we worked on that in the, I think the second to last week of May. We worked on the plan May 21st and rolled it out May 22nd and began execution on the 23rd of May. We have released instructions to the field that particularly where we have confidence in our wait time data, that the field is required, if they cannot offer that care in the VA facility, first they must assess their capacity, increase their capacity by running nighttime clinics, overtime, weekends, and if they cannot, then they are instructed to offer non-VA care to the veteran, and then we've asked them to tell us what do you need in terms of resources to make that work.

So, we are providing a different set of instructions to work with the veteran. It is a veteran's choice to get timely care and to make sure we offer it.

Mr. Michaud. Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Lamborn, you are recognized for 5 minutes.

Mr. Lamborn. Thank you, Mr. Chairman. I appreciate the work you're doing on this issue.

One of the areas that is going to have to get further review is in Colorado Springs, Colorado, and there are three anonymous whistleblowers who have come forward and said that there are

problems with manipulating waiting times. And I have talked to the leadership in both Denver and Colorado Springs. They have told me personally that this is not going on, and I believe them, but at the same time, we have whistleblowers saying that it is going on.

Mr. Matkovsky, how does the VA treat whistleblowers? And what I'm getting at is, there is intimidation taking place. How do we change the culture from intimidation to where people are free to step forward?

Mr. Matkovsky. Part of how we design this audit was to have direct access to the frontline from our senior staff. When our auditors went to the field, they met at the same time with union representation at the field and facility management. Not two separate meetings, one meeting. We did not provide advance announcement of who we wanted to interview. We provided that when we showed up so we could have a direct conversation.

I will tell you, I have read through the open-ended comments of all of the responses that I could, and nothing, nothing saddened me more than an employee who says I was trying to do it right, I know it is right, and I received instruction to do it wrong. That is just simply not tolerable. Retaliation against whistleblowers is also not tolerable. We cannot condone that. We require a leadership and cultural shift in our way of managing.

Mr. Lamborn. And I raised this a couple of weeks ago in our last late night hearing, and that is, if you can't rely on the data, if you can't rely on the records because secret waiting lists, by their nature, are meant to conceal the truth from someone who is doing a review, like yourselves. Does the alternative to go in and do a case-by-case analysis, talking to every single veteran who tried to get an appointment and doing this on a one-by-one, even if that takes hundreds of thousands of contacts, how do we get to the bottom of it when the records or the reports are not reliable?

Mr. Matkovsky. I believe we have to begin with the end in mind. If what we want to do is to provide veterans with timely quality healthcare, let's ask them. How are we doing? How's our care? How's our access? Is our access meeting your requirements? Is it not? If not, let's fix it.

The thing that's terrible about this crisis is this isn't even an output measure, right. It's an activity measure. And what happens when we change that activity measure is we can't tell where we're not timely. If we can't tell where—in no cases were we finding frontline staff who were delaying care by moving the appointment later in the calendar. They were changing the reference point. When that happens, we don't know where we're late. When we don't know where we're late, we can't identify where we need resources or to realign resources, and when we don't know that, our entire system of requesting for resources is thrown off.

Mr. Lamborn. And Mr. Matkovsky, I hope we've seen the final days and never again where bonuses or promotions are based on metrics that can be manipulated instead of like you mentioned, and I've mentioned this before and others have also: Outcomes like patient satisfaction or good care that can be documented, not metrics that can be manipulated.

Mr. Matkovsky. I concur.

Mr. Lamborn. And do either of you other two folks want to comment on that issue? Mr. Griffin.

Mr. Griffin. I think it comes down to accountability of the senior leadership out at these facilities, and once someone loses his job or gets criminally charged for doing this, it will no longer be a game, and that will be the shout heard around the system.

Mr. Lamborn. Thank you.

I yield back.

The CHAIRMAN. Ms. Brown, you are recognized for 5 minutes.

Ms. Brown. Thank you, Mr. Chairman. Mr. Chairman, thank you for having this hearing, and colleagues, I want to make sure that we are firing at the right target here tonight. We're all on this committee because we care about the veterans. You can be sure the only reason why I'm on this committee is I care about the veterans, and I've been on this committee for 22 years, and so I have a couple of questions.

Dr. Draper, you mentioned—and I want to thank you for your service—but the case that you gave about outsourcing that particular case and it wasn't the right kind of coordination, can you expound on that a little bit more because a lot of people want to see us partner with veterans if they can't get their service right away.

Ms. Draper. Yeah, I think it's an important point because, you know, there is a lot of talk of sending more veterans out to the community for care, and while that is a way to expand capacity, as I mentioned, there are some pitfalls because VA does need to do a better job of monitoring wait times, managing the coordination, and just making sure that the veteran actually receives the care that he or she is going out to the community for, and that was why we illustrated this particular case. On many points, coordination did not happen and the veteran waited a long time and ultimately died waiting for care.

Ms. Brown. I have a question about the survey because a lot of veterans tell me and a lot of discussion, once they get into the system, they think the system is the best. No complaints about once they get in. Can you—both of you, can you expound upon that? And a lot of the specialties that is involved in the VA is not necessarily out in the community. I mean, we are the cutting edge as far as different kinds of technology, working with their unique ailment.

Ms. Draper. I would say, in my experience, and reviewing various VA facilities, I think there is variation among facilities. There are some that are very, very good and some that are more problematic, so I think it's not consistent across all VA facilities, the quality of care.

Mr. Matkovsky. Congresswoman Brown, I think we have a good system. It is not the best it can be. The system belongs to veterans and their families. We are a system that is designed to understand their need, to work for them, and on the frontline, you find our staff are so engaged. I think their passion is unequal.

Ms. Brown. What the percentage of the staff who are veterans that work at the VA?

Mr. Matkovsky. Over one-third of our staff are veterans themselves. It's a matter of making sure, however, that we have integrity in the system so that we can identify where access is not work-

ing. It's not okay anymore, with all due respect, to say it's great care when you can get it. It must be that it is great care, and you can get it.

Ms. Brown. Timely, I guess that's—

Mr. Matkovsky. Timely.

Ms. Brown.—the key.

Mr. Griffin, any comments about—one of the problems, it seems, is that a lot of the equipment, the technology that the veterans have is outdated, you know, the computer systems and the different systems. Could that affect part of the schedule problems that we're identifying?

Mr. Griffin. Absolutely. Going back to 2005 on the audits that we've done, one of the recommendations has been that they needed to have an automated capability to review wait times remotely. A lot of money has been wasted. Millions of dollars have been wasted on contractors trying to create a better system for capturing this data, and over the past 15 years, going back to 2000, it hasn't had any success.

Mr. Matkovsky. If I may, Congresswoman—

Ms. Brown. Yes.

Mr. Matkovsky.—Brown, it's important to understand that our scheduling system scheduled its first appointment in April of 1985. It has not changed in any appreciable manner since that date.

Ms. Brown. What about the equipment that I'm asking you about, the technology. I mean, we've had lots of meetings about technology. Even people coming into the system, you know, we brought in the banking community to make sure that people can't go in and—what do they call it, steal your identity. So, I mean, that's part of the system also; is that correct?

Mr. Matkovsky. It is. So we have—some systems are evolving and are improving. We have a new Veterans Health Identification card, which has removed the Social Security number from the bar code and the magnetic stripe. That has been a good change. But I think across the board, if you look at our engineering systems, our facilities management systems, our building systems, our scheduling systems, our administrative systems, these are old systems that in many cases date 20 and 30 years ago, before the Internet. I was still in college. You know, these are old systems.

Ms. Brown. Yes, sir. Well, thank you all, all for your service, and I'm looking forward to round two.

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

Mr. Bilirakis, you are recognized for 5 minutes.

Mr. Bilirakis. Thank you, Mr. Chairman.

Again, thank you for holding the hearing. I have a question, and I know Mr.—I want to follow up on Mr. Michaud's question. This is for Mr. Matkovsky, and as Mr. Michaud said, in GAO's testimony, it was stated there were no detailed systemwide VHA policies on how to handle patient no-shows and cancellations. Are you aware of any department-wide policy for cancellations, Mr. Matkovsky?

Mr. Matkovsky. We do actually have—in our directive, we do actually have policies for managing no-shows and cancellations, and we also have a policy that is supposed to guide our staff on how

to manage veteran appointments and communicate with veterans and their families to minimize the challenges—

Mr. Bilirakis. Well, describe that policy briefly. I don't have a lot of time but—

Mr. Matkovsky. Okay. So, for instance, if we have a veteran who has once not shown up for an appointment before or has repeatedly not shown up for an appointment before, we have a no-show list that allows us to contact veterans, and that's actually part of our policy, and sites are supposed to be implementing it. We need to do a better job of training, following up, and ensuring that that practice is performed.

Mr. Bilirakis. Well, I agree with that. I hear about the long wait times. I just—I had a town meeting last week, but I meet with veterans frequently through our town meetings. And one of the complaints, of course, is the wait times. Everybody knows about that.

Missed appointments, for example, the veteran gets the appointment finally, and maybe through no fault of their own, they can't make the appointment, maybe an illness or maybe somebody just forgot, and then they have to wait another 2 months, for example, for an appointment. Let me ask you this question, I think, because that's a huge problem. Is there any input? I mean, I hear about the lack of communication between let's say the schedulers. You can call over and over and over again. Does the veteran have input on when that appointment might be? You know, for example, they could have a conflict, a family conflict, medical conflict, what have you.

Ms. Draper. Could I answer that?

Mr. Bilirakis. Yeah, because that was an issue with the case that you cited.

Ms. Draper. It is, and I wanted to elaborate a little bit more on the no-shows. I mean, part of the issue is that VA needs to better understand why the no-shows and cancellations are happening, and part of it is, a pretty good percentage of schedulers are engaged in what is termed "blind scheduling," so they schedule appointments without being in contact with the veteran. The veteran receives the appointment through the mail, and sometimes it may not be convenient or it could be that the letter was received after the date the appointment actually was scheduled for, and then we also see that, sometimes the VA contact information is bad so the veteran may never receive that appointment notice.

So there's a lot of factors that go into the no-show and cancellations.

Mr. Bilirakis. Have you ever asked the question of the veteran, how would he or she prefer to get this information with regard to appointments?

Mr. Matkovsky. We need to improve the ways that veterans can see their appointments, manage their appointments and, frankly, ask for appointments. We need to make that an integral part of our online system for My HealtheVet. We do have a patient self-scheduling application, which we are trying to roll into a state of production, but frankly, it just starts with the phones, you know, pick up the phone, call repeatedly, and talk to a veteran and find out their preference and then schedule.

Mr. Bilirakis. Thank you.

And again, the My HealthVet is—it's a great thing to have, but again, that should be in addition to the personal contact, and of course, a lot of—some people don't have access to a computer either, so—let me ask you one more question. I know I don't have a lot of time.

Again, with regard to the wait list. In the hearing this committee held on May 28th, 2014, members of this committee repeatedly, and I know I asked, who authorized the destruction of the interim electronic wait list? However, Dr. Lynch maintained that it was protocol for when the appointments were canceled. If there is no department-wide process for no-shows or cancellation—now, you stated there is, but what was he referring to?

Mr. Matkovsky. I don't know specifically. I have not been on the ground in Phoenix myself. I do know that one of the things they were working on was to try to move appointments sooner, and what they may have been doing, which he referenced, I believe, in his comments, was printing, rescheduling, and then shredding the evidence because it contains personally identifiable information. I think that's what he referenced, sir.

Mr. Bilirakis. All right. I will continue to ask some questions.

Thank you very much, and I yield back.

The CHAIRMAN. Thank you, Mr. Bilirakis.

Mr. Takano, you are recognized for 5 minutes.

Mr. Takano. Thank you, Mr. Chairman.

For Mr. Griffin or Mr. Matkovsky. In your investigations and audits, did you identify any sort of pattern when looking at wait times and scheduling practices? And what I mean by this is, are there some types of facilities better or worse than others? Are wait times longer for certain types of care, primary care versus certain specialty care, for instance?

Mr. Griffin. I would say one of the principal methodologies that we have witnessed is a veteran calling in for an appointment, he gets an appointment 120 days out because that's the first available appointment at that facility, and then that appointment gets scored as the desired date of the veteran, and therefore, zero waiting days. The vast majority of the cases that we have seen involve that scenario.

The other scenario would be you get that appointment 120 days out. Two weeks before the appointment, it gets canceled in the system, and then it gets recreated; veteran is no wiser for the fact that his appointment was canceled because it's recreated for the same time and date, but once again, it reflects a waiting time which does not reflect the reality of the amount of time that veteran has been waiting for care.

Mr. Matkovsky. Those are similar to what we found as well. I would say in terms of the wait time data for new veterans, we tend to be able to trust that data better because it has a computer date stamp in it. It's not perfect, but it's better. We do find specialty care has longer waits among those veterans, and then we also note wait times in primary care.

RPTS JOHNSON & DCMN ROSEN, [8:25 p.m.]

Mr. Takano. Thank you. That was a very clear illustration of sort of the pattern. Can you tell me, so in Phoenix, there was both wait

times of this nature for both primary and specialty care? I mean, I saw that the primary care numbers were——

Mr. Matkovsky. We did see a significant count for primary care. There are a number of veterans on the electronic wait list waiting for primary care appointments. What will typically happen is you will then see a subsequent demand for specialty care. So as we are bringing in resources for primary care, we are also very cognizant of the fact that we are going to require to address specialty care in Phoenix, sir.

Mr. Takano. Well, I don't want—in my question I don't want to excuse at all the manipulation of the wait times. That is not the point of my questioning. But I want to ask you if, from your data and your audits, are you able to comment on whether there is an underlying shortage of providers? You mentioned a scarcity of appointment slots. How much of that is attributable to a shortage of providers and how much is that attributable to maybe inefficiencies in the way the facilities operate?

Mr. Matkovsky. I think we have to check them both. I think that in some cases we have provider shortages, but I think, frankly, we owe it to the American taxpayers to run an efficient system as well. So we have to look at productivity data and we have to look at the amount of time in clinics serving veterans. But I think it is both.

Mr. Takano. Mr. Griffin?

Mr. Griffin. If I may, I think an integrated health system is the best system for veterans who have multiple conditions that they need care for. The further you dilute the locations where that care is provided, the greater chance of the care not getting properly reflected back in the medical record, the greater chance that that particular provider for that one instance of fee care may or may not be fully aware of all the other conditions that the veteran is facing.

So I think what it is about is the business process of return on investment for getting your own doctors who are committed to the VA mission, who are full-time employees at VA, as opposed to the \$4.8 billion in fiscal year 2013 that we spent for fee care. I think there just has to be a strategic analysis of what, in the long run, is going to be the best outcome for veterans. And it is something that has to be continual, because you will have a different mix of conditions from one facility to the next.

Mr. Takano. Along those lines of the integrated care question, is there a pattern in your research to the quality of care related to whether or not a VA facility is affiliated with a university hospital?

Mr. Matkovsky. I don't think so. I mean I think our affiliate hospitals tend to be the more complex hospitals, and will have a more complex set of services available to veterans. But we have some of our highly rural unaffiliated hospitals that also wind up being top performers in health care industry rankings.

Mr. Takano. Thank you. My time is up.

The CHAIRMAN. Thank you very much, Mr. Takano. Dr. Roe, you are recognized for 5 minutes.

Mr. Roe. Thank you, Mr. Chairman. Last week during the recess, I had an opportunity to do something that was very personal to me as a Vietnam era veteran. I went to Vietnam. And we talked to the folks there that were looking for our 1,200 MIAs. And quite frankly, I think we owe it to the honor of those who didn't return to pro-

vide for those who did. And we are not doing a very good job of that right now. And one of the things I think the problem with the VA system is is that the financial incentives are lined up to not provide the care. Let me give you an example. In no shows, for instance, when that's a problem with a consult, in our office, when we had patients who were supposed to come in as a consult, not a regularly scheduled patient, we had ways to check for those folks. Because if they didn't show up, they took up a slot that we couldn't fill with somebody else. There is no penalty when somebody does that at the VA. That is just free time.

And I will give you an example. I am looking here at a medical center that saw 68,796 patients. That was an entire medical center. Our practice of 10 doctors saw 40,000 patient visits in a year. So I think part of it, as Mr. Matkovsky, you said is productivity, it is the incentives to make sure that when you have a consult on there you consult that. As Mr. Bilirakis just said, I don't just put a patient on my list when I am seeing a patient in my office and say show up. I find out is it convenient with you, the baby-sitter, maybe my wife is sick. There are lots of reasons. And you can call—there is a thing called a telephone you can pick up and call somebody. And Mr. Jones, are you going to be able to keep your appointment next week at 10 o'clock? Those are simple things. It doesn't require computers, it requires just a human being and a personal touch to check with that person.

I can tell you they appreciate it. The patients appreciate it. And they will keep their appointments if you do that. When you make something for me in September, I may forget about it. By then I have 10 other things to do. And I think that is part of the problem right there. Again, the financial incentives, and then just making them so far out. And I guess a question, Dr. Draper, I have for you, did you all notice any particular kind of consult? Because I think, you know, there are areas, for instance maybe in cardiology you have enough, but rheumatology, maybe neurology, those are very difficult positions to fill anywhere. Did you notice a difference in the type of consult?

Ms. Draper. We looked at three specialty areas: Gastroenterology, physical therapy, and cardiology. And we heard from the VA medical center officials, particularly in the areas of physical therapy and gastroenterology, the demand did not keep pace with the number of providers that they had. So the demand kept increasing, and VA really didn't have the providers to always take care of the patients or fill the slots.

Mr. Roe. So didn't matter which type. I thought it probably did.

Ms. Draper. And we didn't look at all specialties, but those were the three that we did look at.

Mr. Roe. Okay. Mr. Matkovsky, one question I had, is how much is your pay for performance—I asked this last week or the week before last—when you are evaluated as a senior person at the VA, is your pay for performance related to how many veterans are sent out in the private sector along with the wait times? Is that part of it? No one could give me an answer.

Mr. Matkovsky. I don't believe it is, sir.

Mr. Roe. Okay. That is fine. If it is not, it is not. And also Mr. Griffin, you know for me personally, I know the chairman asked

this question about the potential, when you have put a system in place that fraudulently puts information out there, and then you gain financially from the taxpayers, that would seem to me to be a fraudulent case. I am just simply looking at it as—I am not a lawyer—I am just simply looking at it as a layman. When you have gone out there and on purpose misled, knowing that you would get a financial bonus if you did that, which is exactly what is happened, is that—is that fraud? I think it is.

Mr. Griffin. I agree. The issue is you start with the GS-5, GS-6 schedulers, who have many, many layers above them before you get to the top leadership of the facility. So you have to work your way back up the supervisory chain to determine who put that order out to do it in this manner. And that is what we are having to do at 69 facilities other than Phoenix right now, with additional facilities reporting in every day. So it is not an easy task. I suspect if people do start getting charged, maybe that middle level person will say wait a minute, I'm not going to take a fall here for somebody higher up the food chain than me who directed that we do this.

Mr. Roe. I certainly don't want to see a scheduler making somebody's appointments head roll and nobody—that is not right. I yield back.

Mr. Griffin. Absolutely.

The CHAIRMAN. Thank you, Dr. Roe. Ms. Brownley, you are recognized for 5 minutes.

Ms. Brownley. Thank you, Mr. Chairman. And thank you again for your leadership on this committee. My first question is to Mr. Matkovsky. I understand that the Acting Secretary has sent a triage team to Phoenix, as you testified, which I wholeheartedly concur with. But after reviewing today's audit numbers and some of that data, it is clear that there are other medical centers across our country who are experiencing similar, or even worse wait times. Greater Los Angeles is a good example of that, whose wait times exceed the wait times in Phoenix. So my question is really about, okay, a triage in Phoenix is good. We need triage elsewhere. What is the plan? When are we going to get to that?

Mr. Matkovsky. I believe we need two things—by the way, thank you, Congresswoman Brownley—but two things. First, we need to reset how we measure so that we know where we are performing well and where we are not with confidence. As part of accelerating care, we looked at wait times that we could assess. We requested medical centers to survey their capacity. We broke it down by clinic, by medical center. We used something called stop codes. So cardiology would be a stop code, a GI would be a stop code. And we have individual wait times for each of those. We were also able to produce the productivity numbers for each one of those clinics, and asked if they had low productivity and wait times to address the productivity concerns. There are a couple ways you can do that. I think I mentioned them. Run a few more clinics per week. Run some evening, run some weekends. And then if you could not find capacity, if you were at capacity, request the resources. If you don't have it and you need it, ask for it. Part of our job as well is to make sure that our staff at all levels can raise the flag. So system-wide, that is what we have done. I think we have, at this point,

identified an additional requirement for \$300 million, the vast majority of it to support the acquisition of health care now. I think those funds are dropping tomorrow morning to the field.

Ms. Brownley. So can you just tell me as a follow-up how you are going to prioritize that? Is there a schedule for that?

Mr. Matkovsky. Yes.

Ms. Brownley. My veterans in Ventura County, the west LA facility is their primary medical facility. I would certainly—this data is now public, as it should be, but the first question my veteran community is going to be asking is when?

Mr. Matkovsky. Tomorrow. And beginning on May 23rd, each medical center with wait times for veterans was requested—directed, I am sorry, to contact veterans after they could determine if we could have additional clinic capacity. If we could not have clinical capacity, and we could acquire care in the community. One of the things we have to be careful about is that there is not an infinite supply of primary, specialty, or mental health care in the community, right? So if we can find the quality health care to purchase in the community, coordinate that care. The next step is to pick up the phone. Call the veteran and ask them when they want to be seen. As of Friday evening, I believe, we had made 50,000 phone calls in the facilities and networks across the country. We want to finish those phone calls. And then we want to move onto the next set of phone calls, working back from wait times as we get closer and closer to what we think is timely care. But that has already started. And we will be tracking, I think beginning this week, the rate of obligations of those funds. So we created specific account codes for the funds, and then we will be tracking in the non-VA care the use of those funds to accelerate care.

Ms. Brownley. And that data you will be sharing with us?

Mr. Matkovsky. I will share that, yes.

Ms. Brownley. Thank you. And you mentioned about—my colleague here also mentioned about having enough personnel and professionals in the system as well to meet the needs. And I know that the Acting Secretary also has ordered a hiring freeze across the VA. And so I want to know what that means. And because it seems to me, you know, we have to, you know, fix this airplane while it is flying, and it seems to me that we should be looking at our hiring practices and hiring as well as addressing some of these other issues that have been broken within the VA.

Mr. Matkovsky. I think we need to look at the time that it takes to hire staff, to recruit, hire, onboard, and credential our staff. I think we have to look at that. But the Acting Secretary's point here is not to restrict us from hiring staff in the field. It is to request that at our network offices and in headquarters we have a hiring freeze. And the point behind that is so that we can dedicate our H.R. resources to hire for the field. At some point in time we may lift that when our H.R. machine is working and we are able to staff for vacancies where we identify them. But we can't be satisfied with having a vacancy and then initiating the recruitment process and allow that to take 6 months.

That means we are running at undercapacity for 6 months in that specialty. We have to change it. We have to hire to budget, make sure that we don't hire or have a conservative resource com-

mittee locally that prevents us from having the clinical resources we had when we set our FTE requirement. The Acting Secretary is not telling us do not hire in the field. What he is telling us is focus.

Ms. Brownley. Thank you. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Brownley. Mr. Flores, you are recognized for 5 minutes.

Mr. Flores. Thank you, Mr. Chairman. I also thank the witnesses for testifying today. Mr. Matkovsky, in your testimony, you referred to something, I think you said high performance facilities, Is that correct?

Mr. Matkovsky. High performing facilities, yes, sir.

Mr. Flores. High performing facilities. How many of those are in the VHA system, and roughly, where are they?

Mr. Matkovsky. We found them in different ways, sir. So we found facilities that have a good handle on access, patient satisfaction. I think the Acting Secretary came back from his visit to San Antonio. And the passion, the mission, the drive, the energy is palpable in some of our facilities. I will tell that you in some cases entire networks we did not find facilities that had integrity issues worth us reviewing. And in some networks, we only had selected instances. So both from an integrity perspective and from a veteran focus perspective we have high performers who get the process right, schedule with integrity, report your wait times with accuracy, find resources where you need them. And we have a number of them.

Mr. Flores. So we have these high performing facilities that have much better outcomes than the other facilities. What is it that makes it different?

Mr. Matkovsky. Culture and leadership, sir.

Mr. Flores. Okay. It is the leadership of the facilities. I am going to move to Dr. Draper. In your reviews of the VHA, did you find similar high performing facilities like Mr. Matkovsky referenced?

Ms. Draper. As I mentioned, we see variation in facilities. I think there are some really excellent facilities and some that seem to struggle. I would agree that part of it is the leadership issue.

Mr. Flores. And Mr. Griffin, did you find—similarly find high performance facilities or teams?

Mr. Griffin. If I could expand a little bit. We have done a couple of reviews of the VISN networks, and we concluded that if you have seen one VISN, you have seen one VISN. It seems like if you have high-performing facilities, whether at the network level or the medical center level, you need to export those best practices around the system. There have been issues in the past where a problem has been identified, and you send it out to the medical centers, and in many instances, top leadership in VHA sent out safety alerts and directives and what have you, and they weren't followed.

Mr. Flores. Okay.

Mr. Griffin. So you have got an accountability issue there, you have got an integrity issue there. But there ought to be a best model for similar size medical centers so that when a directive goes out, you know, okay, at this facility, or at all the facilities the chief of staff owns this issue, or the chief of surgery, or one individual. Some of our reports, like on reusable medical equipment not being

properly sanitized after use, there was no one person at every facility who had ownership of that issue. So, you know, you reap what you sow. And when you send it out there and there is no consistency in ownership, then the results are predictable.

Mr. Flores. And so do you concur with the other two observations that it is the leadership of those facilities that sets them apart from—

Mr. Griffin. I think it is leadership in the field, it is also leadership in headquarters.

Mr. Flores. Right. Okay. And Mr. Griffin, the interim report cited the need to minimize the chances of evidence destruction, data manipulation, and coaching employees on how to respond to the OIG questions. Do you have any evidence that any of those activities took place? Evidence destruction, data manipulation, or coaching employees?

Mr. Griffin. There is plenty of evidence of data manipulation. The question of destruction, we had a contact from a Hill staffer the first weekend in May reporting that they had heard there were parties going on destroying documents at medical centers. We responded to 50 medical centers that weekend and didn't find any destruction that we came upon in those unannounced visits.

Mr. Flores. How about coaching employees on how to respond to the questions of your team?

Mr. Griffin. Our team's questions are not similar to the questions that they were posed by the audit staff the VHA sent out there. All of our interviews were taped interviews. People were put under oath. And we asked them straight up who told you to do this? Some produced emails, some said, well, we have always done it this way. The range of answers is what caused us to identify it as systemic, along with all of our previous audits.

Mr. Flores. And one last quick question. Did you run across any employees that said they would be willing to cooperate but they weren't because they were concerned about reprisal?

Mr. Griffin. We had anecdotal reports of reprisal occurring around the system.

Mr. Flores. Thank you. I yield back.

The CHAIRMAN. Thank you, Mr. Flores. Ms. Titus, you are recognized for 5 minutes.

Ms. Titus. Thank you, Mr. Chairman. In May, the VA launched the accelerating Access to Care Initiative. And this program is highlighted in your press release today. We have all talked about it. We know that the goal of this is to help veterans who have been waiting for a long time get access to care in the private sector. Now, I support these principles. I think that is a good idea. But as you have heard kind of referenced here, the U.S. is facing a significant physician shortage nationally, and not just in the VA, but in the private sector. For example, in Nevada, we have a chronic shortage of doctors, both in primary care and among specialists. Just the statistics, we are 46th in the Nation for general and family practitioners, 50th for psychiatrists, 51st for general surgeons.

So as a result, it is not only the veterans in Las Vegas who have these long wait times, everybody is affected. And there seems to be this big emphasis on getting into the private structure to get care, and that will solve the problems. But I wonder what you are plan-

ning to do to ensure that veterans receive care in the private sector in communities like in Nevada, where the issue of physician shortage and waiting times is not just limited to the VA facilities, but is out there in the community.

Mr. Matkovsky. Unfortunately, Congresswoman, I do not have an easy answer for that. There are things that maybe we can explore on how we can attract clinical talent to Las Vegas that might help us as well. I know that even in the Las Vegas campus we had, at times, talked about creating a medical school hub that would help us attract talent. We have found that that works, by the way. One of the benefits we have in terms of having our affiliate partnerships is the ability to attract talent. Roughly 70 percent of America's doctors have received some of their training from the VA. One of the things that allows us to do is attract young talent that frankly falls in love with our mission and comes to work for us.

So I think that we do need some help, but we need broader help than just contracting or just VA. And we need to explore other solutions. And I think Las Vegas is one of those areas.

Ms. Titus. Well, we have the University of Nevada Medical School, we have Touro there, we have this big new hospital. What about the increase in residencies and some kind of partnership?

Mr. Matkovsky. Absolutely. I think we need to look for that. Yes, ma'am.

Ms. Titus. One other question. If money were to become available now, like we have heard about from the Senate side, to hire more doctors and to build more facilities, are you ready for that? Do you have a list of priorities? What are those priorities? And what kind of metrics or planning are you using to make those determinations?

Mr. Matkovsky. We have a significant, as I think this committee is aware, we have a significant construction requirement, both to maintain our facilities, which I believe are roughly, on average, 60 years old. There are land-locked facilities. As a matter of fact, in Phoenix, I know we are talking about Las Vegas, but in Phoenix we had to bring down mobile clinics to handle the extra staff. Space matters. We need space. So we do have a list of priorities where we require space, whether in the form of leases, in the form of minor constructions, or frankly major constructions and overhauls. Or just refurbishing our aged infrastructure. And we clearly have an identified need for providers. Over the next 30 days, however, we are going to take a much closer look at our current productivity, and where we find demand and our inability to meet it.

Ms. Titus. Well, I know when the new hospital opened in Las Vegas, before it even got started, the emergency room was determined to be too small—

Mr. Matkovsky. Right.

Ms. Titus.—because the demand on the hospital was much greater than anticipated. I think usually it is about 2 percent. In Las Vegas it increased by 19 percent. So I just want to be sure that as you look at your priorities, you include in those plans some demographic calculations for growth in the need for service. Because once it is there, you build it and they will come. Okay. Thank you. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Titus. Mr. Denham, you are recognized now for 5 minutes.

Mr. Denham. Thank you, Mr. Chairman. Mr. Matkovsky, is this the audit that came from the VA?

Mr. Matkovsky. Yes, it is.

Mr. Denham. I noticed in here that on the 14th of May, Livermore, which is in our contract area, was audited. Now, I sent a letter in over a month ago asking the VA, requesting that each of our districts we be given the information, whether that is a private briefing or whether we get public information. But I think every member of this committee has a right to know what is happening in their own districts. Is there a reason we don't have in that information yet?

Mr. Matkovsky. The only reason we didn't prepare it, sir, is that we were completing phase one and phase two. One of the concerns we had in some of our very small CBOCs there aren't a lot of respondents, so there aren't a lot of staff. We guaranteed our front line staff anonymity, and we wanted to preserve that. So as much as we can, we want to make sure that we roll the data up to the parent facility, sir. But I will be happy to organize briefings or any similar mechanism to provide the information.

Mr. Denham. So there is no reason that we shouldn't receive that information very, very soon.

Mr. Matkovsky. No. No reason. The only concern, once again, that I would have is in our very small clinics, where there are just a small number of folks who we interviewed, I want to preserve their anonymity. These were front line staff members, and we made that promise to them when we did our interviews.

Mr. Denham. You say in this report some locations were flagged for further review and investigation, for instance, of suspected willful misconduct, where misconduct is confirmed, appropriate personnel actions will promptly be pursued. Livermore VAMC in California is on that list.

Mr. Matkovsky. That's correct.

Mr. Denham. So at a certain point, I assume you are going back into that facility to get further information.

Mr. Matkovsky. We will. The Office of the Inspector General and I and others will actually be meeting this week. We are working on a plan to make sure we coordinate those reviews. We do not want to impede an investigation, but we will.

Mr. Denham. Appropriate personnel actions will promptly be pursued. What type of personnel actions will be pursued?

Mr. Matkovsky. Commensurate with the nature of the problems we identify.

Mr. Denham. Firing?

Mr. Matkovsky. If required, yes.

Mr. Denham. I just recently went to Palo Alto. I took a group of local veteran leaders throughout my district to Palo Alto. And I will tell you we saw some very dedicated doctors. We saw some very dedicated staff. But we also saw some big glaring challenges that they recognized were big challenges. Now, we have heard in this committee many times now that the VistA system is state of the art. Do you think it is state of the art?

Mr. Matkovsky. I can speak for my domain, sir. I am administrative. I am in the finance domain, and the business applications and engineering. I can tell you that for engineering, it is not state of

the art. For our work order management, for our biomed technicians, it is not state of the art. For our facilities management staff, it is not state of the art. For our housekeeping and environmental management staff, it is not. For our billing—

Mr. Denham. What is the state of the art as?

Mr. Matkovsky. I believe in the electronic health record, as an integrated health record that captures all documentation associated with a patient and enables the collaboration and the delivery of that care, it set the standard. In some of these other domains, I think we need to look to industry to find other solutions.

Mr. Denham. And you are doing scheduling under that same system?

Mr. Matkovsky. I put scheduling square in front of that same question. I think we need to look to the industry that knows how to deliver systems and acquire.

Mr. Denham. So if all those areas are lacking, why is this not part of the VA action plan?

Mr. Matkovsky. The scheduling package is a part of our action plan, sir. So one of the immediate things that we need to do, we are working with OI&T, we plan to have an award before the end of this fiscal year for a replacement scheduling system. Our intention is not to pick someone who can write for us a book about how they are going to develop a scheduling system, but rather, to acquire a scheduling system and then deploy that scheduling system.

Mr. Denham. And one final question. Another thing that I noticed there, obviously you have seen how this committee, as well as the House, feels about the firing process. We think that we need to help you through that process and give you the tools to implement that type of discipline. But one of the things that I also saw was that the staffing system was flawed. I mean, if it is taking you 3 to 6 months to hire a doctor that is ready to be hired, you are going to lose them to the private industry every time.

Mr. Matkovsky. I am not an H.R. professional, but I would agree. We need to work on our speed.

Mr. Denham. I yield back.

The CHAIRMAN. Thank you, Mr. Denham. Ms. Kirkpatrick, you are recognized for 5 minutes.

Mrs. Kirkpatrick. Mr. Matkovsky, I am encouraged by the fact that you are looking to industry to help solve this problem. I actually sent a letter to the President last week recommending that that be done, because we know that there are organizations that do massive scheduling, and they do it right, and they do it well, and we want that to be available to our veterans. So thank you for that. My first question, actually, is to you, Dr. Draper. But I would like the whole panel to address this, if they could. I represent a very, very large rural district in Arizona. And my veterans get care at four facilities, Albuquerque, Prescott, Phoenix, and Tucson. And Dr. Draper, you said that there is not consistency among the various centers. And I wonder if you could identify for our committee the top three reasons for that inconsistency, and then what we can do to make sure this is the best health care delivery system possible for our veterans?

Ms. Draper. Well, part of it is, as I talked about in my oral comments, the weak and ambiguous policies. And I will go back to the

canceled appointments and no-shows. The VA policy is very ambiguous. So what you find is each facility develops its own policy. So we have seen anything from a 1-1-30 rule in one facility, which gives a veteran one phone call, one letter, and 30 days to respond or the consult is canceled. Another facility gives a veteran two canceled appointments. So there is a lot of variation at the local level. And the key point with the consults information is VA is trying to put together a system-wide database of consults. So if you have these local policies that vary, then your data is going to reflect variations. So you are really not going to be able to compare apples to apples. That is one example. And we see similar things such as that.

Mrs. Kirkpatrick. Mr. Matkovsky, can you address that question?

Mr. Matkovsky. I would agree with Dr. Draper. I think one of the things that our policy does, it sets about the operating principles. But we need to tie a handbook to that or standard operating procedures that provide precise instruction so that there is not an interpretation. If we have a contact policy, this is how you do it. If we have a scheduling policy, you are to contact the veteran and work with them to schedule the appointment. What do we mean by contact? We need to spell that out. Either three or four telephonic attempts spread over the day as follows, followed up by a letter or something like that. We do need to do a better job, and spell it out in our policies so that the rules are standardized.

Mrs. Kirkpatrick. Is there a structural problem in the administration at the Veterans Affairs Office? I mean, it just appears that it is just all over the place. And I am just wondering if there needs to be a total reorganization of the VA system in terms of oversight, supervision, accountability, and transparency.

Mr. Matkovsky. I think we just need to get back to our core of delivering safe, quality health care to veterans that they expect and that they have earned. And start with that in mind, understand how we want to do that, define the practices in policy, promulgate that policy. Don't allow us to have a separate policy that can interpret a different set of rules from a national policy. We write a national policy, publish it, and hold people to it.

Mrs. Kirkpatrick. I just have a feeling the problem goes beyond that. Maybe, Mr. Griffin, you can address it. Because you said that the technology is outdated. It goes back to 1985. I guess I have to wonder why. I mean, this committee wants to get this right. We have got to get to the bottom of this. But why are we still using 1985 technology? Is it a lack of funds? Is it a procurement problem?

Mr. Griffin. I would approach it from a different angle.

Mrs. Kirkpatrick. Okay. Go ahead.

Mr. Griffin. Your facility is only as good as the people working there. And basically, there are five qualities to every great team. Communication, upward, downward, and lateral communication. Managers need to get out of their office and walk around the facility and find out what is going on there. Second thing is collective responsibility. Everybody on that team has ownership of the outcomes there. Pride. Be proud of helping our Nation's veterans. Be proud to go to work every day to help our Nation's veterans. Caring. Of course, in a medical center caring has got to be one of those qualities. And trust. And if you have those five qualities, you are

going to have a great team. I think that is what needs to be instilled in the personnel at all the facilities.

Mrs. Kirkpatrick. Thank you. I am running out of time. But it sounds like, Mr. Chairman, that policy and personnel are two key issues in getting to the root of this problem. And I yield back.

The CHAIRMAN. If I can, real quick, and I apologize, Mr. Runyan, but I kind of want to bring the committee up to speed, because there is a very important question that needs to be answered. Why are we still using outdated scheduling software and programs? VA has requested, and Congress has funded, IT enhancements, to include a new scheduling system, which has been dubbed a failure by GAO. The scheduling replacement project was \$127 million over 9 years. And it was hindered by management weaknesses. Then we had other issues, VA scheduling replacement project, which is what I just talked about. Then there was a \$249 million used for core FLS. Its follow on was Flight, \$607 million. And then there is the VistA FM, \$2.4 billion in investments that this Congress has made. And yet we sit here asking what is the answer to the question: Why are we still using outdated systems when we have given hundreds of millions of dollars to the VA? Mr. Runyan, thank you. I apologize. You are recognized for 5 minutes.

Mr. Runyan. Thank you, Mr. Chairman. And first of all, I want to associate myself with the comments that my colleague, Mr. Denham, made. Two of the VISNs that my veterans visited, number four and number three, three of the facilities, the Lyons facility, the Philadelphia facility, and the Wilmington facility are all in that further review category. And I request the same information that Mr. Denham did. I have a, for purpose of, I think, why all this started and the secret lists so we say, as a simplistic question, is VistA not capable of scheduling 2 years out? And if we didn't have the metrics that Dr. Lynch sat here numerous times a couple weeks ago and said these metrics are forcing us to play these games, is that a possibility?

Mr. Matkovsky. I think it is part of it. I think that they go hand in hand. But first of all, I think setting an unrealistic performance metric and tying rewards or incentives to the meeting—again, this isn't even an outcome measure, right? This is an activity measure. Tying rewards or incentives to the attainment of an activity was a mistake. Not understanding the capacity of our system when we set that was a mistake. There are reasons why we don't schedule 2 years in advance, quite frankly. Just you don't want to hold up the entire set of appointment slots with appointments that are so far out that they might end up getting missed. I mean there are technical reasons why you wouldn't do that. But for the most part, this is a leadership and culture question.

We have found in some of our networks where staff are using the same outmoded technology as other staff, using the same policy, and can schedule with integrity.

Mr. Runyan. I bring that up because I think you kind of touched on it there. There is a balance there. And what is it? And I think it is going to go to my next question. And I think several people have brought it up. Standardized procedures and policies from Washington. I mean, you have seen it, you know, the different VISNs, the wait time issues, and it goes to this question that I

asked last time, and I, believe it or not, got a response this afternoon. There was a—I asked a question about an auditing feature that was turned off in the Phoenix region there, and got a response that it had been turned on nationally. Could any of those audit features been turned on helped the IG in the process and/or internally in that region for them to avoid these situations?

Mr. Matkovsky. Sure. I think the one thing that I would clear up is that that audit—there is audit logging inside VistA that sort of records who edited what and captures those edits was never turned on anywhere. The concern was that it would affect system performance, and it would create a huge data storage requirement. So it was never turned on. That is now turned on across the board. That will help us understand who edited what kind of appointment. So, for instance, I think one comment was made how you would cancel an appointment, we could see who do that. And if that occurred numerous times, we could marry that up and find that behavior. Who edited what kind of field at what time helps.

Mr. Runyan. And I just—you probably—I just want to make this statement, because I am sure, as the chairman just said, there were millions of dollars spent for that feature in the initial outroll of that system.

Mr. Matkovsky. I would say the one thing that we are going to do different with this acquisition is that it is not going to be just a proposal. Part of what we're going to expect folks to give us is working software that is proven to integrate with our system. Not a book about how that software at some point in the future will integrate, but a working product. That is part of the proposal.

Mr. Runyan. Thank you. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Runyan. Dr. Ruiz, you are recognized for 5 minutes.

Mr. Ruiz. Thank you, Mr. Chairman, for holding this hearing. With the release of the Department of VA access audit and the Interim Inspector General's report, it is clear there is a systemic failure of responsibilities, widespread misconduct, and coverups that led to the deficiencies in scheduling, resulting in lengthy wait times and veterans dying waiting for care.

The veterans in my district and across our Nation deserve better. I demand that the new leadership of the VA put an immediate and decisive end to the severe misconduct and hold those responsible accountable for their actions. As I have called in the past, and which we have discussed today, a criminal investigation is needed to remove individuals who knowingly prevented veterans from receiving the timely and quality health care they needed, and resulted in harm or death. A criminal investigation will put an end to this wrongdoing, will change culture, and now and for the future.

Currently, there are over 1,500 veterans that utilize the Loma Linda health care system, many of which live in my district, that are either waiting over 90 days or going without an appointment altogether. It is time that the House pass the Veterans Access to Care Act, H.R. 4810, to make it easier for veterans who are too far from a VA or waiting too long for an appointment to seek care outside of the VA system.

As a physician, I will continue to work as a member of this committee to, one, stop the scheduling misconduct; and two, treat the veterans, give them the care when they need it. And after reading the audit today, I had several questions. The first, what are the possible solutions to get veterans triaged and cared for immediately, or sooner than anticipated? Now, let me preface this that there are other veterans with aneurysms, perhaps, that need care now. There are other veterans with suicidal ideation that need care now. There are other veterans that have cancer that are on the verge of spreading that need care now. We must hold the individuals accountable. Yes, we do, and we will. But we need to give care now to our veterans. When I was in Haiti working in a disaster zone with the 82nd Airborne, there were immediate striker teams formed that would go out, educate the population of the—do the research, educate the population of the health care available, form teams, go out there and treat the patients. What are we doing to treat our veterans now?

Mr. Matkovsky. On May 23rd, we asked all of our facilities, we provided them the productivity data, and we asked them to assess if they could get more productivity out. We also gave them their local wait data, computed nationally and distributed to the field. The instruction was clear: Where you can find capacity now, overtime, extra clinic slots, you name it, find it in the system. The system belongs to veterans. We have to make it efficient. That is the first order of business. The second order is that if we cannot identify where we can acquire that care in the community, beginning May 23rd contacts were going out to the field. One network, network 10, which is Ohio, completed all of its contacts the following week. All of them. Every veteran who was waiting they called. Can we make it faster? Yes. But we also identified \$300 million in requirements in the immediate term.

Mr. Ruiz. Now, if you rely on a broken system, you are going to get broken results. So I encourage you to find a model, a benchmark, form a special operation unit that not only identifies physicians within the national VA system, but also within the private sector to rapidly deploy to the priority health care systems and create a form of health care event, a health fair, or triage and get them seen sooner than relying on a broken system to fix itself.

Mr. Griffin. Mr. Ruiz, may I respond to your desire for criminal investigation?

Mr. Ruiz. Yes, sir, please.

Mr. Griffin. The 69 additional facilities that we have sent rapid response teams to are all criminal investigators. We coordinate with the FBI in all of our investigations. It is a requirement of the Attorney General guidelines. Whenever we open an investigation or the FBI opens an investigation, there is mutual notification so that we are not wasting resources, but also for safety and efficiency considerations so you don't find yourself going to arrest the same person at the same time and have someone get hurt. But trust me, we have an excellent criminal investigative staff, and they are pursuing all leads in this manner.

Mr. Matkovsky. One additional item that I would make reference to in the case of Phoenix was the use of the disaster and emergency medical staffing team, which we call DEMS. That is now being

used in Phoenix. So we have a cell, which is a whole number of clinicians, physicians, nurses, and others, who have identified and are willing to move across the country at a moment's notice. I think starting on Sunday, there were 21 such clinical staff on the ground in Phoenix providing care.

Mr. Ruiz. I look forward to working with you to see if we can extrapolate that experience to other VA systems, including Los Angeles and other areas like Loma Linda, where they might have very long wait times that is causing harm to our patients.

The CHAIRMAN. Thank you, Doctor. Dr. Benishek, you are recognized for 5 minutes.

Mr. Benishek. Thank you, Mr. Chairman. Mr. Matkovsky, I kind of feel sorry for you being here today, because you are really representing a system that really has no defense. And I appreciate your apology at the beginning of your statement. And I will just start today by looking at page 27 of the VA's internal audit which was released today. The medical system in the Oscar G. Johnson VA Hospital in Iron Mountain, Michigan, was listed as being in Wisconsin. Now, you can't place the facility in the right State, so I don't know how we can trust you with the big stuff.

Like I say, I feel sorry for you standing there today. You know, the IG's interim report said that the VA told them the wait times in Phoenix averaged 24 days, with 43 percent waiting more than 14 days. But when they went there and took a similar sample, they found the average wait time of the sample was 115 days, 85 percent being more than 15 days. How are we supposed to trust anything the VA says about this?

Mr. Matkovsky. Dr. Benishek, thank you for your question. I would just tell you that we had a few slight version control issues towards the tail end of this, and we know where Iron Mountain is, and it didn't make it into the final paper.

Mr. Benishek. How am I supposed to trust this data you did today? You submitted it today. When the last data you submitted was completely different than the IG reported shortly thereafter. You see the problem that we have here, Mr. Matkovsky. I feel sorry for you sitting there.

Mr. Matkovsky. Every 2 weeks from here on out—rather, I am sorry, bimonthly we will produce data. As our integrity and our reporting improves, we may likely see that our timeliness worsens.

Mr. Benishek. All right. Frankly, I don't believe you, Mr. Matkovsky. I tend to associate myself with the thought of Mrs. Kirkpatrick across the aisle there who said that this system needs a complete revamp and restructuring because there is no accountability here. There is complacency. I would like to associate myself with Mr. Ruiz, who strongly recommended prosecution. And with you, Mr. Griffin, for your comments about people aren't getting fired for not doing their job.

And frankly, I think we need leadership at the VA to—hopefully we will get that—where we have some leadership that will make people responsible and fire people that are not getting the job done, because this culture of not being able to get the job done, it doesn't matter, has got to stop. And I appreciate your comments. You kind of slid them in there in your testimony that people need to get fired. We need to make that happen despite whatever the work

rules and all the criticism that we get. We need to have a system that the management at the top can fire the people that aren't doing the job, and to listen to the people at the ground who have the comments.

Dr. Roe talked about the simplest thing that every private practice in the world does, is they call the patients a day or two before the appointment to confirm that they are coming to the appointment. And the VA hasn't figured that out? I mean, it is impossible to believe that that actually occurs, and that the appointment people are writing people letters telling them when their appointment is without talking to them. It is like, really? Nobody's getting fired over this kind of decision-making? I mean it is just unbelievable that this is occurring.

And I appreciate you, Mr. Griffin, for your comments. And we need to have leadership within the VA and a system within the VA that holds people accountable and makes it known that if you don't do your job you are going to be out of there or you are going to be prosecuted. Just simply that happening will change the entire culture there.

Mr. Griffin, could you comment, I have had a few more seconds left, on where do you think this leadership should come from? Do you think it should come to the top or you think it should come from the bottom? Give me some more thoughts about your comments on this.

Mr. Griffin. I think you need leadership up and down the chain of command. What we have witnessed on some of our previous work was the VHA has sent out requirements, they sent out safety alerts, they directed the medical centers to address the issue and to certify that they had taken corrective action.

Mr. Benishek. Does somebody sign these certifications, Mr. Griffin?

Mr. Griffin. Just to finish the thought, we went out unannounced and determined that 42 percent had actually did what they said they did, and the other 50 percent did not, even though they certified that they had accomplished the directive.

Mr. Benishek. Without any consequences to their careers?

Mr. Griffin. Not that I am aware of. I would ask VHA to speak to that. I am not aware of anyone being held accountable for that. But I don't know how you could not hold someone accountable for a direct disobey of an order like that.

Mr. Benishek. But apparently, it occurs every day, Mr. Griffin. I am out of time. Thank you.

The CHAIRMAN. Thank you, Dr. Benishek. Ms. Kuster, you are recognized for 5 minutes.

Ms. Kuster. Thank you, Mr. Chair. I want to thank you all for being here, and for your candor under obviously challenging circumstances. But the comment I want to just focus in on is restoring trust, because I think that's the challenge that we have, the integrity issue above all else. I am interested in the notion about this decision to acquire a scheduling system that works in the private sector. Is that the intention, Mr. Matkovsky?

Mr. Matkovsky. Yes, I am not going to get into the arcana about our scheduling process versus the private sector's. I just want to address one comment. You know, this audit that we did was de-

signed to be the start of our change. I just want to be very clear. If anybody thinks that I am not committed, if the team that did this is not committed, if we are not committed, please understand that we are committed to this change. This is the start. It is not the end. It is not the final report.

In the private sector we see resource-based scheduling, which is the resource is the provider, their clinical resources, using telehealth or other mechanisms to deliver that care. In the VA, we have grown up around something we call sort of clinic-based scheduling. So we manage clinics as opposed to resources. And it makes it tough for us to be able to aggregate all of those views of one provider and know how many slots does Dr. Smith, how many slots does she have? It makes it tough for us to do that. That is not an excuse, but we do need to move to resourced-based scheduling, which allows us to know how much capacity do we have in our system and how does that map to the providers we have.

Ms. Kuster. So we have referenced what I think is causing the exponential effect of the loss of effective appointments with the no-shows and the canceled appointments. I won't dwell on that. But getting back to the resource-based, you mentioned that there is not an infinite supply of medical personnel, and that what we are talking about is a lack of slots. I wanted to focus in on the issue of graduate medical education. And one option that I have seen discussed is to relieve medical student debt, whether that is physicians, whether perhaps there could be greater use of nurse practitioners, ancillary personnel. And I would like for you to address that in terms of the quality.

In my district, our White River Junction Health Care Center is very closely affiliated with Dartmouth Medical School. And it is a very positive arrangement. But I think we could replicate this around the country.

Mr. Matkovsky. We can. I think we had discussed it a little bit earlier about the nature of our academic affiliations. It provides us a wonderful opportunity to recruit new young talent, have them exposed to the mission of our organization, which is a noble mission, and a dedicated workforce, and the people we serve, veterans, to attract them to that mission is something we can do. We do have certain authorities to offer repayment and other programs as an incentive. I think there has been some discussion. I would have to take it for the record to give you a precise answer on what the nature of those costs may be.

Ms. Kuster. I think it is something that we could look into as well on a congressional basis, the idea that relieving medical student debt—

Mr. Matkovsky. Absolutely.

Ms. Kuster. —if for in exchange for service within the Veterans Affairs. Could you address the issue of nurse practitioners and ancillary services in terms of providing greater access, more efficient access?

Mr. Matkovsky. There I will get myself in trouble, Congresswoman, so I will take that one for the record. I know it is a discussion we are having.

Ms. Kuster. I would be very interested. I mean certainly in the private sector this is something that is happening across our health

care delivery system, using more physician assistants, that type of personnel.

Mr. Matkovsky. I do know that it is something we are looking at.

Ms. Kuster. Okay. Great. And then just in closing, back to the issue about restoring trust and integrity. I appreciate the comments here, thank you, Mr. Griffin, I tend to agree with you. I think a few high profile prosecutions would clean things up rather dramatically. But I think it is important and the time has come. So thank you very much. I yield back my 20 seconds.

The CHAIRMAN. Thank you, Ms. Kuster. Mr. Huelskamp, you are recognized for 5 minutes.

Mr. Huelskamp. Thank you, Mr. Chairman. A couple questions following up on the issue of restoring trust. Ms. Moody from the VA was before our committee I guess 2 weeks ago, and her stated goal was to be open and transparent in working with this committee, Members of Congress, and hopefully with the public. Are you aware of any gag orders or orders or instructions from Washington that would forbid employees from visiting with the media and/or Members of Congress about these issues?

Mr. Matkovsky. I personally am not, Congressman.

Mr. Huelskamp. When Wichita at the Dole VA Center, let me give you a little background on that, as of Friday, May 30, a U.S. Senator was told there was no one on a secret waiting list. Three hours later, a letter was released from the VISN, from the center, that said there were three—or excuse me, actually nine individuals on the waiting list. And at that time, on a Friday afternoon, evening, I began calling the leadership at that center, and received no response until the following Wednesday, when I began hearing rumors of 385 on a secret waiting list. I jumped in a vehicle, drove the 1 hour, it happened to be fairly close to me for my district, and there was met with an email from the VA that forbade employees from visiting with Members of Congress about these issues. Now, if that indeed was an accurate email, do you think that helps build trust?

Mr. Matkovsky. That does not, sir.

Mr. Huelskamp. But you are certainly not aware at all that those types type of emails were sent out through the VA system? At least—there were actually, and they wouldn't provide me a copy of the email, I think there were probably a hundred different names it was going to. I didn't know them. I knew the one sentence at the end, which said don't talk to anybody. But so you are absolutely not aware of any such email?

Mr. Matkovsky. I don't know, Congressman. I have been sort of working on the audit and some preparations. It is possible that—

Mr. Huelskamp. Why would an email like that ever be sent out?

Mr. Matkovsky. I think the one reason, Congressman Huelskamp, would be the following reason: We were going to release an audit that would contradict a statement that someone locally might make to say everything's fine, we have no issues here. And we are about to release an audit that might contradict that. So that would be the concern that I would have. I would hate for somebody to tell you everything is fine, and along comes an audit

that says not everything is fine, and oh, by the way, here is the official data.

Mr. Huelskamp. In your audit that you have released today identifies 104 veterans waiting in Wichita for care.

Mr. Matkovsky. Correct.

Mr. Huelskamp. The facility says 385. How are those two numbers different?

Mr. Matkovsky. I will need to compare the numbers.

Mr. Huelskamp. Well, 104 to 385. There is a difference.

Mr. Matkovsky. Here is how. And I am not certain that this is the cause. But the data that we published today was current as of May 15th. If you went to the facility on May 30th, you would pull a local number that might be bigger. One of the things that we identified with the audit as we went to sites was that prior to coming to the sites there started being a change in some of the scheduling practices.

Mr. Huelskamp. Let me interrupt you in the specific circumstance. The facility said they knew of 385 on May 21st. Then they told the public and Senator Roberts zero. And then they told us nine. And then they said maybe 385. And until I knocked on the door, they wouldn't confirm the 385.

Mr. Matkovsky. Okay.

Mr. Huelskamp. So the numbers have changed. And then in the middle of this, you have a gag order. One other issue I want to—and I would like a quick response on that, certainly much quicker than the March 2013 request I gave to the VA that has not been fulfilled yet, is how do you handle folks who game the system illegally in clear violation of the policy? And I asked you at that time has anybody been fired or punished or otherwise for violating those rules?

RPTS KERR & DCMN ROSEN, [9:30 p.m.]

Mr. Matkovsky. We have begun the removal process for our leadership team in our one of our medicals.

Mr. Huelskamp. You have not yet responded to that question. I have not seen those policies.

Mr. Matkovsky. I'm sorry.

Mr. Huelskamp. Is there a reason you didn't respond to that question in committee?

Mr. Matkovsky. I'm not sure what the question was, sir.

Mr. Huelskamp. Well, you go back to the testimony. I'll be happy to provide that to you again, but that question is—matches up with a April 26th, 2010 memo, and I know my colleague kind of felt sorry for you, but this is not new stuff.

Mr. Matkovsky. It is not.

Mr. Huelskamp. It is not new stuff, and you came before this committee—I wasn't here yet—and said you had 26 different schemes for gaming the system, and have you changed any of those? Has anybody lost their job for doing this? We know veterans have lost their lives, and I don't have any clue or any information anybody's been punished, that anybody's lost their bonus, or otherwise because of something you've known for years, 36 different reports from the GAO and the OIG about this, and you come here

and say we're going to do better next year. Yield back, Mr. Chairman.

The CHAIRMAN. Thank you, sir. Mr. O'Rourke, you're recognized for 5 minutes.

Mr. O'Rourke. Thank you, Mr. Chairman.

Dr. Draper, you—first of all, I appreciate your work, and I'm learning a lot listening to you this evening, and one of the things you talked about was the cancellations and the no-shows. And in El Paso, we've heard anecdotally of cancellations that are recorded as no-shows. A veteran last week, for example, told me that she had gone to the VA in El Paso for a mental health care appointment. A second appointment was made by that psychiatrist. The VA called her to cancel that appointment.

She, thereafter, requested a copy of her medical record and found that that cancellation was recorded as a no-show, so hits against her record, doesn't hurt the VA's wait times reporting.

Have you found evidence of those kinds of practices in your investigations thus far?

Ms. Draper. Not specifically that, but we did find, as I mentioned, more than 50 percent of the 150 cases that we looked at had at least one no-show or canceled appointment. For each facility, we looked at 30 consults, 10 consults per the three specialty areas we looked at. It was interesting because one of the specialty areas, they canceled all 10 appointments—all 10 of the appointments that were in our random sample were canceled, so it raises questions about whether they were really canceled or there were other things going on.

Mr. O'Rourke. We, in El Paso, have long heard from veterans who said that they couldn't get a mental health care appointment and certainly couldn't get it within 14 days, and the discrepancy between what the VA was saying, which is that they were seeing everyone within 14 days and what we're hearing from veterans was so great that we commissioned a survey. We released a report last week. We found that 36 percent of the veterans in El Paso requesting mental health care were unable to get an appointment at all. And I want to thank you and the VA for not challenging the facts.

It was a well-designed, well-implemented survey, large sample size, and instead, the VHA is now working with us to identify those one-third of the veterans, hundreds or thousands of veterans in El Paso who could not get a mental healthcare appointment, and so I appreciate that. And I also appreciate the audit that you released today that shows that new patient mental healthcare average wait times in El Paso are 60 days. That's the fourth worst in the Nation. But I'll tell you that May 9th, I received this report from Dr. Petzel and Mr. John Mendoza, the VHA administrator in El Paso, that showed that zero veterans waited more than 14 days, not just the previous month, but the month before that, the month before that, and at worst, 15 percent of veterans waited more.

So, you know, a simple question, following your audit, which should I believe, the information that Dr. Petzel gave me that showed no wait times over 14 days or your information today that shows that it's 60 days.

Mr. Matkovsky. The information today. And I will tell you that as we improve the integrity of our reporting and our wait times,

the established patient data may also get worse as it becomes a more valid reflection of reality, and that is important to have.

Mr. O'Rourke. That news would be welcome, because as you said, it would be rooted in reality and to facts and then what we're hearing from our constituents and the people we serve, and we will not be able to correct this problem until we know how extensive it is, and so I appreciate your commitment to that as well.

And on a related note, I will be introducing a bill this week to essentially replicate what we did in El Paso throughout the VA system. We cannot, right now, trust the VA to tell us how the VA is doing, but we can trust veterans to tell us how the VA is doing, and we should ask them directly what their wait times have been. I really like your commitment that you made earlier that when you have a no-show, that no-show—that veteran who's been recorded as a no-show will have a phone call from the VA to confirm that that is what has happened. Was that essentially what you committed to earlier?

Mr. Matkovsky. I have. We do patient satisfaction data today, and veteran patients, by and large, rate the quality of healthcare experience overall, as very high, but they also tell us in our satisfaction surveys that they rate their access as pretty low.

Mr. O'Rourke. So I would just ask for your continued cooperation. We're going to introduce this bill this week, the Ask Veterans Act. I think having an independent third party, the OIG, the GAO, someone apart from government altogether asking veterans what their wait times are is part of the solution in that we will get real information that we can then make better decisions from.

So, appreciate your help and appreciate the testimony and the expertise from everyone on the panel. And with that, Mr. Chair, I will yield back.

The CHAIRMAN. Thank you, Mr. O'Rourke.

Mr. Coffman, you are recognized for 5 minutes.

Mr. Coffman. Thank you, Mr. Chairman.

First, I want to thank the Veterans Administration here today. This is a first. This is my second year on this committee, and I'm proud as an Army Marine Corps veteran, I'm proud to be on this committee, I'm proud of the members of this committee, it's the most bipartisan committee in the Congress, Republicans and Democrats standing shoulder to shoulder to make sure that our nation meets its obligations to those who served this country in the military, and I feel that every hearing I've had prior to this, it's— it's deny, cover up, and then delay getting any information to us; no accountability, no transparency on behalf of the Veterans Administration, and I got to tell you, I think there are a lot of great men and women who work for the Veterans Administration, and a lot of them are the whistleblowers who have put themselves at risk, if not for them, we wouldn't be here today cleaning up this problem.

And I just want to say that I think a third, if I understand it right, of the men and women that work in the Veterans Administration are, in fact, veterans themselves, and I would love if you would look at whatever you can do to increase that number. I think that there is nobody that understands the needs of veterans more

than those who have worn the uniform, and so whatever you can do to get that third up, I'd really appreciate it.

So, when we get to this 14-day wait period, and then I heard that it "was simply not attainable," what is realistic?

Mr. Matkovsky. I honestly don't know tonight. I do know what is unreasonable. I think 90 days is unreasonable. I think 60 days is unreasonable. I don't know what the right measure is. We have to study it. We have to look at what is right for an individual veteran is based on his or her own preferences. Acuity also needs to come into the mix. For cardiology, 14 days is not soon enough, right. It has to be based on an individual veteran's requirement.

I think setting an across-the-board standard encourages an attempt to meet that standard. We'll still measure timeliness, we'll still aspire to be faster, but we won't tie rewards or incentives to that activity.

Mr. Coffman. Then did that benchmark, when you interjected financial rewards into that, fuel the incentive to manipulate these wait times?

Mr. Matkovsky. I didn't ask. I mean, in our surveys, we didn't ask people. A simple—

Mr. Coffman. I mean, in your opinion, don't you think that it was the financial reward that incentivized this behavior, the secret waiting lists where veterans were ultimately denied care as a result of this manipulation?

Mr. Matkovsky. The simple act of stating this is our goal, you shouldn't do anything other than this goal, even without a financial incentive might drive that behavior.

Mr. Coffman. Wouldn't they have spoken out, though, wouldn't they be more inclined to speak out without the financial incentive, that what's going on is wrong here?

Mr. Matkovsky. We have to look at that second question. I think they're two separate questions, sir.

Mr. Coffman. Okay. I just think it's going to be so hard. I think that this culture of bureaucratic incompetence and corruption is so deep, and I appreciate the forthright nature of your testimony today, but I think it is so deep and so ingrained in this organization that it's going to be very hard to turn around, and what I hope occurs from this is that veterans have a choice, that veterans have an option that if you're not able to meet their healthcare needs, that they can go outside the system, and I hope that then incentivizes the Veterans Administration to see them as customers, to see them as their patients.

And right now I think there's great variances between facilities, as you mentioned, across this country, but I think that there has to be an incentive for them to see them as their patients, for it to drive some quality standards for them to care.

Mr. Matkovsky. If our veterans are happy and more of them choose to come to us, we're having a good year. If we can deliver safe quality health care that is timely, we'll get there.

Mr. Coffman. And if you're not, they ought to be allowed to go outside the system, reimbursed by the VA, and I think, as you mentioned, Dr. Draper, the management structure really isn't there to support that, and I think it needs to be developed to support that.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Coffman.

Mr. Walz, you're recognize for 5 minutes.

Mr. Walz. Thank you, Mr. Chairman. Thank you-all for being here. I think all of you're here, when—when our system of government works right, we're to be a reflection on our constituents, and I think you hear it. You hear it, I would hope, loud and clear, the frustration, the lack of trust. It's universal. Many decades of good work can be erased very quickly by bad actors, and the question is, is where do we go from there. I want to thank you-all for the work you did on the IG and the GAO, we're—Ms. Halliday, we go way back on a number of these things, and when the system works right, you were here with Dr. Roe as a ranking member, with Murfreesboro, in Miami with the contaminated equipment, we brought in best practices, we fixed that, we implemented it across the system, and by all accounts, we made a correction based on that, so there is a model there to try and do this.

With that being said, if you look around, there are many in this room that have a long institutional knowledge of both the military, the VA working on this together, many of them are sitting behind you, and many of them have been coming and talking to us and telling us there were issues, so the idea that this is anything new incredibly frustrating to many of us. The breakdown comes when I have to be very honest with you. I think I have proven myself of trying to get this right. What I am seeing is more of an obstruction and a nuisance to answer questions when we call over to try and get them instead of being a partner to fix this, and that, in itself, is systemic cultural issues.

For example, I have an institution in any district that has offered to help, and I've gotten no response. When the Mayo Clinic wants to help you with this, perhaps I can get a call, perhaps someone will call back, but this has gone on and on and on. I am at a loss to understand why that is because the people here are committed. They are speaking with the voices of their veterans. They stand—there's people sitting back behind you that sat in my office and asked us to do this, and we sent a letter in and get nothing back from it.

So, Mr. Matkovsky, you've heard it, and I think your sincerity and the work you've done, certainly I'm not going to question it, but the issue we have here, and I'm reading today, this was from Dr. Haney and Armstrong, they were up at Syracuse, and this is how they started out. They quoted Peter Drucker and said the greatest danger in times of turbulence is not the turbulence, it's to act with yesterday's logic, and their question was, where's the big idea? My question to you is, where's the big idea for reform?

Because if you're going to come here and ask for technology money, that was a cursory thing they found. When they pulled the testimony of the people who sat there and the questions that I sat here and asked about technology, you are going to be embarrassed and my guess is you will not want to come and ask for that money. That is what I would anticipate right now, so my question to you is, where is the big idea? Where is the vision?

Mr. Matkovsky. I think the big idea—it may not sound like a big idea, but it is back to basics. Back to delivering safe quality health

care in a timely manner, knowing where we can achieve that, where we cannot. I think it's on open engagement with our partners. Veteran service organizations weren't mentioned enough today, but they are our partners. When we actually talk and listen with them, they have good ideas for us about how to get back to basics, how to listen to veterans, what they want, what they're telling us. I've worked with members of this committee staff in the past.

Some of those things actually when we listened and worked were when we started measuring wait times that were too long and directing care to veterans who we thought were waiting too long.

I don't have a big idea, sir. I think our idea is back to basics. It is a good system. It can be a great system. It has phenomenal employees who are mission-driven. Our big idea is to get back to basics to deliver veterans care in their system.

Mr. Walz. Mr. Griffin, is that possible as it currently stands with the leadership in the structure that's there, in your opinion?

Mr. Griffin. In my opinion, it's going to take a fair amount of time. It won't happen overnight, that's for sure. There are a number of different areas that need to be addressed. When you're talking timely quality care, one of those is performance standards. I've heard Dr. Roe talk previously about people who do GI work in the private sector, and maybe they're at an HMO or somewhere else, and they know every day I have to do X number of colonoscopies every day, and when we did our review in December of 2012 of specialty care, we looked at 33 specialty areas, and only two of them had performance standards. The other 31 did not.

So, if you don't know how many colonoscopies you're going to do in a day, or how many other procedures, you need that basic information in order to be able to then generate the number of doctors you need.

Mr. Walz. And I, like my colleagues, have been questioning all the data. I'm questioning the satisfaction surveys. I'm questioning everything that's coming out now, and it's very frustrating. I would leave it with this before my time runs out, too, is today, in this report that comes out, and you heard Mr. Denham, you've heard others say this, when you flag those entities that are out there, those locations, you do realize every single veteran that attends those is tonight calling, wondering, asking what happened, what's there, what's going on, and we don't have a hard timeline when you're going to come back, we don't have an idea where it goes. So now, instead of creating a transparency and an honesty and a reconciliation on this, we've created another layer there that is causing angst among veterans. So I would just encourage you—we've got to look at this a different way. I yield back.

The CHAIRMAN. Thank you, Mr. Walz.

Dr. Wenstrup, you're recognized for 5 minutes.

Mr. Wenstrup. Thank you, Mr. Chairman, and following up with what Mr. Walz is just referring to. Last week, the White House deputy chief of staff Rob Nabors visited the Cincinnati VA Medical Center, and that's in an area where many of my constituents are veterans that go there, and I learned that as a result of the internal audit, that they were flagged as requiring further investigation.

So, at this time, can you tell me what's happening at the Cincinnati VA Medical Center that got them flagged, and should veterans in my district be apprehensive about the care that they're receiving or the timely fashion in which they receive it?

Mr. Matkovsky. They should not be concerned about the quality of the care they are receiving. I think, you know, there—there are specifics behind each one that got listed. In some cases, I'm not saying this was in Cincinnati, but in some cases, it could be just a single concern that came in as an anonymous whistleblower concern at the time that we were there, and we felt, in those cases, that we needed to make sure that we listed that.

Mr. Wenstrup. Well, do you know when we'll get the details of why that was flagged and what we should be—

Mr. Matkovsky. I do not know yet, but I will accelerate that. We have to—we have to move that quicker so that we reduce the level of angst, as Congressman Walz alludes, we have to do that, so I will double down and make sure we get that done quickly.

Mr. Wenstrup. I would appreciate that. You know, the problems that we have within the system, in my opinion, I come from private practice as well, you know, a veteran seeking care is, in some ways, a liability to the VA system or to those they administer, and that's a problem. They're not a desired customer, and then we've talked about that. Dr. Roe talked about it, Dr. Benishek did, and you know, we really need to have incentives for quality and incentives for proficiency, and you know, we need this.

In private practice, a no-show is a liability, a huge liability. You can't keep your doors open if you have no-shows, and there needs to be not a reward for this. There needs to be a reward for coming up with ideas of increasing access, which a private practice will do, how can I see more patients, get the patient in with the doctor in a more timely fashion.

The other thing I'm concerned about is with the consults, you know. There's obviously, sometimes with consults a level of urgency, depending upon, as you mentioned before, the acuity of the problem, and you know, if I'm referring a patient for an acute problem that needs to be addressed right away, I will get on the phone and talk to that person I'm referring to to say can you get them in, will you get them in. This is something that we do in private practice. You want to make sure that your patient is taken care of.

Also, when we have a no-show, if it's somebody that you've been treating and they don't show up, as a practitioner, you have a personal responsibility to that patient. You're finding out why they missed, and if they need to be in there, you get them in that evening, the next day, whatever the case may be.

My feeling, as you move forward, and you talk about a big idea, is at the administrative level, we've got to look for someone outside the VA, because if you spent your whole career in the VA system, you don't know what you don't know. You don't know these things that make an efficient system. It's not on your radar because you haven't had to do it, and it is changing an entire culture, and if you're going to get somebody from within the same culture, we're probably going to have a problem.

We've got to have people that understand what competition is about, and as you said, if somebody desires to be at that VA, that's

a good day, and that's what the VA should be seeking, but the only way you're going to get that and deal with human nature is to have competition.

Would you agree with that—with that concept of maybe coming from with outside—outside the VA?

Mr. Matkovsky. I'm an old consultant by training, so for me, time was money, and the availability of your time was billable. I think there's a balance. We don't want to turn into, you know, 15-minute appointments or 10-minute appointments where nobody looks at you. There has to be a balance, but there has to be accountability for time. You know, we talk about resources and the management of resources. Time is the most valuable asset in our system. We have to manage that time. We have to extract value from it. We have to be respectful in the way we do it, but I would agree, competition to know that we can get more clients, more veterans who want to come in our system, who are happy with our system, we need to introduce some of those concepts into our thinking.

Mr. Wenstrup. It isn't just the time. I mean—

Mr. Matkovsky. Right.

Mr. Wenstrup.—it's the quality of care and the patient's perception of are they being cared for. That's always a challenge in private practice, somebody who needs more time than someone else, or someone needs more time than you maybe planned on that day, but you give it, and you find a way to work within that system to make sure that when they leave there, they feel satisfied.

So, my advice at this time, one, I do—I want to hear what's going on in Cincinnati, obviously, but I also would really suggest that we take a look outside of the VA system because if that's been your whole life, you don't really understand how it could be, and I think competition is the key, and I yield back.

The CHAIRMAN. Thank you, Doctor.

Mrs. Walorski, you're recognized for 5 minutes.

Mrs. Walorski. Thank you, Mr. Chairman.

Mr. Matkovsky, I find myself again tonight, I associate myself with the comments of everybody on this committee, and the more I learn it sitting here by the questions they're asking, the more baffled I am on the things that we heard 2 weeks ago and the things that we are hearing tonight, but primarily, I guess on behalf of every American taxpayer, where the heck is the money, the billions, with a "B," dollars that this Congress and previous Congresses have allocated to IT upgrades? What do you tangibly have? We funded all kind of things the chairman just read. What time did the VA tangibly spend money on that is working right now?

Mr. Matkovsky. I would have to take that one for the record. I mean, there are a number of things that we have developed and delivered in the IT domain. You know, we have Veterans Benefits Management System, which is a paperless claims development system for VA—

Mrs. Walorski. But sir—and I apologize for interrupting, but Mrs. Kirkpatrick asked the question and you gave the answer, we're using 1985 programs. 1985. I've only been here 18 months, and we've allocated millions of dollars, and the IT people sat right here that I think somebody else referred to, and we asked and asked and asked all kinds of questions. In fact, I specifically asked

them, sir, who is in charge of the IT department, do you have enough money to purchase what you need to get this VA system moving? And the answer was, yes, ma'am.

We've seen all these budgets. We funded everything under the sun, and it is baffling to me, it has to be baffling the American taxpayers watching tonight that we are using a 1985 antiquated system. But here's my other question. I guess the thing that I think is very, very interesting is did you not have any idea, based on Mr. Griffin's comments from 2005? I've only been here 18 months. I've heard IG report after GAO report after IG report, and I know there's a problem, but in the system—and you said you're the business side, you're the engineering side, did those IG reports never make it to you?

Mr. Matkovsky. I reviewed the GAO report, and I believe we had testimony here in I think it was April of 2013. In response to that GAO report, we went back and looked at how we computed the wait times for veterans who are new to our clinic, maybe not new to our system, but it was the first time they were going to podiatry or—

Mrs. Walorski. And were you satisfied with the results you came up with and thought that you fixed them?

Mr. Matkovsky. No, we changed the performance measure from using the desired date to measure knew appointment wait times, and we switched the create date. It gave us a much more valid measure. We started measuring veterans who were waiting longer periods of time, and we started trying to change that.

Mrs. Walorski. And obviously—but can you—you say that today, that's a failure? What you guys did in an intermediary level was a failure?

Mr. Matkovsky. I would say that we did not know at that point in time, Congresswoman, the nature and the scope of the problem.

Mrs. Walorski. Well, I guess the two things that, you know, I came away with 2 weeks ago was this, there has to be criminal investigation, and to know that are 69 criminal investigations going on tonight, I think, is breaking news to the American public, and I agree. Indianapolis and Danville, Indiana are on your list for further investigations. My Hoosiers in the State of Indiana are going to ask the questions, well—well, what do I do, well, when are we going to get the information, and I guess I'll take that on the record that we are going to get information when you get it, but I have a question for Dr. Draper, because it goes to this issue of IT, because I'm sensing that where we're going to end up in one of these grand revelations is that this IT department, this IT system is unbelievably messed up, and we've asked the questions, but we've been—have not been provided truth when its come to those kinds of things, but Dr. Draper, as you know, the VHA is only permitted to use one authorized electronic list, the EWL.

According to your written testimony, ma'am, officials from a VA medical center that was piloting another electronic system stated that after evaluating the pilot, they decided not to use this approach. Do you know if that pilot program was vetted by the VA's OIT office.

Ms. Draper. We found that when we spoke with VA, that they have not done a system-wide check to see what people are doing. If this is related to the future care consults, consults that are—

Mrs. Walorski. Correct, but would you identify that problem as being—would that program be legitimate through the eyes of the VA?

Ms. Draper. It may not be legitimate. I mean, one of the problems is for some of those programs, the data doesn't end up in the consult data that is going to be used as a monitoring tool system-wide, so it can be problematic.

Mrs. Walorski. And could that not be also considered a separate electronic system, a separate electronic list if nobody has vetted it, if nobody is in charge of it but there's a system that is out there?

Ms. Draper. Well, we've seen in the last few months for the consults and new business rules, the five medical center included in our review, are changing their processes. They started out with something and they've now changed their processes, so it's really very confusing. I think that all the different ways that the medical centers are tracking those future care consults has not really been vetted with VA.

Mrs. Walorski. Thank you.

Mr. Chairman, I yield back my time.

The CHAIRMAN. Thank you. Colonel Cook, you're recognized for 5 minutes.

Mr. Cook. Thank you, Mr. Chair.

I guess everything in Washington comes full circle. And the old term, waste, fraud, and abuse is, going back through my brain, housing group tonight, but a couple of questions. By the way, Mr. Griffin, unannounced inspections. I am delighted that you went in there.

Ms. Titus, the last time we had a hearing here, she asked the question about one of the individuals on the panel that came down to Phoenix, I believe it was on a Friday, didn't work on the weekend and left the beginning of next week. Has anyone declared a state of emergency, decided to say, hey, let's work weekends, let's work maybe 6:00 to 6:00. If we're going to send striker teams, or if people are dying on our watch, has this ever occurred to people to, hey, we've got to do something about this? Mr. Matkovsky.

Mr. Matkovsky. Absolutely. We are encouraging and requiring our staff to work longer clinic hours, nights, weekends, you know, we are all working.

Mr. Cook. Maybe I'm missing some encouraging. I'm looking for a better action verb like can they go down there?

Mr. Matkovsky. Yes. We have put folks on the ground in Phoenix. They have been on the ground working, fixing the problems on the ground at my direction. They are working hard. They are finding ways to improve the practice. We are bringing folks in from our disaster and emergency medical provider system, they are—personnel system. They are on the ground as of Sunday to work Monday morning on the ground.

Mr. Cook. Okay. Then let's go back, the subject of mission performance standards, public administration 101, if you will. You know, in the military, there is a number of us that were there, we evaluated combat units, whether C1 or C4, fully combat ready or

not combat ready, and I have to ask myself, is—are some of the hospitals fully mission-capable and some not mission-capable, or others partially? Do we ever evaluate that in accordance with the mission that we have to take care of our veterans?

Because I'm getting the feeling, and I'm not trying to lead you, but I'm getting the feeling that each hospital does their own thing because the policies are different and ambiguous, if that was the word that I heard correctly, and open to interpretation? Anyone?

Mr. Matkovsky. We have—we have some great facilities. I think we also released today data that shows quality, efficiency, and others, and provides quantitative comparisons of our hospitals, and there are some that are lower, and we work with those to try to improve their performance directly.

Mr. Cook. Yeah. Mr. Griffin, you kind of hinted on this, and you know, at which you're talking about trust and all those things which I think some of us are—all believe in. But unless you have standardization coming from Washington and verification of the outcomes, are we working at cross purposes if it's open to interpretation?

Mr. Griffin. I think the expression "trust but verify"—

Mr. Cook. Absolutely, and that's where I was—

Mr. Griffin.—is what we talked about.

Mr. Cook. You're stealing my stuff. I am only kidding.

Mr. Griffin. In our organization, we go to 50 medical centers a year for 1 week review and specific areas of interest. We go to about 100 outpatient clinics a year, and then we roll up the results and we can tell the Under Secretary of Veterans Health Administration that X percent of your facilities aren't measuring up in these two categories, and then we would expect there to be corrective action on those.

Mr. Cook. You know, and I haven't followed this, and I'm sure you've got whistleblowers and everything else, but after I got out of the Marine Corps, I became a college professor, dangerous place for me to be, but every student nowadays, they have a thing called "rateyourprofessor.com," and I tell you, you want to find out how good, bad, indifferent you are or whether a student is just—read that, and I'm just wondering, because I was trying to go through about—and look at different hospitals, rateyourvahospital.com. Sometimes it's eye-opening and sometimes you need that, that self-evaluation.

I obviously am looking for a more standardized evaluation method on whether they are completing the mission. I would hope we could do that, or we're just going to have, I think, bad results in the future. I yield back.

Mr. Griffin. If I could respond.

Mr. Cook. Yes, sir.

Mr. Griffin. In our combined assessment program, when we go to those 50 facilities, one of the last documents in the back of those reports is a VHA document called "The Sale Report," and it ranks every hospital on about 100 different performance metrics, and it's published in those reports. So, the data is collected and it is available. Now someone needs to act upon the ones that aren't measuring up.

Ms. Draper. Can I also respond to your—

Mr. Cook. Subject to the chair.

The CHAIRMAN. Yes, go ahead.

Ms. Draper. Yes. What we found is a great reluctance on the part of the VA to standardize policies and procedures, that also leads to complications when you're trying to do oversight, so I think there are issues there.

The CHAIRMAN. Mr. Cook.

Mr. Cook. Well, the only thing I wanted to say, this came up this year with the cuts to all the military units. If there's a deficiency of training, equipment, and everything else, this report, what have you, would have those deficiencies that could be corrected. Now, all I'm saying is that I would hope that the VA would look at more standardization from my standpoint.

The CHAIRMAN. Thank you, Colonel.

Mr. Jolly, you're recognized for 5 minutes.

Mr. Jolly. Thank you, Mr. Chairman.

Just to confirm, Mr. Griffin. You said there were 69 cases where you are now following up to review possible criminal implications; is that right?

Mr. Griffin. There are 69 separate facilities beyond Phoenix that we have sent rapid response teams to as allegations have come into us.

Mr. Jolly. Specifically criminal allegations?

Mr. Griffin. No, they're—first of all, they're just allegations.

Mr. Jolly. Sure. I understand.

Mr. Griffin. We sent criminal investigators there to take sworn testimony and try and get to the ground truth, but in some instances, you know, you're only as good as your source, right?

Mr. Jolly. Sure. No, I understand.

Mr. Griffin. Right.

Mr. Jolly. And allegations have to be vetted out.

Mr. Griffin. Yes, sir.

Mr. Jolly. But You used the term "criminal." I wanted to confirm.

Mr. Griffin. That's right.

Mr. Jolly. This is the different, though, Mr. Matkovsky, from the follow-up visits that are required of some of the institutions based on your audit, correct?

Mr. Matkovsky. That is correct.

Mr. Jolly. Totally separate. Okay. The timing, and I know it's come up for additional information on those follow-up visits, is it weeks or months? I realize it's weeks.

Mr. Matkovsky. Weeks. We will be working with the Office of the Inspector General this week putting together a plan, which we've already started, and then it will just be a matter of weeks. I agree that we need to make sure that veterans understand that their care is still quality care and that what we've identified here is questions of practice integrity.

Mr. Jolly. Okay. Mr. Matkovsky, I want to thank you for your candor this evening. You know, Congress often gets frustrated with trying to get information from this administration. You are demonstrating an exception to that tonight, and I want to compliment you for your honesty, and your references to some of the frank problems within the VA. You spoke about non-VA care, in your

terms, being now the veteran's choice, and this is one of the issues that I've raised repeatedly now.

I think within the current system, the ability to get to non-VA care sometimes is obstructed by a process where a patient has to go to the very same medical staff that said they didn't need it. Has that changed? Your term now, patient's choice, has that changed?

Mr. Matkovsky. It is changing, sir. It's going to take time. In conjunction with accelerating care, we provided training to roughly 1,900 of our facility and regional staff. That was over a period of about 6 days. In addition to that, we've since offered and delivered training to about 2,700 staff for appropriate use of the scheduling package and how to manage no-shows, how to schedule appointments, et cetera. It's going to take a lot of that. It's going to take a lot of communication, constant communication, and then, frankly, monitoring. If we see delays and we don't see use of non-VA medical care, incumbent on us in Washington and at the network and at the facility to ask the question why.

Mr. Jolly. Right. But has there been a change in the same medical staff that initially said no having to sign off on now saying yes.

Mr. Matkovsky. The change is the degree of vigilance that we have in the communication of our objective that the veteran must be offered a choice.

Mr. Jolly. Okay. Along those lines of analogous to non-VA care, I think each of you would agree tonight you referred to as a problem within management, at least places of management throughout the system as opposed to the staff and some of the doctors that the veterans say provide great care.

Currently, in some VA facilities, private sector healthcare systems provide management different than just seeing a non-VA physician. Is there value in expanding the use of regional healthcare system providers to provide them management? So, I understand from a number of the veterans I speak to, they want to stay within the VA system, they like their VA hospital, so the idea that some have suggested of just feeding everybody out or using the voucher program is a not something that I believe the veterans' community would really embrace, but can we expand the use of private sector healthcare systems to provide management for facilities? What would your thoughts be on that?

Mr. Matkovsky. On some cases, we do use that. As you know, with contract community-based outpatient clinics, we do have some partners—

Mr. Jolly. Sure.

Mr. Matkovsky.—in the private sector that help us manage it, some of our outpatient clinics.

Mr. Jolly. But those are really smaller facilities, right? What about the very large hospitals where peer-to-peer—I mean, and let's be honest. It's not a criticism. There simply cannot be the private sector efficiencies in a large VA hospital currently. Is there value in looking at larger facilities and saying can we provide private sector management?

Mr. Matkovsky. Sure. I mean, we can look at it. The one thing that I would tell you, if this crisis has taught me anything is to question everything and the intent behind everything.

Mr. Jolly. Has there ever been a comparative study performance based on management from private sector—

Mr. Matkovsky. Periodically we do. The one thing that I would just—just one moment of concern. A lot of our measure of the private sector efficiencies are revenue-based metric—

Mr. Jolly. Sure.

Mr. Matkovsky.—which is to generate revenue, so I would say that, you know, other agencies, Medicare and others have had some issues with that. So, our version of productivity, I would just ask us to have some measure of skepticism in the interpretation of that productivity data. It is tied to revenue.

Mr. Jolly. I want to thank you again. I really do appreciate your candor, and I will tell you 2 weeks ago many of us were asking for urgency. I think we heard that from you tonight. I know the Acting Secretary has demonstrated his approach as one of urgency as well, so thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Jolly. I do ask unanimous consent that the former chairman of the Subcommittee of Oversight and Investigation, Mr. Johnson be allowed to ask questions.

Without objection, Mr. Johnson, you are recognized for 5 minutes.

Mr. Johnson. Thank you, Mr. Chairman, and thank you to my colleagues for allowing me to participate.

And Mr. Matkovsky, I, too, commend you for your candor. I—I want to focus a little bit on more on the IT issue. As subcommittee chair Roe and I, one of my very first requests of the VA was to show me the IT architecture for the VA. Now, I don't know what your IT background is, so I don't mean to be insulting. Do you know what an IT architecture is?

Mr. Matkovsky. I do.

Mr. Johnson. Do you realize that it's now going on 4 years, and we still do not have the IT architecture? You know, I sat with the Secretary in his office, and I gave him an analogy, and an analogy that he is very familiar with. As a battlefield commander, you would not go into a conflict. I mean, our young people that we are now trying to take care of in their veteran years, when they were serving, they depended upon leaders to make good strategic decisions and know what the enemy had out in front of us, know what our capabilities were to offset those risks and those threats. They have the same expectation now of the VA to understand what their needs are and what the capabilities are that are required to meet them.

The VA has got hundreds and hundreds of IT systems. You made a statement a little earlier ago. You said, I think to my colleague, Mrs. Walorski, one of the systems you said you would not approve it until it was proven to integrate with our current system.

How, in God's name, can you expect new IT integration to be complete and accurate if the VA still has no idea what the architecture of its VA IT environment is? You're spending hundreds of millions of dollars a year on IT related things, and Dr. Draper, Mr. Griffin, Ms. Halliday, I hope that that's one thing that you'll take away from here as you're looking and investigating into what the problem is. Part of the reforms that the VA needs to get to is com-

ing into the 21st century with IT not only in terms of systems, but in systematic processes and current state-of-the-art methodologies for managing those systems.

Mr. Matkovsky, when are we going to see what the VA plans to do with its information architecture?

Mr. Matkovsky. Sir, I'll have to take that one back.

Mr. Johnson. I heard that 3 years ago, and I'm not trying to be disrespectful, but that's the same old question. It's like a dog race. You know, we come out every 2 years and we chase that rabbit around the circle, and then we put the dogs up until we ask it again.

Mr. Matkovsky. I think we have to ask what do we want. You know, in this case, for scheduling, we want to be able to provide timely, accurate, information about when veterans want to be seen and what capacity we have in our system to see them, whether we build that or acquire it. I would rather buy what the industry has and knows can work. The healthcare industry has something called "HL7," which is the interface language. Most modern systems speak that language, so does, frankly, our old Legacy VistA system. I would not look to have really complicated interfaces but rather delivers what the industry can show us.

Mr. Johnson. Well, I would agree with you because I suggested to the Secretary in 2012 that, you know, he said there's three priorities: We're eliminating the homeless problem, reducing the backlog, and getting an electronic health record, and I would not approve a single new dollar of new IT spending until someone in that IT department could show me the current architecture and how all these systems fit together, and how any new IT spending is going to affect that. And let me make one more point because I'm running out of time.

You talked about the electronic health record and you made some very positive comments, and I confess that I don't know where the status is as of today, but I can tell you that at the end of 2012, we had a joint hearing with Secretary Shinseki and Secretary Panetta, and they were proudly saying that we were going to have a single transparent electronic health record for our military from start to finish within the next 5 years. You've been working on it for 10 years.

This is not a matter of can do. It's a matter of want to, and the Department does not want that electronic health record because the IT technology to get it is there today if they really wanted to do it.

Mr. Chairman, I yield back. Thanks for giving me the opportunity.

The CHAIRMAN. Thank you very much, Mr. Johnson.

Members, the clock says 10:10. We will stand in recess for 5 minutes.

[Recess.]

The CHAIRMAN. If everybody could start making their way back to their seats. Hearing will return to order. We will start a second round of questions for those who would choose to ask.

Mr. Griffin, if I might, in your testimony and in the interim report, you stated that the OIG is "not providing VA medical facili-

ties advance notice of our visits to reduce the risk of destruction of evidence, manipulation of data, and coaching staff on how to respond.”

However, in documents received from VA pursuant to the May 8th committee subpoena, it shows that OIG notification was provided to facility directors prior to criminal investigative visits at some facilities. Could you help us reconcile your testimony and the information that we have?

Mr. Griffin. The original testimony that you read from us is as stated and accurate. There has been confusion created by some people at medical facilities who thought that the VA audit personnel were my personnel. We saw that on a number of occasions alleging that we've let directors sit in on the interviews. There was too small of a population of schedulers interviewed. That was not the IG interviews. That was the VA audit teams.

The CHAIRMAN. Thank you very much for clearing that up.

Mr. Matkovsky, why haven't you already determined which non-VA providers are in communities? Isn't this the PC3 program that has been so highly touted, designed to identify qualified providers who can provide care when VA doesn't have the capacity to do so? You testified that you're going to go out and figure out who you can use. Haven't you—shouldn't you have already done that?

Mr. Matkovsky. Mr. Chairman, to some extent we have, already through PC3. I want to set some realistic expectations. PC3 received its first authorization of referral for care in January, the contractors, so it's going to take some time to fully flesh out those networks and run at a rate that we want them to be. In some networks, in some regions, they may have difficulty finding providers, so we'll continue to use non-VA care previously known as fee-based defined care.

What we did, we provided the list of veterans who were waiting in our facilities for the particular types of care. We also shared that with your our PC3 contractors to see if they had that capability to understand our demand.

The CHAIRMAN. Okay. Thank you. Also, we talked about Dr. Davies and the electronic wait list issue and the fact that it has grown since he first testified, but he also said that the wait list would be eliminated by April 1st of 2009, and it would remain at zero by the 1st of July of 2009, so my question is, don't you think that would be the impetus for the problem and the fraud that's been perpetrated in regards to the secret waiting list?

Mr. Matkovsky. I think we need to be, Mr. Chairman, careful what we say. We should not be telling facilities that they should not have an electronic wait list. If our policy says that they cannot schedule a veteran within 90 days, they should go on the electronic wait list. If those clinic slots are not available, we're to record those delays for care where we can find them. So we should not be telling people to have no electronic wait list.

The CHAIRMAN. I guess that's an answer.

Mr. Matkovsky. Sorry, sir. Let me be more direct. We should not do that.

The CHAIRMAN. I've got another question. My time is running out. I apologize. But you talk about credentialing and the time that it takes to credential physicians. Are you aware the chief of staff

of the Miami VA Healthcare System Medical Center signed a consent agreement in 2009 with the State of New York never to practice in that State due to his failure to meet the standard of care for abdominal surgeries while practicing medicine in Florida? And in this regard, the Florida Board of Medicine has already fined this doctor \$5,000 and ordered him to complete community service attending remedial training. So the question is, why is this doctor—twofold. Why is this doctor still at the Miami VA Medical Center, and how is it he remains the chief of staff of a major regional healthcare facility?

Mr. Matkovsky. Sir, I found out about that last night and this morning and collected some data. I don't know the specifics of the case. I have to research it, and I will get back with this committee.

The CHAIRMAN. Would it be proper for that person to still be in his position if, in fact, that information is true, or would it be more accountability on your behalf if that person were to be suspended?

Mr. Matkovsky. I cannot conjecture as I don't know the specifics of the case, but if it turns out to be valid and these are valid concerns, then some appropriate action comparable to suspension. I believe that there was a merit systems protection board, an MSPB review. I don't know that for certain, sir, but I just have to go back and research it.

The CHAIRMAN. So the merit system protection board is the same thing that Senator Sanders wants to interject into the bill that we passed out of this committee, correct?

Mr. Matkovsky. I don't know. I believe that some of that is in his bill, yes, sir

The CHAIRMAN. Yeah, he has a 1 week filing or appeal and then a 3-week period, but that's the merit system protection board that you believe is allowing a physician who surrendered his license in the State of New York and is still the chief of medicine for the VA Medical Center in Miami, it's that medical—that board that's allowing him to stay in his job?

Mr. Matkovsky. Sir, we need to look at this case. I found out about it this morning. I do not have all the facts on it, but we do need to look at it.

The CHAIRMAN. Okay. Thank you.

Mr. Michaud.

Mr. Michaud. Thank you, Mr. Chairman.

That same position that the chairman talked about, is that a Title 38 employee or a SES?

Mr. Matkovsky. That is a Title 38 employee, sir

Mr. Michaud. Title 38 employee. Have you looked at—as you know, we passed the chairman's bill before the break, and actually I have H.R. 4399 that deals with Title 38 and set metrics and performance standards. Have you had a chance to look at 4399?

Mr. Matkovsky. I'm sorry, sir, not in detail.

Mr. Michaud. And is that something, when you look at metrics and performance standards—ask you to look at that and see whether or not you might want to implement that administratively because one of my biggest concerns with the bill that we had previously is it leaves out 80,000 Title 38 employees where we actually, the GAO report stated that the doctor let the—his license expire and he still got, you know, awarded, and when asked the VA

about that situation and he said that that was not part of the metrics.

For me, if you're a doctor, you should have a license, so I'd encourage you to look at that legislation to try to implement it immediately versus having to try to get it through the system

I also want to say, Mr. Matkovsky, I do agree with what Mr. Jolly said. I really appreciate your candidness and your willingness to be forthcoming this evening. It definitely is refreshing to hear you come forthcoming in that regard. My question, actually getting back to PC, you mentioned the PC3 contracts. Are they reducing delay in accessing non-VA care?

Mr. Matkovsky. What we are witnessing with PC3, we have a service level. That service level is that veterans must be scheduled and have their appointment performed within 30 days, and that should be true 90 percent of the time. We are not at 90 percent of the time, but we are north of 70 percent of the time, and most networks in most regions are now above 80 percent of the time, and we'll—I think we'll stabilize at about 90 percent plus, and there are certain incentive payments that we'll make if care is delivered more timely

Mr. Michaud. Okay. You mentioned about resources and some facilities—well, there is about \$300 million, I believe you said, additional for some facilities. Taken into consideration, your budget was put forward with the wait times at 14 before this whole issue broke. Do you anticipate, in order to take care of that huge backlog that's out there that we never anticipated, that you're going to need more resources to deal with that particular backlog? And if so, how much?

Mr. Matkovsky. Right now we know of a requirement for 300, and we've been able to identify how we can allocate resources to address that. Those funds will be available—will be made available starting tomorrow to the field. I think the entire amount, our chief financial officer is committed to release tomorrow, and then we'll track the execution of those funds.

Over the next 30 days, we're going to perform a more detailed review. I don't know what that review is going to return, but if it identifies that we require additional resources, we will come back and notify this committee.

Mr. Michaud. All right. But you're moving that \$300 million from somewhere else within the VA, the Department, so where you're moving it from, isn't it going to hurt those particular areas?

Mr. Matkovsky. Well, it may. I mean, I think in one potential case, it might be using some of the carryover as a target for those funds.

Mr. Michaud. Okay. You heard Mr. Johnson talk about the IT architecture. If you look at the bill that we passed, I'll tell you unanimously in committee dealing with advanced appropriation, but it also calls for planning, you know, a quadrennial report as well as a 5-year planning process within the VA so you can focus on where you should be. And at that point in time, I believe the VA, I don't believe has taken a position or you were opposed to that advanced appropriation. Have you reconsidered that, particularly the planning process?

Mr. Matkovsky. We have actually introduced some new planning processes for our budgeting, so one of the challenges we have is when, you know, demand of the realities on the ground are different than some of our planning assumptions. It's harder for our system to react than, say, a private sector that's going to be based on revenue, but we are using some of those principles today. We call it, I think, PPB&E, planning programming, budgeting, and execution, so some of those principles are coming in already.

Mr. Michaud. Okay. Thank you. Thank you, Mr. Chairman.

RPTS JOHNSON & DCMN SECKMAN

The CHAIRMAN. Thank you very much.

Mr. Lamborn.

Mr. Lamborn. Thank you. Mr. Matkovsky, I am glad to hear that the VA is going to use some of the I think it is \$450 million of carryover for fee basis. I know I was calling for that 2 weeks ago. So you are going to use \$300 million. So that takes care of the money side of it. On the medical side, what problems do we have to look for, for instance, if someone goes in and out of private care from the VA system, like the potential of losing records?

Mr. Matkovsky. Right.

Mr. Lamborn. What are the medical issues that we have to be cognizant of when they go back and forth using fee basis? And I think we have to use fee basis. Don't get me wrong.

Mr. Matkovsky. I think we have to watch that very carefully. I think one of the things we have also learned in our audit is that we need to ensure there are sufficient non-VA care coordination staff in facilities. We can't simply feed to the community and assume it is going to take place. We have to coordinate that care. Part of that coordination is the transfer of medical records out. The other part of that is the transfer of medical records in. With PC3, where we have a contractor or other contract arrangements, we can stipulate terms in the contract. In a lot of our non-VA medical care, it is an individual authorization, it is a little bit harder to specify that. But we have to be careful about that. I know with PC3, we currently have a requirement that the data come back upon the delivery of an invoice, and it's partial terms for payment, right? So in order to go to the processing of the payment, we have required data. It is not in a computable form; it comes in a PDF form. We are researching other ways in which to use something called a Nationwide Health Information Network to transfer computable data. And we are going to see if we can build that into some of our contracts as well. But we have to be careful.

Mr. Lamborn. Well, we really need to use more fee basis. I believe that the chairman's legislation that the House is going to consider takes a big step in that direction, at least for the backlog.

Mr. Matkovsky. Yes.

Mr. Lamborn. And I think we are going to need it even beyond that. And for Dr. Draper, I have a question on fee basis. What obstacles do veterans face right now under VA policies for using fee basis? I have talked to veterans who didn't even know that it was available. That is one obstacle. They don't even know it is out there.

Ms. Draper. Right. And I think as in the case that I described in my oral comments, and as has been talked about here, is really critical to make sure that the veteran and the VA Medical Center and the non-VA provider are coordinating, and the patient records are getting transferred appropriately, information is getting transferred back and forth. It is really difficult for a patient or a veteran to navigate any health system, so dealing with two separate systems is an added complication.

Mr. Lamborn. And Mr. Griffin, do you see other problems that need to be overcome as veterans have more awareness and ability, I hope, under pending legislation to use fee basis where there is a backlog?

Mr. Griffin. As has been stated, it has to be managed very carefully. We have done audit work in the past of both inpatient fee-basis care and outpatient fee-basis care. And the financial management processes were not there sufficiently to preclude duplicate payments for that care. Payments to a medical center that billed for the doctor's care as well as the care for the hospital facilities. Separate bill came in from the provider. So we have been working with VHA on that. And Mr. Matkovsky is one of the leads on trying to make sure that the internal controls for that \$4.8 billion are in place and we are getting what we pay for.

I still think the bigger question is you got to figure out what the balance is between full-time VA staff—you will always need some fee basis, no question, especially in rural areas that are removed from the metropolitan areas where the old medical centers are located. But we got to make sure that it is a good business decision to go in that route as opposed to hiring more full-time staff that is committed to working with veterans.

Mr. Lamborn. Thank you.

Mr. Matkovsky, do you have any final comments to my question on fee basis?

Mr. Matkovsky. One of the items that we are working right now is to structure some regulation as well that makes it clearer. Not all of the authorities that are in statute cover all of within terms of fee. And we are making some efforts to allow us to use other forms of agreements in the same way. I think that is important as well. The IG has noted that we have had historically certain deficiencies in the use of our authorities. We have tried to correct those. And now we are trying to regulate them.

Mr. Lamborn. Thank you very much.

The CHAIRMAN. Ms. Brown, you are recognized for 5 minutes.

Ms. Brown. Thank you.

And first of all, I don't mind being the minority on this committee. And I think my voice is a little bit the minority on this committee.

VA is just as good as other stakeholders. And for example DOD, its seamless transfer is not happening. So that is part of the problem.

But Mr. Griffin, I don't want to go out and hear on the news—and you know how the news blow everything up. I know it is not us; it is just the news—that we got how many investigations and criminal investigations going on? Because we have a whistleblower doesn't mean that the facts are going to check out. Is that correct?

Mr. Griffin. That is correct. I think I said we were investigating allegations.

Ms. Brown. Absolutely. And “allegations” does not mean criminal.

Mr. Griffin. That’s to be determined. That’s why we are doing the investigation.

Ms. Brown. Fine. I mean I think—I don’t want my veterans to feel like that they are not getting the proper care. And I really have not heard that the care is not the quality. It is the timeliness of getting the service. Can you correct me on that?

Mr. Griffin. I think there are private sector surveys that show that veterans are satisfied more so than some private sector facilities, are satisfied with the care they get at the VA.

Ms. Brown. Absolutely.

Mr. Griffin. But part of quality is timeliness also.

Ms. Brown. I understand that. When I don’t show up for an appointment, they charge me. You know, like if I have an appointment at Mayo and if I don’t show up, they still give me a bill. Now, we don’t penalize our veterans in that manner. And this fee base for service, we need to be careful because it could be a slippery slope. Veterans like the care that they get in the VA facilities. I don’t have any problems in making sure in some cases that we use private providers. But we have got to make sure it is the same quality, and we have got to make sure that we still have that open—we are making sure, as Ms. Draper said, that we have the same kind of coordination. Somebody want to respond? I only have but a couple of minutes.

Mr. Griffin. I agree. It has to be quality. But as I mentioned earlier, I think the best quality is an integrated system. And the more of the care that gets farmed out, the more you lose on the integration aspect and the keeping track of the care that was provided and the medical record for the veterans.

Ms. Brown. I have this report from the Washington Examiner. And it talks about the clinics, outpatient clinics. And it cites Jacksonville as having the largest delay, 13 years. I want to turn this in, and I want to be clear that this is not correct. I don’t know who did this survey. But I met with the mayor. I met with Shands. I met with the VA, and it didn’t take us 13 years to get our clinic done. But we have one of the best clinics in the country. And I am very pleased with it. But when you are dealing with developing clinics, you got a lot of stakeholders, including buying the property, working with the city, working with the permitting. And so I want to turn this in. And it did not take 13 years for my clinic to be built.

The CHAIRMAN. Without objection.

Ms. Brown. So I don’t know who is doing this research, but it is not correct.

Secondly, I want to give to the chairman an article I read today on the way to Washington in the Times-Union, the paper in Jacksonville, where the State of Florida is suing the VA because the State wants to come in and investigate the VA. At some point, Mr. Chairman, you need to deal with your Governor. Pass this over to him.

The CHAIRMAN. Ms. Brown, I will deal with my Governor when you deal with your President.

Mr. Bilirakis.

Ms. Brown. No, no, I got 32 seconds. Mr. Chairman——

The CHAIRMAN. Ms. Brown.

Ms. Brown. Now, you know that is not a good comment. And I just think you owe me an apology for that, because the fact is the State of Florida is sending people into the VA. That's like sending them into a military facility. That is not acceptable. And it is not a joke.

Now, this President——

The CHAIRMAN. Your time has expired.

Mr. Bilirakis, you are recognized.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it very much. A couple questions. To follow up on Mr. Lamborn's question, Mr. Matkovsky, currently what percentage of the health care is outsourced or farmed out, whatever, on the fee basis in other words? Currently.

Mr. Matkovsky. Roughly about \$4.8 billion, which is about——

Mr. Bilirakis. What percentage?

Mr. Matkovsky. About 7 to 8 percent, sir, somewhere right around there.

Mr. Bilirakis. Seven to 8 percent?

Mr. Matkovsky. Yeah. And then we also have State veterans homes that provide us long-term care. And that is a slightly larger number. I think the total expense would be somewhere around \$5.5 billion, which is closer to 10 percent.

Mr. Bilirakis. All right. Thank you. Let's see. I will move onto Mr. Griffin. Sir, in your testimony, you stated that the OIG has issued 18 reports that identified deficiencies in scheduling within the VA since 2005. Can you elaborate on some of the recommendations identified within your reports?

Mr. Griffin. I would like to give Lynn Halliday, our assistant IG for audit, who directed most of those reports, an opportunity to answer that question.

Mr. Bilirakis. Absolutely. Is it okay with you, Mr. Chairman?

The CHAIRMAN. Please, Ms. Halliday. Thank you. We are glad that you could join in the conversation.

Ms. Halliday. Thank you. In the audit of VHA's outpatient scheduling procedures, when we really started work in 2005, we identified that the national electronic waiting lists could be understated by as much as 10,000 veterans. At that point, and we were early in our careers, we made recommendations to improve the oversight over scheduling procedures and to come up with standardized training programs for scheduling. At that point, we had found a lot of inconsistencies at the sites we went to. Then, in 2007, we had another major audit, our audit of VHA's outpatient wait times, where we looked at consults, similar to what Dr. Draper had looked at. And we started working there to look at the issues that are actually going behind the waiting times. There was debates on whether the numbers are more correct, only overshadowing the primary points in our early audits. We came to the conclusion that VHA's scheduling system was incomplete. It was not providing reliable information. We made, again, recommendations for addressing

the delays in obtaining subspecialty procedures. We continued to look at the quality of care. And then we moved on, and we took on looking at wait times in a VISN network, VISN 3, and we again found that the scheduling procedures were not followed. There were systemic problems throughout VISN 3. I would point out on that particular audit, we had nonconcurrences with the recommendations. We wanted VHA to establish a formal scheduler national training program, something with some more rigor to it so we would eliminate some of the inconsistencies with the scheduling. We wanted required audits of the schedulers' performance. We definitely wanted to make sure that the national reporting software linked the consult create date with appointment creation dates. Some of this is very technical. We tried to work with VHA throughout these various issues. There was a lot of resistance to really accepting the fact that there was a major problem with inaccurate scheduling and not having reliable data.

Mr. Bilirakis. What were their responses to your requests? I mean, give me an example when you talk about resistance.

Ms. Halliday. Resistance, in the VISN 3, I thought it was sort of the tip of the iceberg. There were complete nonconcurrences with the recommendations made. They didn't feel it was necessary. They didn't feel that they had a major problem. I think our more recent work, I know Mr. Matkovsky has been far more receptive to working with what we have been telling them about how to go about fixing some of these problems. You have to have good documentation of what your demand is for scheduling in all of these various EWLs or you are never going to have good information to make the decisions you need to make. So in working and trying to tell and change a culture in VA to hold facility directors accountable so that you get integrity over your information is really key. We have stayed in that area as far as the recommendations.

Mr. Bilirakis. Thank you. In your opinion, do they have the necessary funding, the VA has the necessary funding to implement these recommendations in your opinion?

Mr. Griffin?

Ms. Halliday?

Ms. Halliday. Funding was never given as a reason why not to implement these recommendations. I believe, as we started to tiller that, yes, and they had money for the replacement of their scheduling package.

Mr. Bilirakis. Thank you so much. I appreciate it.

The CHAIRMAN. Thank you Mr. Bilirakis.

Mr. Takano you are recognized for 5 minutes.

Mr. Takano. Thank you, Mr. Chairman.

Mr. Griffin, I just want to examine more this statement you made earlier about the proper balance between fee basis and the full-time work of the veterans health care employees. So your sense is that we really should look at the fee basis as a way to sort of deal with access to health care in maybe some of the rural areas, but our greater efficiencies over time are going to be with an integrated approach to health care?

Mr. Griffin. I think you will always need fee basis as a safety valve.

Mr. Takano. So you see it as a safety valve.

Mr. Griffin. But I think you need to make a business determination. Based on the number of veterans coming into your facilities, you need to determine, based on staffing and performance standards, how many full-time doctors you need to take care of that load of patients. And I don't think that analysis has been done.

Mr. Takano. So we don't really know whether we are adequately staffed with full-time doctors because the data has been—has kind of muddied the waters, right?

Mr. Griffin. That is correct. Without the data integrity, you are without a basis for making a decision.

Mr. Takano. What I mean by muddying the waters is that we definitely can't tell whether it is a shortage that's driving—part of the driver of this problem. Is that right?

Mr. Griffin. That is correct.

Mr. Takano. Is it possible, Mr. Matkovsky—have I said it right, Matkovsky?

Mr. Matkovsky. Yes, sir.

Mr. Takano.—that not only do we need to look at fee basis, but also maybe arrangements with our federally qualified health clinics in some of our rural areas and areas that are impacted like mine that are not rural but have a physician shortage?

Mr. Matkovsky. I think we could. One point that I want to make is we are looking at productivity, staffing, and efficiency now as we determine our resource level. We do have productivity and efficiency. The efficiency data can be skewed by the timeliness data. That's important to know. But we have academic affiliate agreements that we use through our medical sharing authority. And then we also have other sharing authorities that we also use with other Federal Government partners, to include DOD. So yes.

Mr. Takano. Thank you. And Dr. Draper, if I understand you correctly, one of your concerns about fee basis care is the interchangeability or the seamlessness of the electronic health records that we have at the VA and whatever system they are using in the private care?

Ms. Draper. Right. It is coordination of care, and that includes the transfer back and forth of records.

Mr. Takano. And it seems like only one of the ways that IT is being used, you mentioned, Mr. Matkovsky, maybe seven or eight of the ways in which we use our business system, but that VistA did set the standard for the actual health record part.

Mr. Matkovsky. I would say that, prior to VistA, there was a general market failure in the world of health IT. It set the standard. It created the standard that the industry grew up around.

Mr. Takano. So Dr. Draper, is there a standard in the private sector of health care, or is it a multiplicity of different kinds of health records?

Ms. Draper. I think the latter. But there are probably practices from the private sector that could be looked at.

Mr. Takano. We have had trouble trying to connect DOD and their health records and VistA, but you are saying with regard to private sector systems, there is even a greater challenge posed by the fact that we have a multiplicity of health systems out there?

Ms. Draper. Yes.

Mr. Takano. What about our FQHCs? Do they use a standard at all, and would we have problems integrating with those?

Mr. Matkovsky. I think that there is an initiative that is still in its early stages of deployment, maybe folks here have heard about it, but the Nationwide Health Information Network. I think NHIN is what it is called. We have pilot deployments. We have sort of led some of the industry in that, both with DOD and with private sector. I know we have been working with Kaiser to actually establish interoperable transfer of records. It is a long way away from being, you know, completely ready across the country.

Mr. Takano. Have we given much thought about what it would take for proper oversight with an expanded fee basis relationship?

Mr. Matkovsky. We need to make sure that when we are using non-VA care—this is not a direct answer. I don't know that we have the specific answer today, just to be candid and direct.

Mr. Takano. Okay.

Mr. Matkovsky. And we need to know what it is going to take to coordinate it correctly.

Mr. Takano. Thank you.

The CHAIRMAN. Thank you, Mr. Takano.

Dr. Roe, you are recognized for 5 minutes.

Mr. Roe. Thank you, Mr. Chairman.

I am going to give you a simple principle that will make the VA better tomorrow. And that principle is if you walk on a VA campus and ask who do they work for, they will say the VA. The answer should be the veteran. And what I used in my practice for 30 years was, and it was a philosophy in my practice, was we don't work for the insurance companies. We don't work for the hospital. We work for the patient. And if you will do just that and put that culture in, the VA will be better tomorrow night. And bring that culture from the top all the way down to the person sweeping the floors at the VA, I promise you it will be a better organization. If you will take that back.

I have a couple things I want to ask you about along the fee based. If a veteran is in a situation where they cannot be seen, they are on a long wait list or whatever, and this is a qualified veteran, and they want to get TRICARE for life, has anybody thought about just, look, here is TRICARE for life, that is your insurance policy now as a veteran and you can go utilize that? Has that been thought about?

Mr. Matkovsky. We have been. In some cases, we have DOD sharing agreements where we recognize TRICARE for life as the beneficiary, and we will establish a sharing agreement and do a reimbursement there. So we have done that as well.

Mr. Roe. And that could be a possibility of helping VA out.

Mr. Matkovsky. Potentially.

Mr. Roe. Another question. You mentioned that in Ohio, I think it was, where veterans had literally in a week or two, you all cleared out that backlog. My question is if that happened, why did it ever occur? If it was that easy to clear out?

Mr. Matkovsky. I wish we had done now what we had done now 10 years ago. Just to return this focus on speed of care, ensuring that we get the good data, and then, frankly, returning our man-

agement practices with veterans at the center of it. That's all I can tell you.

Mr. Roe. Let me go with a couple other things. First, on data sharing, I was on the private side as a veteran, worked in a community with a VA Hospital. The problem I had was getting information from the VA to tell me why the patient was in there to see me. So that is an issue also. The VA doesn't share information about drugs that are prescribed. And we have a huge prescription drug problem in Tennessee. We cannot get that information.

Mr. Matkovsky. Yes.

Mr. Roe. And the VA needs to be more forthcoming in their sharing of data also with the private sector. And that's just a comment. I want to very quickly, because our time is limited, the audit findings intermediate actions, the bullet points that we have right in front of us. One is to suspend all VA senior executive performance awards for 2014. I have never yet had anybody explain to me what are those metrics? And I know you don't have time tonight, but what do I do to get a bonus? I bet there is not anybody on this committee that can tell you. I can't, and I have been here 5 and a half years. So I want to get that written. And we will remove the 14 performance goals and VA will revise, enhance, and deploy scheduling training. VA will implement a site inspection process. When will that occur? That is intermediate. Is that going to occur in a week, in a month, in a year?

Mr. Matkovsky. No. Some of those have actually already occurred. We promulgated instructions this morning to remove the 14-day performance measure from all staff. We have come up with a mechanism that allows us to have the medical center management, each one of them, report and record all the staff where we have amended their performance plans to remove that. That occurred today.

Mr. Roe. So if we come in back in 90 days, or in the fall, when the chairman holds another committee after the August recess, we can assume that all of these things will be implemented on the intermediate actions?

Mr. Matkovsky. On the immediate, sir, yes.

Mr. Roe. Number two is the audit findings long term and other actions. And I want to know what long term is. The VA, and there are five bullet points that you have here. When will that—what is the timeline on those?

Mr. Matkovsky. Some of those extend out about 6 months, and others about 12 to 18 months, but none of them are stretching out much more than 12 or 18 months, sir.

Mr. Roe. Okay. So we will have a 90-day or so on the first—I am not going to hold you to exactly—but approximately 3 months on the intermediate and then, in the long term, will be 18 months on the outside.

Mr. Matkovsky. Eighteen months on the outside, correct.

Mr. Roe. Correct. That is something I want to get on the record, because these are all good things I think that you have on here.

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

The CHAIRMAN. Thank you, Dr. Roe.

Ms. Brownley, you are recognized for 5 minutes.

Ms. Brownley. Thank you, Mr. Chair.

Mr. Matkovsky, I wanted to ask you, we have talked a lot about training, or perhaps the lack of training for schedulers across the country. Were the schedulers trained to raise the issue of fee-based services? I am sorry, Mr. Veteran, I am not able to set an appointment for you in a timely basis, but you do have this option to go to a private practitioner?

Mr. Matkovsky. We used that just now in the accelerated care. And I think I mentioned that there were roughly 1,800 or so employees who were trained for that. And part of it, we developed a script on how to offer care for veterans. That is new. That is now part of our standard training.

Ms. Brownley. So it is now part of the standard training, but it hasn't been part of the training—

Mr. Matkovsky. It had not been before, no.

Ms. Brownley. —previously to that. Well, I want to thank both the GAO and the inspector general for being here. And certainly I want to thank you for your persistence in trying to make the American people and all of us aware of the magnitude of the problem. I don't think we still fully understand the magnitude. And I don't think we will until we get all of the data in. But we will get our arms wrapped around the problem. And I appreciate, again, your persistence with that. Once we do fully understand the magnitude of this problem and the depth of this problem, I wanted to know what you see as your role as we move forward. As the VA tells us we are going to implement this, this, and this, and we have discovered that we need to do this. And we are going to need some timely feedback as that—as we proceed in that direction, and some help and guidance and your assessments of, is this the right direction to go? And is the VA doing what they say they are going to do? So if you could comment on that.

Mr. Griffin. I would say that I am pleased that it appears we are at a tipping point, and we are going to see actions taken in order to address this problem that's been identified for many, many years. I refer back to my trust but verify comment earlier. We are in the oversight business. Our auditors and our health care inspectors will be going to VA facilities and checking on things. I think there will be some other specific recommendations in our final report that will deal with accountability issues and certification. I mean, there have been occasions over time where after the Schoenhard memo from 2010 was put out addressing all the various schemes, as it was referred to in the memo, to manipulate data, for a short while after that there was a requirement that directors certify that their facility was in compliance with the VHA regulations for scheduling. And then that disappeared. So I think when you identify a problem and you make the head person accountable to certify that that problem doesn't exist there, there is no reason to take that certification requirement away. Let's keep it there and make them certify annually, and then we will go check. And then if they lied about the activities at their facility, then somebody should hold them accountable for that.

Ms. Brownley. Thank you.

Dr. Draper?

Ms. Draper. We work at the request of Congress. And I think much of our work in the past has been related particularly to con-

cerns regarding scheduling and oversight of the scheduling and wait time process. Our work going forward will be at the request of Congress, but to really continue what we have been doing in the past, it will make sure that policies and procedures are playing out the way that they should at the local level, and it will look at how VA is conducting oversight, which we have found to be problematic. And really to make sure that things are being carried out the way that they are supposed to be. We are an independent voice. We are nonpartisan. We do provide an independent evaluation of many of the programs.

Ms. Brownley. I know I only have a few more seconds here. But would either one of you comment on how you feel about the accuracy of the data that was collected in this nationwide audit?

Mr. Griffin. I would say that it was a proactive attempt to determine if they had a systemic problem or not. I think the process had its limitations in the manner in which the questioning was conducted. And there was no attempt, by design, to have accountability as part of the process. This initial phase was just to determine to what extent do we have a problem. And to that extent, it was successful. But it was with its own limitations.

Ms. Brownley. Thank you.

I yield back.

The CHAIRMAN. Thank you, Ms. Brownley.

Mr. Flores for 5 minutes.

Mr. Flores. Thank you, Mr. Chairman.

Mr. Griffin, this question is for you. The testimony tonight, and earlier reports that we have gotten, says clearly that we have a reporting problem related to the appointment system and waiting time calculations, and the way those have been reported. Did your studies of the VHA find any other reporting issues that we have to be worried about? One of the things, the VA comes and gives us plenty of testimony, and they always are armed with reams of reports. But if we can't trust these reports related to waiting times and patients seeking care, that calls into question other reports. Did either of you find anything in your studies to indicate to us we have other reporting issues to be concerned about?

Ms. Draper. We have found data reliability issues with both the wait times and the consults data in the work that we are currently doing. But I think there is another issue that is not just about the data. We found, and we reported in our 2012 report, that phones, weren't being answered. At each VA medical facility. We even got complaints from within the facility that people would try to call a clinic, and no one would answer the phone, or return phone calls. So I think it is a complicated issue. It is not just about the process itself, but some of the supporting systems as well that are problematic. So there really needs to be a holistic look at how to improve the overall process.

Mr. Flores. Mr. Griffin?

Mr. Griffin. I think the decentralized VHA, with 1,700 points of care around the country between the medical centers, and the outpatient clinics, and various other places where care is provided, makes it very challenging to try and stay on top of what is happening at all those facilities. As I mentioned earlier, when we did an audit of the VISN network, they were all different. It seems like

you need to have a better organizational structure that applies to all the networks. And as was mentioned earlier, the people at the network seem to float back and forth between medical centers and what have you. Now, you either need them or you don't need them. Maybe we need them on the front lines providing health care as opposed to being administrators and in networks that were supposed to be spartan in size when they were first established. And they just kind of grew. And again, they all look different, both from a management structure and from the way they handle contracts.

Mr. Flores. Thank you for the testimony. I just have some comments for our VA leadership. I think Americans have received another disappointing reason to not trust big bureaucratic government. We have had the VA disability claims problem that's been out there for quite a while now, and we have this new VA issue. Over at HHS, they spent several hundred million dollars and can't build a Web site for the Affordable Care Act. And so tonight you all have heard comments—when I say you all, Mr. Matkovsky, and I am assuming some of the VA management is listening to this tonight—but you have heard comments about things like this. Question everything. What is the next big idea? Former Special Operations team. Try to institute a culture of putting the veterans first. I would say you need to do all those things as you are trying to create the VA of the 21st century. And it should be one that's focused on less bureaucracy and more in taking care of the patient. And that may be a totally different model than what you have got now, which is a heavy bureaucratically structured system with a lot of bricks and mortar. I would urge you to think outside the box. If we truly put our veterans first, then I think we are going to find there is a new model needed to do that versus what we are doing today.

Mr. Chairman, I yield back. Thank you.

The CHAIRMAN. Thank you very much.

Ms. Titus, you are recognized for 5 minutes.

Ms. Titus. Thank you, Mr. Chairman.

Mr. Matkovsky, like all the members here, I am concerned about the facilities in Nevada that are on the list for further review. That's our new hospital, and it is a clinic in the southwest. So the sooner you can get that information about the specifics, the better. Because we had one news report that kind of confirmed one former supervisor at the hospital had been encouraging these scheduling practices that we have been talking about. And I would just like to see those details if you can get them to me. The question, though, is about the goal that you all announced today of notifying the 90,000 veterans and trying to help them either get an appointment or see a doctor in the private sector. And you had some 57,000 that were waiting to be scheduled and another 64,000 who had enrolled in the VA but had never been to an appointment. I wondered if you could outline for us kind of which populations you chose to notify, how you are going to go about notifying them. And then if you could get the information to me about how many in Nevada will be part of that 90,000, I would appreciate it.

Mr. Matkovsky. I will do that. If that was a question right now—

Ms. Titus. No, I know you all have to get that back to me. But just in general—

Mr. Matkovsky. In general, what we did for accelerating care, we did not have the new enrollee appointment request data yet. That was a recommendation coming from the IG, and we are worked on that over a couple of weeks and finished the list in time to publish today. What we focused on was veterans who did not have an appointment yet, that was the 57,000, and veterans who we knew were waiting for care, and they were new to their clinic and we could identify them for wait times. That came together for roughly 90,000 veterans. And that was just the start. It is not where we stopped. We also encouraged facilities to focus, if they knew their NEAR number, to pull that and request funds for that. If they had established patients that they knew wanted care sooner, to work that list as well. And that was what went into the \$300 million. We are starting, I think tomorrow we will be able to make the data available to the facilities. We had to correct a defect on the NEAR. We did correct that. And we are asking facilities starting tomorrow to have an engagement plan for every veteran on that New Enrollee Appointment Request list, that entire contact to be done in 30 days. If they can not do it, we are going to use the process that we used for Phoenix as well. We used our national call center in Topeka, Kansas. That national call center jumped to action right away, scripted the calls, and contacted all of those veterans and more in a short period of time. And so our goal there is for the remaining 64,000 on the NEAR in less than 30 days.

Ms. Titus. Okay. Thank you. If you will get that information to me for Nevada, I would appreciate it. Thank you for staying with us tonight.

I yield back.

The CHAIRMAN. Thank you, Ms. Titus.

Mr. Huelskamp, thank you for yielding your time. You are recognized for 5 minutes.

Mr. Huelskamp. Thank you, Mr. Chairman. I appreciate the opportunity to ask questions. I will note at the facility I was at, I had more than 5 minutes. It worked out much better that way.

But I would like to follow up on a couple things. Putting together the OIG report with the numbers today, Mr. Matkovsky, you mentioned 64,000 roughly that are on the NEAR list and 57,000 that are on the electronic waiting list, if I understand. And recall the report from OIG last week the NEAR was considered an unauthorized waiting list. But in addition to that, they had identified at Phoenix alone 600 veterans that were in other type of unauthorized waiting list. And so if the averages would hold, the numbers that would identify 30,000 to 35,000 veterans on other unauthorized and secret waiting lists. Do you have any data on that that would shed a light on it? Because again, that was one third of the total at Phoenix you haven't referenced at all in your report today.

Mr. Matkovsky. Sure. For Phoenix, I believe there were three—I would let Ms. Halliday actually correct me—but I believe there were three sources of data in addition to the electronic wait list. One of them was the New Enrollee Appointment Request. The other was a consult for an appointment, typically coming from the ED to primary care. And the last one I believe was the help line.

That help line process is stood down. That was not an appropriate process. They have now moved somebody into their call center who actually manages the EWL for them. The consult for primary care appointment would get picked up in our consult review, though.

Mr. Huelskamp. Okay. What are the numbers for that? How many are waiting—

Mr. Matkovsky. I don't have that tonight, sir.

Mr. Huelskamp. Okay. So that would not be included in the 64 nor the 57. Do you have a rough estimate of how many other veterans are in that list?

Mr. Matkovsky. Sorry. The process for—the correct process for processing a consult for an appointment request is either schedule that appointment timely, or if you cannot schedule that appointment, to have it in the EWL.

Mr. Huelskamp. I understand that. The OIG referenced 200 veterans in the consult list out of the 1,100—or 200 there and then 400 on screen shot paper printouts. So again, that was about a third of the total. So are you picking up these other unauthorized lists? And any guesstimate of how many nationwide? Because that would be beyond the numbers you revealed today.

Mr. Matkovsky. Yes, sir.

Mr. Huelskamp. Is that correct?

Mr. Matkovsky. So as we continue to report this, bimonthly we are going to report these data out, it will change. There will be more folks on EWL—

Mr. Huelskamp. I understand. But how many today are on the consult list that is, again, is an unauthorized waiting list?

Mr. Matkovsky. I am sorry, but the consult process is not an unauthorized mechanism. What is not correct is to not act on that. And that's what Phoenix did not do. That was what was not correct. It is correct to use the consult system from the emergency department.

Mr. Huelskamp. I am about out of time. So the OIG was inaccurate in calling that—

Mr. Matkovsky. No, not at all. They were accurate.

Mr. Huelskamp. Okay.

Mr. Matkovsky. What they were saying was—

Mr. Huelskamp. So how many are on this consult list?

Mr. Matkovsky. Actually, I do not know. We can get that data.

Mr. Huelskamp. I wish you would. Because the media is reporting 57,000, and then the NEAR list of 64,000. What I am saying is by my guesstimates, we are talking about another 25,000 or 30,000 on unauthorized lists separate from those. In addition, going back to the VA report from April of 2010, they also identify manual logbooks. Is there any evidence of manual logbooks being handled in any VA facility?

Mr. Matkovsky. I don't have any evidence, but we did not do an evidence collection process for manual logbooks. Those are not to be used.

Mr. Huelskamp. So is block scheduling not to be used, so is consult management and playing with the desired date. And again, these are all unauthorized. That was my question.

Mr. Griffin. There were some handwritten lists that have come to our attention in the course of our work. And we are pursuing those as to who created them at whose direction and so on.

Mr. Huelskamp. Were any of those found in Phoenix, Mr. Griffin?

Mr. Griffin. Not a handwritten list, per se. There were 400 or 500 desired appointments that were in someone's desk drawer that were not officially accounted for at the time that they were given to us.

Mr. Huelskamp. Okay.

And lastly, Mr. Griffin, we have a report of the OIG's investigation at Richmond VAMC where the investigator arrived at 12:10 p.m., searched one room for a document shredder, and left the premises 10 minutes later. Can you give me the criteria of these type of searches if it lasted 10 minutes and only involved one room?

Mr. Griffin. That is not familiar information to me. I would be happy to take that for the record and determine whether or not it really was an IG employee or somebody else.

Mr. Huelskamp. Okay. And lastly, also disturbing reports the VA has insisted it be allowed to have representatives present during the OIG interviews of scheduling clerks. Is this the case at all?

Mr. Griffin. No. I think that is the VA audit. We have had a couple of directors try and barge into one of our interviews, and we threw them out.

Mr. Huelskamp. Okay. Even though they have an investigation going on at the same time, those are entirely separate and—

Mr. Griffin. This would be a medical center director who was trying to impede our interview with their schedulers, and we threw them out of the room.

Mr. Huelskamp. How about general counsel? Any union representatives in these investigative meetings?

Mr. Griffin. Not in ours.

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

The CHAIRMAN. Thank you, Mr. Huelskamp.

Ms. Kirkpatrick, you are recognized for 5 minutes.

Mrs. Kirkpatrick. Thank you.

Mr. Matkovsky, I am going to join my colleague from Nevada's request for data relative to Arizona. And this is a concern I expressed at our meeting last week, that I represent a very large rural district. And it has 12 Native American tribes. And a lot of those folks don't have telephones. And they don't check their mail for months. So I just want to make sure that we are contacting them. And I visited with some of the VSOs in Arizona when I was home last week. And they can be helpful in that process if we need that. But I just want to express that concern.

And then my question is a follow-up question on the audit that you put out today regarding further review. And I just want to read these first two sentences. It says, as a result of these audits, some locations were flagged for further review and investigation. Any instance of suspected willful misconduct is being reported promptly to the VA Office of Inspector General. That's good. Here's my concern. You then go on and say, there are three locations in VISN 18 that require further review. And one of those is Prescott, Arizona. My concern is, do I read this to think that there could be

suspected willful misconduct at that Prescott facility? And what was your criteria for singling out these locations for further review?

Mr. Matkovsky. Just to give a sense of the limitations that Mr. Griffin alluded, we started I think it was on Tuesday before the week of May 12th to plan this out. I think that night, May 11th, which I think was Mother's Day, most of our staff dropped everything and went to the field. And our goal was to complete the entire audit of all of our major medical centers and our CBOCs with 10,000 or more patients.

Mrs. Kirkpatrick. I appreciate that. Thank you.

Mr. Matkovsky. It allowed us to interview nine people per facility and one clinic manager per facility. The rules were that the staff member could have a union representative present if they so desired. If they did not, they did not need to. And if they didn't want to participate in the interview, they didn't have to. That did not allow enough quantitative data to say we have a representative sample. But the site audit team, which was comprised of four senior people, wrote a report. One of the questions we asked them to answer is, is there something you want to tell management about what you found in your site? If they said yes, they constructed a narrative response, and we read that narrative response and matched it up with qualitative responses on those questionnaires and determined there was a practice that we thought was inappropriate that involved changing dates. And that was the criteria. It was really qualitative. And we were using a combination of the quantitative data. But frankly, these were leaders in our organization, and we used their judgment.

Mrs. Kirkpatrick. Thank you.

I am very concerned about the Prescott facility and will follow up with you more. I will be very interested in your final review on that. Thank you very much.

And I yield back.

The CHAIRMAN. Thank you, Mrs. Kirkpatrick.

And Dr. Wenstrup, you are recognized for 5 minutes.

Mr. Wenstrup. Thank you, Mr. Chairman.

You know, I recognize that we have a lot of great caregivers in the VA system. There is no doubt about it. A couple from my own private practice would go 1 or 2 days a month to operate at the VA. My question comes in as how much caregiver or physician input is available to the administrative end of the VA system? For example, while I asked Dr. Petzel one time when he was here, I said, how many administrators have been providing care? And he said, Well, we have all been in academia. So I think there is a component missing there that is a valuable input. And I wonder, you know, if our providers are ever asked, what is it that keeps you from seeing more patients and being more efficient? Do they have the opportunity to have that input? Because besides the love of work, and taking care of veterans, or just taking care of patients in general, what is their incentive to see more patients? And then do they have the ability to provide input and make change? You know, we talk here about things on a national level. Well, every place can be a little bit different and every practitioner is a little bit different. And so do they have the ability to say, you know, if I had one more

medical assistant, I could see 10 more patients in the same amount of time, or something along those lines?

Mr. Matkovsky. They do, and we have collected some of that data and in some of our other questionnaires, and we have used that. I just wanted to make one statement, if I may.

Mr. Wenstrup. Sure.

Mr. Matkovsky. Our staff on the ground give great care. They are committed. They are good people. They take care of veterans every day. Sometimes we don't give them the resources they need, and we need to fix that. The problem here is having inaccurate data that can't tell us where we need to fix things. That is a systemic problem. We have to fix that. But some of the issues we find are simple things. You know, having enough housekeeping staff to actually help turn the rooms around so they are quick and ready to use for the next patient. Having a system that is easier to use and interface with so that instead of looking at your screen, you are looking at your veteran and you are having a conversation. Having additional clinic support staff to make that easier to do. Having access to modern technology in a timely basis is also a challenge. Adequate space for meetings, for collaboration, for private offices for mental health. These are all challenges they tell us that we need to open that up, we need to listen to the front line, and we need to find out what they need so that we can provide it to them.

Mr. Wenstrup. And do you have plans in place for that? I mean, if a doctor is running around getting supplies and things like that, that is a tremendous waste of time.

Mr. Matkovsky. Correct.

Mr. Wenstrup. And do we really want to take a look at all the paperwork that a physician is asked to do and maybe isn't necessary?

Mr. Matkovsky. Absolutely. I think one of the things we hear from our clinicians on the front line is, You have got me doing administrative work when I should be seeing veterans. You have got me tied up doing this and I can't actually do my phone clinic time. And we need to look at that, yes.

Mr. Wenstrup. I look forward to hearing what you come up with and what the solutions are to allow for that physician or caregiver input.

Mr. Matkovsky. Oh, absolutely.

Mr. Wenstrup. Thank you.

I yield back.

The CHAIRMAN. Thank you, Doctor.

Mr. Walz, you are recognized for 5 minutes.

Mr. Walz. Thank you, Chairman.

Again, thank you all. And I think I encourage you, continue to push for the transparency, continue to push and do the soul searching to get it all out there. We cannot make good decision unless we understand what the systemic problem was with the data to drive where we are getting.

And I pulled back up something, Mr. Matkovsky, from 2006. It says, To help reveal the business specifications of rehosting and modernizing its legacy enrollment system, the VHA brought in Philip Matkovsky, principal with Macro Design Group of Arlington,

Virginia. Matkovsky is a systems consultant with plenty of experience in the public sector. It is not as if this is a new idea. I ask all, this is to members of this committee. This is our opportunity. No one was under any illusion that this was anything but a zero sum proposition. If one veteran gets left behind, we failed. We know that. Your providers know that. We know that in this committee. We have an opportunity to do something big here, to get this right.

But don't be under any illusion—and heard it there. So electronic medical records. *New England Journal of Medicine*, 12.2 percent of private sector has this. You are not going to have collaboration between the VA and the private sector because they don't have it. They don't have the ability to send that back to you in any way. VistA is probably the gold standard. The people at Mayo Clinic told me it was probably one of the better ones there. And don't be under any illusion: 98,000 people die in this country from medical error every year. Now, I understand it is an art and a science, but we have to do something. And I am supportive of this, getting out and getting the care as quickly as we can. But don't think it is a panacea and a magic bullet that you are going to send them to the private sector. Next year, you are going to have a CEO from a private hospital sitting here, wondering why your veteran died in that.

We can do something. There is a new model here. There is something that can be done. But if we fall back into these old traps—nobody is going to defend any type of bureaucracy, both public or private, if it doesn't work, because Dr. Roe had it right, what is best for the veteran? What is that model going to look like? And I understand on this fee-for-service as long as it is a VA Medical Center director deciding if there can be fee-for-service the veteran's truly not in charge of his own health care. I get that. We have got to have that model be different or you are going to get skewed results. So my I guess plea to all of us in here is we got to keep pushing for the data. We got to have it come clean. We got to get people in jail if they violated the law if that's it. We have got to let due process do its work. But we have a responsibility both for the veterans, and those 98,000 are our constituents, too, out there, to improve the system and have accountability. So I would encourage all of you, I would encourage my colleagues, it is not going to be good enough and you are not going to be judged by pointing out what the problems are. That needs to be done. But that's a means to an end. The end is improved care for our veterans in a timely manner that is cost-effective to the taxpayer.

So I think, again, Mr. Matkovsky, you said it, this is a starting point. It isn't even the starting point for us I would argue. The data is going to come. We need to let the data drive us to where we are going. And then I think it needs to fall back on us. If you really want to get this right, we don't just come at the middle of the night a couple times to try and do this. This is important work, don't get me wrong. We have got to find this out. But the really important work and the legacy will come if we make a difference. And I don't know if we have noticed this, this is a shifting ground amongst the VSOs like I have never seen in 30-plus years of being around this. They are out there ready again to engage in this. But don't bring them in to tell them what you are going to do. Bring them in to

get some ideas. Patient advocates is something they told me. I am hearing this all the time from some of them. Patient advocates to help navigate the system. And if they go into the private sector, and that's what needs to work, I am all for it, that is great. But there is going to have to be someone to help them navigate this. I heard the Vietnam veterans said if you are medically credentialed, get on the floor. We use today say that, grab your rifle and go man the perimeter. Get on the floor and do it. And as Dr. Wenstrup was right, don't get in their way. If there is forms and other things like that that we can reduce to get them out there, get them out there, they are willing to do it.

So that's my rant. But I am telling you there is not a person in this room that is not going to be judged by what the outcome is of what we do here, not the talk, not the pointing, whatever. So you guys keep doing your job.

Mr. Matkovsky, you keep doing your job.

VSOs, you keep doing your job.

And we have to keep doing our job because it is not going to be—again, not that we pointed it out or found it, what did we do to fix it.

I yield back.

RPTS KERR & DCMN ROSEN, [11:30 p.m.]

The CHAIRMAN. Thank you very much, Mr. Walz.

Mr. Jolly, you're recognized for 5 minutes.

Mr. Jolly. Mr. Chairman, no questions. I think that's an appropriate way to conclude.

The CHAIRMAN. Thank you very much. Members, we appreciate your attendance tonight. To the witnesses, thank you so much for all being here with us. I will tell the committee that we are going to be having two committee hearings per week for the foreseeable future, and we will be talking about manipulated wait times, bloated middle bureaucracies, the IT issue that we have heard tonight among others, so thank you for your attendance, and this hearing is adjourned.

[Whereupon, at 11:32 p.m., the committee was adjourned.]

GAO Highlights

Highlights of GAO-14-679T, a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care to veterans, and in some cases, these delays have reportedly resulted in harm to patients. As the number of these reports has grown, investigations have been launched by VA's Office of Inspector General and VA to examine VAMCs' medical appointment scheduling and other practices.

In December 2012, GAO reported that improvements were needed in the reliability of VHA's reported medical appointment wait times, as well as oversight of the scheduling process. In May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consults process and develop system-wide consult data for monitoring.

This testimony is based on GAO's ongoing work to update information previously provided to the Committee on April 9, 2014, including information on VHA's (1) process for managing consults; (2) oversight of consults; and (3) progress made implementing GAO's December 2012 recommendations. To conduct this work, GAO has reviewed documents and interviewed VHA officials. Additionally, GAO has interviewed officials from five VAMCs for the consults work and four VAMCs for the scheduling work that varied based on size, complexity, and location. GAO shared the information it used to prepare this statement with VA and incorporated its comments as appropriate.

View GAO-14-679T. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

June 9, 2014

VA HEALTH CARE

Ongoing and Past Work Identified Access, Oversight, and Data Problems That Hinder Veterans' Ability to Obtain Timely Outpatient Medical Care

What GAO Found

GAO's ongoing work examining the Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) process for managing outpatient specialty care consults has identified examples of delays in veterans receiving outpatient specialty care. GAO has found consults—requests for evaluation or management of a patient for a specific clinical concern—that were not processed in accordance with VHA timeliness guidelines. For example, consults were not reviewed within 7 days, or completed within 90 days. For 31 of the 150 consults GAO reviewed (21 percent), the consult records indicated that VA medical centers (VAMC) did not meet the 7-day review requirement. In addition, GAO found that veterans received care for 86 of the 150 consults (57 percent), but in only 28 of the consults (19 percent) was the care provided within 90 days. For the remaining 64 consults (43 percent), the patients did not receive the requested care. For 4 of the 10 physical therapy consults GAO reviewed for one VAMC, between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's guideline of completing consults within 90 days of being requested. VA officials indicated that they may refer veterans to non-VA providers to help mitigate delays in care.

GAO's ongoing work also has identified limitations in VHA's implementation and oversight of its new consult business rules designed to standardize aspects of the clinical consult process. Specifically, GAO has identified variation in how the five VAMCs reviewed have implemented key aspects of the business rules, such as strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days. However, it is not clear the extent to which VHA is aware of the various strategies that VAMCs are using to comply with this task. Furthermore, oversight of the implementation of the business rules has been limited and does not include independent verification of VAMC actions. Because this work is ongoing, GAO is not making recommendations on VHA's consult process at this time.

In December 2012, GAO reported that VHA's outpatient medical appointment wait times were unreliable and recommended that VA take actions to: (1) improve the reliability of its outpatient medical appointment wait time measures; (2) ensure VAMCs consistently implement VHA's scheduling policy, including the staff training requirements; (3) require VAMCs to routinely assess scheduling needs and allocate staffing resources accordingly; and (4) ensure that VAMCs provide oversight of telephone access, and implement best practices. As of June 2014, VA has reported ongoing actions to address these recommendations, but GAO found that continued work is needed to ensure these actions are fully implemented in a timely fashion. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care is provided to veterans, who may have medical conditions that worsen if care is delayed.

STATEMENT FOR THE RECORD

Letter From Richard Griffin

Dear Mr. Chairman:

This is in response to a question from Congressman Tim Huelskamp at the hearing before the Committee on June 9, 2014, on Oversight Hearing on Data Manipulation and Access to VA Healthcare: Testimony from GAO, IG and VA.

At the hearing, Congressman Huelskamp asked about the Office of Inspector General (OIG) investigation at the Richmond VA Medical Center (VAMC) involving allegations that documents were being shredded. The OIG conducted a series of unannounced visits to facilities on Sunday, May 4, 2014, after receiving information from the Committee on May 3rd that widespread shredding was occurring at VA medical centers. We sent Special Agents to facilities where a specific allegation was made, as well as other facilities, such as the Richmond VAMC, located near OIG offices. An OIG Special Agent went to the Richmond VAMC to inspect the Health Administration Service (HAS) scheduling area for any evidence of shredding. No employees were present and no shredders were in any of the HAS offices. No further action was deemed necessary by our Special Agent upon consultation with his supervisor.

As I stated at the hearing the OIG has active investigations ongoing across Veteran Health Administration facilities. Because investigations are ongoing, I cannot share our investigative and review methods, however you and the Committee have my assurance that all leads relating to manipulation of patient scheduling are being vigorously pursued, all appropriate persons are being interviewed in person, and that our investigation is being conducted in strict compliance with relevant Federal laws, Attorney General Guidelines, and the Council of the Inspectors General for Integrity and Efficiency's Quality Standards for Investigations.

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

Sincerely,
RICHARD J. GRIFFIN,
Acting Inspector General

