WAITING FOR CARE: EXAMINING PATIENT WAIT TIMES AT VA

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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WAITING FOR CARE: EXAMINING PATIENT WAIT TIMES AT VA

Thursday, March 14, 2013

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

The Subcommittee met, pursuant to notice, at 1:00 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Huelskamp, Walorski, Kirkpatrick, O'Rourke, and Walz.

Also present: McCarthy of California.

OPENING STATEMENT OF CHAIRMAN COFFMAN

Mr. COFFMAN. Good afternoon. This hearing will come to order. I want to welcome everyone to today's hearing titled, "Waiting for Care: Examining Patient Wait Times at VA."

I would also like to ask unanimous consent that several of our colleagues be allowed to join us here on the dais today to hear about this issue that has directly impacted many of their constituents.

Hearing no objection, so ordered.

We should always be working to ensure veterans have timely access to quality care. However, today's hearing is necessary because evidence reviewed by the Subcommittee, the Government Accountability Office and VA's own inspector general shows little improvement in that area. GAO recently completed its study that was appropriately titled "Appointment Scheduling Oversight and Wait Time Measures Need Improvement."

Despite claims of improvement under higher standards, we will hear today that a lack of reliable information when VA is measuring patient wait times, VA's own testimony supports that premise as it discusses what it sees as no reliable standard and an inability to accurately measure what constitutes a patient wait time.

While the topic of patient wait times may sound like a very narrow issue, the problems, inaccurately monitoring improving wait times for veterans at VA facilities has spread throughout the whole Department of Veterans Affairs. Schedulers at the facilities themselves have to use a cumbersome system that creates a significant chance of error. The problem runs all the way up to the Veterans Health Administration, which has an unclear policy on patient scheduling practices and still seems to struggle to best define its policy on patient scheduling.

I understand that defining these policies is not easy and that perfecting a process for appointment scheduling is a significant challenge, but VA has been well behind in this area for a long time. However, none of this excuses VA from its obligation to veterans. While I understand the system may not always be perfect, it does not mean that VA shouldn't make every effort to ensure veterans receive necessary care.

Backlogs are a fairly common theme at the Department, but that is no reason for VA to gain the numbers to simply show better performance instead of providing medical appointments, sometimes for life-threatening conditions. Sadly, evidence obtained by this Subcommittee clearly shows that in many cases, VA did not do the right thing. Instead, that evidence has shown that many VA facilities, when faced with a backlog of thousands of outstanding unresolved consultations, decided to administratively close out these requests. Some reasons given included that the request was years old, too much time had elapsed, or the veterans had died. This Subcommittee asked VA for updates on these consultation backlogs beginning in October 2012.

Despite multiple follow-up requests to VA, no information was ever provided, and it was only when this hearing was scheduled that the Department offered a briefing on this subject.

I would note that the Subcommittee asked for information, not a briefing. Regardless, we should not be where we are now. This goes to reinforce that the Veterans Affairs Committee wants to work with the Department on this and other issues, but that requires a willingness on VA's side to be forthcoming about its problem so that together we can identify ways to solve them.

I now yield to the Ranking Member for opening statement.

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

OPENING STATEMENT OF HON. ANN KIRKPATRICK

Mrs. KIRKPATRICK. Thank you, Mr. Chairman, for holding this hearing this afternoon on the Veterans Health Administration's scheduling process and how that affects patient wait times for veterans.

Improving access to health care is a continuous effort by VHA, and it is not surprising that we are here today. Excessive wait times and the failures of scheduling processes have been longstanding problems with the Veterans Health Administration. The Government Accountability Office has been reporting on this issue for over a decade. In 2001, the GAO reported that two-thirds of the specialty care had wait times longer than 30 days.

In 2007, the VA Office of Inspector General reported that VHA facilities did not always follow VHA's scheduling policies and process.

In 2012, the VA OIG reported that VHA was not providing all new veterans with timely access to full mental health evaluations. In that same year, the GAO again examined the issue and found that, among other things, there was inconsistent implementation of VHA's scheduling policy that could result in increased wait times or delays in scheduling timely medical appointments.

In my Arizona district, in the City of Casa Grande, one of my caseworkers recently met with an Iraq veteran who made the brave decision to seek VA mental health care after 2 years of being back in the United States from Iraq. The VA required a physical exam before this veteran in my district could schedule an appointment with a mental health care provider. Unfortunately, they weren't able to schedule him for an initial physical for 6 months. That is 6 months of waiting before he could have even an initial consultation with a mental health care provider, and this was after 2 years of not seeing a doctor at all.

These situations were able to be resolved by our veterans caseworker in the district, but the point is veterans should not have yet another hoop to jump through. Access to health care should be easy to schedule. I also understand that VHA is operating with a reportedly outdated system that is cumbersome and slow. GAO reported numerous work realms that some facilities are using which may adversely affect timely health care delivery to veterans.

Delayed care is denied care. This is all too evident with the rash of recent consult backlogs experienced at some of the VHA medical centers. It has been reported that thousands of consults in 2011 and 2012 were backlogged at various facilities which may have resulted in adverse events due to the delay in diagnosis and treatment.

This, of course, is unacceptable. Veterans deserve timely accessible health care. They have earned it. What I would like to hear about today is a sound plan that will assist VHA in transforming into a 21st century organization and will eliminate as much as possible the needless waits, unclear policies and procedures and frustrating technology that only serves to slow down the process, and I yield back.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF HON. ANN KIRKPATRICK APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you.

I ask that all Members waive their opening remarks as per this Committee's custom. However, I understand that Congressman McCarthy is going to have to depart early, and he was a main requester of GAO's work on this issue. I will yield 5 minutes to him for remarks.

Congressman McCarthy.

OPENING STATEMENT OF HON. MCCARTHY

Mr. MCCARTHY. Well, thank you, Chairman Coffman, for holding this oversight hearing for the Department of Veterans Affairs, specifically the Veterans Health Administration regarding the scheduling of a timely medical appointment and for allowing me to make some remarks.

You know, Chairman Miller and I led, along with 28 other Members, in requesting the GAO to conduct this audit on the VHA in the scheduling of medical appointments because I was receiving numerous complaints from veterans in my district who were waiting months for crucial medical appointments at either local VA clinic in Bakersfield or the VA medical center in Los Angeles.

One of the most common and disconcerting complaints for my veterans is that the VA health care administration lacks a sense of urgency when scheduling their medical appointments. This poor customer service mean veterans are forced to wait months for the care when needed. One horror story a veteran shared with me was his experience replacing a set of broken dentures. The VA schedule the veteran for five different appointments and took 6 months before finally replacing the dentures. As a result, this veteran had to eat three meals a day in half a year just in pain.

In addition, veterans stress to me that the VA is unsympathetic and unhelpful when it comes to ensuring that they are taken care of from start to finish. When veterans in my district are scheduled for appointment in the VA medical center in Los Angeles, they must travel over 2 hours, over mountain roads and through LA traffic. Smarter scheduling equals fewer trips to LA for my constituents and more efficient use of VA staff type.

One veteran who came to me was having difficulty obtaining appointment with the VA to receive a knee replacement. After removing the first faulty knee replacement, the VA then required the veteran to make six different trips—this is a 200-mile round trip from Bakersfield to LA—in order to sign releases and take tests before the VA would proceed with his surgery. It was not until our office contacted the Greater Los Angeles Healthcare System that he was finally scheduled for his knee replacement, bringing the situation to a close after eight grueling months.

Finally, when the VA does schedule a veteran for an appointment, all too often I hear they fail to notify the veteran in adequate time for he or she to make an appropriate travel arrangements.

One local veteran, who was waiting for an eye surgery appointment, was notified that he had been scheduled for his surgery in Los Angeles less that 24 hours before he needed to arrive. He was forced to cancel his appointment as he was unable to find transportation to the surgery on such short notice. Even though our office attempted to assist him with the VA-approved surgery, the veteran grew so tired of waiting for the VA to reschedule, he had the surgery conducted with a non-VA ophthalmologist having to pay for the procedure himself.

These are just several stories that I have heard from my veterans and are far from isolated incidents in my district, as evidenced by the GAO report but are indicative of a larger systematic problem within the VA medical centers. The experience these veterans have faced are inexcusable and should not have to happen to our Nation's finest. I think all of us here today can agree that this is a problem that needs to be immediately fixed, especially since we are facing a reverse surge, due to Department of Defense in reducing the troop levels and drawing down in Afghanistan.

So I thank you, Chairman Coffman, for your work on this, Chairman Miller's, and the entire Committee because this is an issue that is not partisan. This is an issue about the respect that we give to those that risk their entire lives for all of us to have our freedom, and how we treat individuals of this nature is unacceptable and what has gone on.

So I thank this Committee for their work on the GAO study and I thank them and will pledge to do everything in our power to make sure we correct this as well, and I yield back.

Mr. COFFMAN. Thank you, Congressman McCarthy.

With that, I invite the first panel to the witness table.

Mr. COFFMAN. On this panel, we will hear from Mr. William Schoenhard, Deputy Under Secretary for Health for Operations and Management at the Veterans Health Administration. Mr. Schoenhard is accompanied by Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations and Management; Mr. Philip Matkovsky, if I am saying that right, Assistant Deputy Under Secretary for Health for Administrative Operations; and Dr. Michael Davies, National Director for Systems Redesign.

We will also hear from Ms. Debra Draper, Director of Health Care at the Government Accountability Office; and Mr. Roscoe Butler, National Field Service Representative for the Veterans Affairs and Rehabilitation Commission at the American Legion.

All of your complete written statements will be made part of the hearing record.

Mr. Schoenhard, you are now recognized for 5 minutes.

STATEMENTS OF WILLIAM SCHOENHARD, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS AND MANAGEMENT, PHILIP MATKOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATIVE OPERATIONS AND MICHAEL DAVIES, M.D., NATIONAL DIRECTOR OF SYSTEMS REDESIGN; DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND ROSCOE BUTLER, NATIONAL FIELD SERVICE REPRESENTATIVE, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF WILLIAM SCHOENHARD

Mr. SCHOENHARD. Thank you, Chairman Coffman, Ranking Member Kirkpatrick, Members of the Committee, thank you for the opportunity to come today to speak regarding a subject that is important to the care of our Nation's veterans and to their satisfaction for veterans who have sacrificed all, as Congressman McCarthy referenced, on our behalf.

Let me first just express regret for the incidents of breakdown in care that was described by the Ranking Member and by Congressman McCarthy. Any veteran who goes without timely care where their care and satisfaction is impacted is one veteran too many in terms of our commitment to serve those who have served us.

I am accompanied today, as you said, Mr. Chairman, by two assistant deputies, Mr. Matkovsky and Dr. Lynch for Administrative and Clinical Services, respectfully, and Dr. Michael Davies, the National Director of Systems Redesign.

As I mentioned earlier and as was mentioned by Members of the Committee and Congressman McCarthy, timely access to care is important to both clinical care as well as the satisfaction of our veterans. We are grateful for the oversight of this Subcommittee. We are also grateful for the report of the GAO and the IG. We have been on a long journey to see what steps can be taken to ensure we have reliable and valid measures to measure wait time and the methods and implementation practices to ensure consistent implementation of those across our system.

We are also informed by our own study of millions of veterans' appointments as well as patient satisfaction surveys that suggests that there is need for improvement, as we acknowledged if our acceptance of the four recommendations of the GAO, as we determine how to go forward in better improving our care to increase patients' experience with our system.

I think it is important to say there are two parts to this effort going forward: First is to have reliable and valid measures to measure wait time. And as is indicated in our written testimony, we have changed the measure for new patients in order for that to be more valid and reliable, and we have undertaken a change with regard to the agreed upon date that the provider and the patient will establish together as a patient visit is completed.

That is informed, as I mentioned before, by the various reviews and our own study. It is important that we have measures that we know will better serve our veterans and reliably be implemented across this system.

Having said that, as important as that is for a foundation, execution is the most important part going forward, and I would offer that in our experience of the past 20 years and what we have learned from the recent studies is that we need to do a better job of integrating our administrative and clinical implementation of this effort going forward. That is why I am accompanied today by the two assistant deputies.

We need to ensure, as we have for the measure for new wait times, that we have effectively piloted these measures with providers in the real world to determine that they work, that they better serve veterans. We need to ensure that we have going forward more robust and complete training of our staff, who actually implement these practices and schedule our patients.

We need to ensure that we have staffing guidelines for schedulers to ensure we have sufficient supply and training of those who do this important work, and I have sat with those who actually go through the scheduling process, and as mentioned by the Ranking Member, we need to have better tools for their use and automated scheduling system to go forward.

Finally, we must have feedback loops to ensure that we have continuous improvement and reality check on what we do going forward.

I pledge to you and to the Subcommittee that this is an effort that will be implemented in an unprecedented way.

As we go forward, this requires joint, administrative and clinical engagement, and we will ensure, as part of that process, accountability and oversight to ensure at all levels of our organization that

this is implemented in a way that it is veteran-centric and important to their care.

We thank you for the opportunity to be here, and my colleagues and I will be happy to answer questions.

[THE PREPARED STATEMENT OF WILLIAM SCHOENHARD APPEARS IN THE APPENDIX]

Mr. COFFMAN. Ms. Draper, you are now recognized for five minutes.

STATEMENT OF DEBRA A. DRAPER

Ms. DRAPER. Chairman Coffman, Ranking Member Kirkpatrick and Members of the Subcommittee, good afternoon. I am pleased to be here today to discuss VA's reported outpatient medical appointment wait times. The bottom line is that it is unclear how long veterans are waiting to receive care in VA's medical facilities because the reported data are unreliable.

Access to timely medical appointments is critical to ensuring veterans are getting needed medical care. However, long wait times and a weak scheduling policy and process have been persistent problems for VA. For more than a decade, both we and the VA's Office of the Inspector General have reported on these problems.

In my statement today, I will discuss key findings from a report we issued this past December that examined the reliability of VA's reported medical appointment wait times as well as the scheduling policy and process.

We found that VA's reported wait times are unreliable because scheduling staff do not always correctly record the required appointment desired date. That is the date on which the veteran or provider wants the veteran to be seen. This is due in part to lack of clarity in the scheduling policy and related training documents on determining and recording desired date, a situation made worse by the large number of staff who can schedule medical appointments, which at the time of our review was estimated to be more than 50,000 people.

During our site visits to four medical centers, we found more than half of the schedulers that we observed did not record the desired date correctly, which may have resulted in a reported wait time that was shorter than what the veteran actually experienced. Some staff also told us they change medical appointment desired dates so that the dates align with VA's related wait time performance goals.

We found additional problems in how the scheduling policy was implemented, which may have also resulted in increased wait times and delays in care. For example, an electronic wait list, which is required for tracking veterans needing medical appointments, was not always used, putting veterans at risk of not receiving timely care. We also found follow-up appointments being scheduled without communication with the veteran, who would then receive notification of their appointment through the mail.

Additionally, the completion of required scheduler training was not always done, even though officials stressed the importance of training for ensuring adherence to the scheduling policies. We also found a number of other factors that negatively impacted the

scheduling process. These included the VistA system used for scheduling, which officials described as antiquated, cumbersome and error prone, shortages and turnover of scheduling staff, and high telephone call volumes without sufficient staff dedicated to answering these calls.

VA is implementing or piloting a number of initiatives in an effort to improve veterans' access to medical care. For example, one such as initiative is Project ARCH, which aims to provide health care through contracts with community providers to reduce travel and wait times for veterans who are unable to receive certain types of care from VA in a timely manner. While information is being collected on wait times for Project ARCH, these wait times may not actually reflect how long veterans are waiting to receive care because the wait times are measured from the time authorization is received from VA rather than from the time the veteran first requests the appointment.

In our December report, we recommended that VA take actions to improve the reliability of medical appointment wait time measures, ensure the consistent implementation of a scheduling policy, allocate scheduling resources based on needs, improve telephone access, including the implementation of identified best practices. VA concurred with our recommendations and identified actions planned or under way to address them.

To conclude, while VA officials have expressed an ongoing commitment to providing veterans with timely access to medical appointments and have reported continued improvements in achieving this goal, unreliable wait time measurement has resulted in a discrepancy between the positive, the wait time performance VA has reported, and veterans' actual experiences. More clarity in and consistent adherence to the scheduling policy, improved oversight of the process, allocation of staff resources to better match scheduling demands, and resolution of problems with telephone access are needed to reduce medical appointment wait times.

VA's ability to ensure and accurately monitor access to timely medical appointments is critical to providing quality health care for veterans, who may have medical conditions that worsen if care is delayed.

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

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

Mr. COFFMAN. Thank you for your testimony.

Mr. Butler, you are now recognized for 5 minutes.

STATEMENT OF ROSCOE BUTLER

Mr. BUTLER. Good afternoon, Chairman Coffman, Ranking Member Kirkpatrick and Members of the Committee. On behalf of our National Commander, James Koutz, and the 2.4 million members of the American Legion, I want to thank you for looking into the problems American veterans are having access in their health care. Whether it is frustration with repeatedly being put on hold, waiting three-quarters of a year for a basic primary care appointment,

or being forced repeatedly to adjust to new primary care providers, the needs of veterans are not being met.

I want to ask you really to take the time to read through Appendix A of our testimony. These are real veteran stories, raw and unfiltered that provide a realistic picture of what is happening to the people of the system. Time and time again, we see veterans who love the care they receive when they can get it. The frustration of the ability to access what is otherwise excellent care has been a factor we have seen in our System Worth Saving visits for the 10 years we have been performing these visits. It is important to remember these veteran stories because that is the real impact we are talking about.

This is not about meeting targeted numbers or looking at where results fall on a chart. This is about what happens to real people who have sacrificed for their country with their military service and are now frustrated by an otherwise excellent health care system. Some of the wait time could be improved if VA did a better job delivering on extended hours for health services, especially mental health. We know VA is trying to address this, and they released a VHA directive on January 9th of this year. Unfortunately, from our experience with visits in the field, this directive would not go far enough to meet the needs of veterans.

The new policy states that any facility that treats more than 10,000 veterans a year has to have an extended session during the week and one on the weekend end, but the required sessions are only 2 hours. The American Legion is concerned that four hours a week simply won't be enough to meet the demands of veterans at these facilities. We believe VA needs to continue to refine the policy to make sure they really are meeting the needs of the veterans.

To address one of the other major problems with wait times, VA must address the problems with their scheduling system. After nearly a decade of indecision between off-the-shelf software and in-house designs, the entire project was dropped in late 2009. Now, 3 and a half years later, there is still no fix in place. There is an open call for submission from the Federal Register to end in July of this year, but our veterans deserve a clear and better plan in place.

We hope VA can provide details on how they will be able to implement a 21st Century scheduling software system. The most frustrating part of the process, something has been since Commander Conley started the System Worth Saving visits in 2003, is that when veterans can access the VA system, they really have good things to say about the care they receive. The American Legion believes VA needs to do a better job getting veterans to this care and on a more timely basis.

Read through the reports. There is no reason that veterans should face 9-month delays just to see a primary care provider. I thank you and the Committee again for looking into this, and I would be happy to answer any questions you might have.

[THE PREPARED STATEMENT OF ROSCOE BUTLER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Butler.

Mr. Schoenhard, GAO reports significant failures in scheduling appointments that span at least 7 years. In addition to this, this Subcommittee has identified a backlog of hundreds of thousands of appointments based on VA's own documentation. How is VA addressing this tremendous appointment backlog?

Mr. SCHOENHARD. Sir, we are addressing this in a variety of different ways, and in terms of new patients, we are creating a new measure to go to create date to ensure, particularly for those who are needing access to our system for the first time, that within 14 days, we would schedule their appointment from the time the appointment is scheduled, not when the patient desires to be scheduled, but the clock starts the time the appointment is being made because we believe that is a more reliable and valid measure of making sure veterans are able to access our system, so that is an important first part.

Also, we are in the process of undertaking a complete review of consultation requests. We have developed new information system tools to be able to have visibility of this at all levels, and we are addressing that in a system-wide review and putting in place work groups that will ensure that we have better visibility than we have had in the past of these consult delays and that we are acting on them in a way that provides proper oversight and audit of that going forward.

Mr. COFFMAN. Mr. Schoenhard, my concern is that VA has or will clear this backlog by simply administratively closing appointments, as they did with 13,000 appointments in Dallas and approximately 40,000 appointments in Los Angeles. Why isn't VA using community providers more efficiently?

Mr. SCHOENHARD. Sir, you touch on a very important aspect of our care and that is being able to use community providers in order to better serve our veterans if we are unable to serve them. I wonder if I could ask Mr. Matkovsky, please, to expand further on the non-VA care efforts we are making to ensure this is done.

Mr. COFFMAN. Please.

Mr. MATKOVSKY. Thank you.

Mr. Chairman, we have begun in fiscal year 2012 rolling out a care coordination module for non-VA care. It allows us to actually be more systematic in how we review referrals to the non-VA care provider, so the care in the community, rather than ad hoc, it allows us to collect all of the referrals for non-VA care, ensure that folks are scheduled timely and that they can be seen in a timely basis. We do that by actually collecting the referral request, having a standard form of authorization for each referral and then being able to monitor how that referral is worked in the community. What we don't want to do is have someone who might be experiencing a wait time in the VA experience the same wait time in the community. This allows us to monitor them both.

That process will be fully deployed across all of our medical centers by the end of fiscal 2013. It is an important change. It may not sound like it, but it allows us to more strategically and more systematically use our non-VA partners in delivery of care.

We have also begun a few larger contracting initiatives, which we have briefed this Committee last year on—Subcommittee,

sorry—that will give us standardized access to care based on performance.

Mr. COFFMAN. I am still unclear on how we are talking about hundreds of thousands of backlog appointments. I mean, what are you going to do today to get that, to take care of this?

Mr. MATKOVSKY. We are not going to administratively close any appointment for care for a veteran. I think you referenced a couple of instances where there may have been referrals that were actually completed but simply not closed out, sir.

Mr. COFFMAN. You mean the 13,000 in Dallas and 40,000 in Los Angeles, the couple that are the few that I referred to?

Mr. MATKOVSKY. Sorry, sir. I meant the few examples you gave, but no, we will not close out any appointment administratively where a veteran is waiting for care at all.

Mr. COFFMAN. Mr. Schoenhard, according to VA documentation, in many instances, veterans were harmed or died due to delays in getting treatment. How many adverse events nationwide is VA aware of due to these delays?

Mr. SCHOENHARD. Sir, we have undertaken review of our facilities, and we are in the process of completing that review. We have instances of institutional disclosure that has occurred throughout our system.

I ask Dr. Lynch to expand on this, but if I could turn to you and if you could give the report.

Dr. LYNCH. Thank you, Mr. Schoenhard.

If I could begin by backtracking for just a second in discussing the process by which consults have been reviewed across VA. The VA consult system is not an ideal system, and unfortunately, it contains not only clinical consults, but also the consult process that has been used for administrative purposes. In certain cases, consults have been used to schedule tests rather than specific patient visits. In some cases, consults have been used to schedule advanced appointments 3 or 4 years in the future. These are called queuing consults.

The process of reviewing consults has been very careful. We have looked at the reasons for all of the, what we term unlinked consults, carefully evaluated whether they are of clinical significance before making a decision whether or not they can be administratively closed. Any of the consults that have been closed to date have been evaluated and there has been assurance that there has been no risk to patient care or to patient life, sir.

Mr. COFFMAN. Ranking Member Kirkpatrick.

Mrs. KIRKPATRICK. Ms. Draper, how confident are you that the Veterans Health Administration will be able to effectively make improvements in the reliability of the reported medical appointment wait times, scheduling oversight and initiatives to improve access to timely medical appointments?

Ms. DRAPER. There is a lot of work to be done, and I think, as we reported, for more than a decade, there have been a lot of initiatives started and the problems still persist. So, I think they have undertaken a number of initiatives to improve the measurement of wait times. And let me just say the measurement of wait times is really important for a number of different reasons, one of which is work load management, so you don't really know —how much ca-

pacity you have which is an indication of what other resources you might need to get veterans in to be seen in a timely manner.

So, it remains to be seen. It is a hard question to answer based upon previous experience. As I said in my testimony, we have reported on these problems for more than a decade, and there is a lot of work to be done. And I will say, it is not just the wait time measurement, but it is having clear policies and better allocation of staff. We heard that there are a lot of problems around telephone access, so better management of the telephone system is needed at the four sites that we visited, we found evidence of long on-hold times and also of high call abandonment rate, so it is a very complex issue, and it is not just one thing that is going to fix this. There are a lot of things that need to be addressed.

Mrs. KIRKPATRICK. In your opinion, what do you believe is the number one challenge VHA faces as they move forward to making improvements and moving the scheduling process into the 21st Century?

Ms. DRAPER. Well, it is very important to have a clear policy. Right now, there is a lot of ambiguity in the policy, so it left a lot of discretion resulting in considerable variation from one facility to another. So, one thing is clear policy, clear implementation of that policy, and oversight. You know, one of the things that VA did in 2007 was to require individual medical centers to do a self-assessment and report their compliance with the scheduling policy, and I think that what we saw was more than 80 percent, or close to 80 percent of the facilities that completed that self-assessment said that they were in full compliance with the scheduling policy, and we know from two of the facilities that we visited that said that they were in full compliance, that was not the case.

Mrs. KIRKPATRICK. Again, Ms. Draper, GAO reported that a scheduler at one of the primary care clinics specifically stated that she changes the recorded desired date to the patient's agreed upon date in order to show shorter wait times for the clinic. Clearly, that should not happen. I think we all agree with that.

While visiting the facilities and talking to staff, did you get a sense that the employees were unduly influenced to make sure that shorter wait times for the clinic were reflected, even if it weren't true?

Ms. DRAPER. I can tell you we heard this across several facilities. So, as you mentioned, in one primary care clinic, we did hear that the scheduler changed the dates to show that there were no long wait times. In another specialty care clinic, we heard that providers were changing dates to make sure that their data showed that they were within the 14 day wait time goals of VA.

We also went to one specialty clinic, which reported a zero-day wait time because they were changing the desired date to the appointment date. So what happened is, in reality, there was a 6- to 8-week backlog, at least. So someone in another part of the facility can look at the scheduling system and it looked like there was no wait time so they would send someone over when, in reality, there was a long, long backlog of appointments.

So, while we weren't specifically told that they were directed by management, I think the current situation provides ample oppor-

tunity to change dates, whether intentional or not, to really reflect the results that you want to achieve.

And I just want to say, too, that these measures are used in a lot of different ways. They are included in the network and medical director performance plan. They are also included with VA's budget submissions, and they are also included in the VA's annual performance and accountability report, so there is a lot of incentive around these measures.

Mrs. KIRKPATRICK. Thank you.

Thank you for your testimony, and I will yield back the balance of my time.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

Mrs. Walorski, Congresswoman Walorski.

Mrs. WALORSKI. Thank you, Mr. Chairman, and thank you to the panel. I think, in the State of Indiana, in my district, have 52,000 veterans just in my district alone, and our little State of 6.5 million people that sits in the middle of the country plays a significant role in military operations around the country and has the fourth largest National Guard.

I find it shocking to sit and to hear these stories time and time again.

And Mr. Schoenhard, in your testimony today, you talked about reliable valid measures and you talked about having these feedback loops, and I am shocked about it. Before I ask you this question, I am shocked about it because when the military is in need and our country is in need, Hoosiers to respond in a rapid form? Our Hoosiers are often the first line of defense and the first folks to go.

So, when our Nation calls them, they go. When they need help from our Nation, to have the kind of stories that we hear, it is very sad and it is shocking to me. So, what feedback loops have you put in place that are going to try to correct these problems, given the past of how long it has taken to actually unveil these issues in the form of hearing?

Mr. SCHOENHARD. Congresswoman, I would say that the first feedback loop we have used is to pilot test the new measure for new patients, moving it from desired date to create date. This will be a hard timestamp at the time a veteran is making an appointment until the appointment is actually made.

Part of the problem we have had in the past is that as the scheduler has asked a new patient when they would like their desired date, sometimes the veteran may ask to put it out somewhere in the future. They may be going on a trip or somewhere and they may want to not feel an urgent need to get in, and so we have been measuring the wait time around that desired date. Moving it to the create date will put emphasis on the day the appointment is being made, is that appointment made within 14 days or not? And part of what we have experienced in the past is that veterans, like myself, often are appreciative of the care VHA renders, and they will ask, well, when do you have a spot available? They are trying to be accommodating, unless they have an urgent need, and you get into this circular conversation. Well, it is not when we are available; it is when you want to be seen. All of that will go away with the new create date where we will work to get them in the system

because I couldn't agree more from my visits with veterans and our own review, the perception of care is higher among those who use VHA than those who have not. And so we want to get them in our system and we owe it to Hoosier veterans; we owe it to veterans throughout this Nation for all that they have sacrificed, particularly in these wars, to get them in as soon as we can.

Mrs. WALORSKI. I appreciate it.

And Ms. Draper, I appreciate the GAO's summary as well and find it revealing. Is it your belief that the recommendations that we have talked about today and the recommendations in the report will suffice in turning some of this stuff around? And my counter question to that is, is there a competency level at the staffing level that needs to be addressed, or can this completely be streamlined through programming?

Ms. DRAPER. Well, it is interesting you ask about this. I assume you are talking about scheduling staff. We have heard that these are high-stress demanding jobs and that they are really entry level pay grade, so we saw a high amount of turnover in these positions. We heard in the facilities that we visited that high performers tend to get promoted quickly out of their scheduling role, so you have a lot of turnover.

And you know one of the issues is that VA really has not determined what its scheduling staff needs are. Just to give you a sense of what happens when you don't have sufficient scheduling staff, providers are picking up where schedulers are not completing their responsibility which takes away time from their direct patient care. So, there is just a lot of issues that come up and it is not simple and straightforward because a lot of things happen when you don't have sufficient staff.

Mrs. WALORSKI. Thank you.

I yield back my time, Mr. Chairman. Thank you.

Mr. COFFMAN. Thank you.

Mr. O'Rourke, Texas.

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

Ms. Draper, in some of your comments, you touched upon capacity, and in El Paso, you know, I often hear from veterans that when they are seen by a doctor at the VA, it is excellent care and they have no complaints and really are just full of praise for the quality of care, the professionalism, the attentiveness. The challenge is getting in a lot of times and having an appointment set and then canceled and reset, and it is particularly acute for mental health care.

And we recently found that there are nearly 20 unfilled positions for mental health professionals in the El Paso VA. When you look at the fact that we have 80,000 veterans in our service area, and we don't have a full service VA hospital, we have this shortfall in our mental health professionals, and if you want to go see, go to an acute care hospital. It is in Albuquerque, a 10-hour drive roundtrip. Did you find that capacity in terms of mental and physical health care professionals was part of the problem in getting the wait times that were desired?

Ms. DRAPER. We did not look at mental health care because the VA IG addressed that issue, but we did look at specialty and primary care. What we heard was that part of the reason for backlogs

is not having enough providers. Officials at the medical centers told us that their providers are often really stretched. For example, consults are supposed to be triaged within 7 days of receipt, which typically falls on a clinician. Some specialty clinics can get 40, 50, 60 consults a day, and someone has to take care of those. So if you have a short staffed clinic to begin with and then add on these other ancillary duties, it really does become a scheduling nightmare.

Mr. O'ROURKE. Mr. Schoenhard, how can we work with you? You know, we met with the VHA director in El Paso, Mr. Mendoza. Again, they are doing a great job, but I think they are working with limited resources and they need more help, and they are challenged by not just having these unfilled positions in their manning table, but we also have a great active duty full service hospital at William Beaumont East, which I think at times poaches health professionals there. Are we not paying enough for, in this case, mental health professionals or primary care professionals? Are we having a hard time attracting and retaining talent at our clinics and VA hospitals?

Mr. SCHOENHARD. Congressman, first, I will follow up with the El Paso situation.

Mr. O'ROURKE. Thank you.

Mr. SCHOENHARD. Look into that personally. We are in a major effort, as I am sure the Subcommittee is aware, of hiring additional mental health professionals. We are doing site visits to our facilities. It is important not only that we recruit, but that we retain mental health professionals. That is part of the vacancy. That is part of the turnover situation going forward. We need to create the best practice environment for our mental health providers and anywhere in this United States.

We should lead in that effort in VHA. And it is important that we not only address new positions, but that we fill vacancies. As it relates to benefits and salaries, we have had, historically, some struggle in being competitive in the recruitment of psychiatrists. Steps have been taken to ensure that. Psychiatry is a shortage everywhere. Having come from the private sector, I can say, particularly in rural areas, of course, El Paso is not that case, it is very difficult to recruit psychiatrists. And so we use telemental health and other ways in which to be able to provide care, which actually has been very well received by our veterans, but we need to ensure we have the wherewithal to effectively retain and recruit mental health providers, and we continue to evaluate that with a major effort in human resources.

Mr. O'ROURKE. Thank you, and thanks for your offer to follow up on these vacancies in El Paso.

Mr. Chairman, I yield back.

Mr. COFFMAN. Mr. Walz.

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

Ms. Draper, thank you for your work. I made it no secret in here I am a big fan of GAO, IG and the oversight.

And Mr. Schoenhard, thank you. I have also made it clear I am the VA's staunchest supporter and the harshest critic, and if I am not mistaken, you yourself are a veteran.

Mr. SCHOENHARD. Yes, sir.

Mr. WALZ. As are what percentage of your people who work?

Mr. SCHOENHARD. Sir, I would need to check, but at least 30 percent.

Mr. WALZ. I was just going to say, I wish the distinguished Whip would have waited for answers today, and I do bristle a bit at the idea of indifference. I would like to know a name of which person in the VA was indifferent because I think to paint with a broad brush the number of people at VA that are out there doing a good job. I am not going to defend you when you fall down, and simply think we can do better, but I think painting with a broad brush.

I have some statistics here. This is a 3-year-old study. These are average wait times in the civilian sector for a doctor appointment: 63 days in Boston; 59 days in Los Angeles; good here, 27 days in Detroit; 47 in Minneapolis. I think many times what we forget here is comparing apples to apples across there.

I know, Ms. Draper, that was not your charge to the private sector, but we pay a lot of money to the private sector in the form of Medicare and things like that, so when we are talking best practice and we are adding things, it is certainly not for the desire to care.

The thing that frustrates me is that I see an unevenness in application. And Ms. Draper, are all VA facilities created equal in your mind on how they do this?

Ms. DRAPER. Are you referring to how they implement their policy?

Mr. WALZ. Yes.

Ms. DRAPER. No. We found considerable variance from facility to facility.

Mr. WALZ. Are there some that are doing this outstanding, and it could be made to say that they are doing it world class?

Ms. DRAPER. I would say in the four facilities we visited, we found issues in all four.

Mr. WALZ. Okay.

Ms. DRAPER. And they range in size and geographic location.

Mr. WALZ. I see it in very small geographic areas between St. Cloud and Minneapolis, I see a difference in wait times on there and how that works, so I think it is trying to both integrate a unified, putting the system in and allowing for geographic variance, but I think one of the most frustrating things for me is, is the uneven care that veterans receive at different facilities.

Mr. Schoenhard, can you talk about that on how you address that or how you deal with the competing desire of local control versus a centralized system that provides that uniform quality care?

Mr. SCHOENHARD. Well, sir, let me begin with a statement that veterans should expect the same standard of timeliness, access, quality in their care whether its Manila or Maine. It should be throughout our system. We are a national system.

Mr. WALZ. And ironically enough, I was just in Manila. It might be better there than anywhere I have been, just as a side note to you, but please go on.

Mr. SCHOENHARD. We will learn from them, but we owe it to our veterans to ensure more consistent delivery of timely quality care. That is an expectation we have here in the central office in Wash-

ington of our VISNs. We rely on our VISNs to ensure that they are providing consistent care within their regional footprint, and it is our responsibility to ensure oversight and monitoring of the VISNs doing their work with the facilities. We have that responsibility.

Mr. WALZ. So, these implementations or these corrections that were given to us, will these help improve system-wide, or will these help improve these four facilities that were looked at?

Mr. SCHOENHARD. It will help the four, and it will help the others who also are in need of improvement. I would like Mr. Matkovsky to expand on the plan going forward because I think it is a more robust effort than we have had in this case.

Mr. MATKOVSKY. Thank you, Mr. Schoenhard.

And I would indicate that I would agree with Ms. Draper's analysis. For a program, we require good, clear measurable policy. So, as we work on the new set of dates, it has to be clearly defined and we have to be able to relay that to everybody in the field who we are expecting to hold accountable to this new set of standards.

Our first step was adjusting some of our policies using a date that is easy to understand. After we do that, we have to test this policy. Rather than roll it out system-wide via memo, it is our responsibility as a program to test it in its application, make sure that the training we provided staff on the front line, training we providing the providers was adequate, that it answered the mail, any changes we made to systems were easy to use and resulted in a measure that was reliable in each of the clinics that we applied this change.

After we roll it out, the next thing that we require, you mention the tension between local care—all care is local—and oversight. It is our job to pay attention as well, to look at the performance, to establish measures that allow us to track the averages, but also allow us to track some of the stories that Mr. Butler relayed, anywhere where there might be a wait that is too long. It is our job to actually evolve our management, our oversight and have that constant feedback that is always looking at how to improve performance, and that is what we are doing differently this time.

Mr. WALZ. Well, I appreciate that, and with the outrage that we express, I would just ask you to always ask us this: how long you have been waiting for us to do a budget and sequestration? What is fair is fair. Emerson might have been right, "how much of life is lost in waiting," but thanks.

I yield back.

Mr. COFFMAN. Thank you, Mr. Walz.

Mrs. KIRKPATRICK. Mr. Chairman, may I have just a moment?

Mr. COFFMAN. Oh, yes. Go ahead.

Mrs. KIRKPATRICK. Thank you very much for having this hearing. I want to thank the panel and the guests. The Democrats on the Committee are leaving to go meet with the President, so I didn't want you to think we are just walking out of the hearing, but we need to meet with him at 2 o'clock, so thank you.

Mr. COFFMAN. Thank you.

Dr. Lynch, I believe you stated in your testimony that you were not aware of any deaths of any veterans due to delayed care; is that correct?

Dr. LYNCH. We were talking about consults to begin with, and let me, if I may, explain a little bit about how the consult process works.

There are two sides to a consult. There is the consult itself, the ask, and there is the response or the physician reply. There is a third component to that which links the two. When the team from VHA undertook to assess consults, they did it in a standardized fashion. We looked, first of all, at all of the consults over a --

Mr. COFFMAN. May I rephrase the question?

Are you aware of any deaths of any veterans due to delayed care?

Dr. LYNCH. With respect to the consult look back, no, sir. With respect to what had occurred in Columbia and Augusta, we are aware that there were some clinical disclosures made and that there were veterans who had died with a disease process that could potentially have been related to consult delay.

Mr. COFFMAN. Well, yeah, I think you have via the internal documents here, and you are actually fairly specific. It is in May that it, in fact, the delay in treatment did cause the death of a veteran in South Carolina, and another date in May—another internal document, last year, May 15, speaks to the Dorn facility, speaks to another death due to delay in care, so I think that clearly there are, by your own internal documents, there are issues concerning the quality of care related to timeliness and, unfortunately, the loss of life unnecessarily of veterans, and that is particularly alarming.

Mr. Schoenhard, when did you become aware of this problem?

Mr. SCHOENHARD. The problem being consult backlog or back --

Mr. COFFMAN. The very problem we are discussing here today, when did you become aware of it?

Mr. SCHOENHARD. Well, I would say the overall issue of wait times, I would say, is a matter that I have been concerned about since arriving when I was appointed in 2009.

Mr. COFFMAN. In 2009?

Mr. SCHOENHARD. Yes, sir.

Mr. COFFMAN. Now, it is 2013, and we are having this discussion?

Mr. SCHOENHARD. Yes, sir.

Mr. COFFMAN. Why are we here today?

Mr. SCHOENHARD. I think we are here today because of a number of factors, most of which deal with better execution going forward and the consistent training, testing and implementation of our scheduling package with measures that are more reliable and valid than we have had in the past.

As I said in my opening statement, I think it begins with the measurement system itself. And I am convinced from what we have learned from the GAO, the IG, particularly the IG review of mental health. That was very helpful last year.

Mr. COFFMAN. Mr. Schoenhard has VA's medical inspector Dr. John Pierce come to any conclusions as a result of the large-scale failure to care for veterans?

Mr. SCHOENHARD. I think that, from Dr. Pierce's report, it showed clearly that we had the important need to do two things: Address the delays in the facilities that he had visited in Columbia, South Carolina and Augusta, Georgia. As important as it was for us to vigorously respond to that report from Dr. Pierce and the

OMI of those two facilities, it was as important as that was to ensure we were providing system resources and VISN resources to those two facilities, it was equally important that we do a system-wide review to see if this was of an issue anywhere else. And that is the process that Dr. Lynch was describing. Because whenever we have a problem arise in a particular facility, or two facilities, we have a responsibility to ensure veterans throughout VHA that we are undertaking a review to see if this is the case anywhere else.

Mr. COFFMAN. When can the Committee see that report?

Mr. SCHOENHARD. I would have to take that for the record, sir. I don't know, but I would certainly take that for the record.

Mr. COFFMAN. Well, when can the Committee see that report?

Mr. SCHOENHARD. Sir, if I could take that for the record, I will provide an answer as soon as we can.

Mr. COFFMAN. You will provide the report.

Major Shepard. I would have to check and make sure that I can tell you the time within which the report would be rendered.

Mr. COFFMAN. Is the—well—Mr. Butler, you mentioned that the Legion's task force had identified a list of 14,000 veterans waiting months for appointments in Bay Pines. Can you cite other locations?

Mr. BUTLER. Our System Worth Saving Task Force has visited a number of VA facilities. And while I can't specifically identify at this time facilities that have excessive wait time, I will take that information for the record. But I can tell you that on as recent as a visit on yesterday, we found that there are some facilities where when we talk about the electronic wait lists, we are still finding facilities that are still using paper lists. So not all the appointments are being recorded electronically. So, therefore, the wait time is not accurately being reported as it should be.

Mr. COFFMAN. Thank you.

Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I apologize for any tardiness in arriving.

I would like to ask Ms. Draper a question of her report and piecing through that, the one issue in particular that disturbed me was you note that staff at some clinics told us they change medical appointment desire dates to show clinic wait times within performance goals. How widespread was that pattern of behavior? And can you describe that a little further for the Committee?

Ms. DRAPER. We actually found this in several places. So it was not a one-time occurrence. For example, in one primary clinic, a scheduler told us that they changed the dates to make it look like they had short wait times. And at a specialty care clinic in another facility, a scheduler told us providers changed the dates to ensure that it reflected wait times within the 14-day performance goal. We had quite a few examples. Another specialty clinic in another facility matched the desired date to the appointment date so that it showed a zero wait time. In actuality, when we went there it had a 6- to 8-week backlog of appointments. I think this question came up earlier. Part of the issue is that there is a lot of confusion among schedulers about what they are supposed to be doing. No one specifically told us that they were asked to change the date by leadership. But I think the situation as it currently exists provides

ample opportunity for dates to be changed, whether intentional or not, to reflect the results that you want to achieve.

Mr. HUELSKAMP. I appreciate that. I apologize.

Mr. Chairman, if the question has been asked before. I want to follow up a little bit more. Is this, in your understanding, is this illegal under --

Ms. DRAPER. Well, it is against scheduling policy, so they are not in compliance with the policy or the process.

Mr. HUELSKAMP. I will ask the VA, how do you handle these employees and what have you done with this information?

Mr. SCHOENHARD. Sir, gaming the system, if that is what is being suggested here, by changing dates in order to ensure that the results look better for performance reviews is entirely unacceptable. Entirely unacceptable. And we—are visible, when that is visible to us, we will take appropriate action. And I will follow up with the GAO report to determine this more specifically. What we need to be doing is ensuring we are taking care of veterans.

Mr. HUELSKAMP. Assuming what we have seen matches up with what you are seeing, sir, what is the—the penalty for an employee that is violating this policy? What would you—how would you handle that?

Mr. SCHOENHARD. Well, sir, we would review the case in each individual case to determine what was the facts and the circumstances and --

Mr. HUELSKAMP. Let's just establish that the facts indeed occurred as indicated. What is the penalty for—I wouldn't call it gaming the system. That is cheating. What is the penalty?

Mr. SCHOENHARD. The penalty would depend on the seriousness of the offense.

Mr. HUELSKAMP. So if they changed it and moved it 6 weeks, and did this repeatedly, what would be the penalty in those circumstances?

Mr. SCHOENHARD. Sir, I would have to say it would depend on the individual circumstance, but it could lead up to termination.

Mr. HUELSKAMP. I look forward for a report on that.

Mr. Chairman, I might note, I want to reiterate a request I have had to the VA for, I think we are up to 6 or 7 months now in reference to budget data. I think we have 23 unanswered questions in reference torch data out of the VA. And I appreciate you coming forward to this Committee and Subcommittee and giving some information. But I have had, again, multiple unanswered questions, basic budget data in reference to travels and activities by your employees that your agency has refused to provide information. And it is very hard to build a level of trust that we need to move forward to help and achieve the goal of helping our veterans when you refuse to answer, again, basic budget questions. So I would appreciate it if you would take that back to the folks in charge. And it has been a number of months. Certainly, we can figure out what responses we need to get to the Congressman other than simply ignoring those.

I yield back, Mr. Chairman.

Mr. COFFMAN. Thank you.

Mr. Schoenhard, and I'd like to thank the entire panel, Mr. Butler, for your testimony, and Ms. Draper, Mr. Schoenhard and your staff.

I just want to say that you have been here since—in this position since 2009. You came in, obviously, the system was in chaos and not serving the veterans' community. You have been there, you haven't made a difference. And I have no reason to think that, under your leadership, unfortunately, that this job is going to get done.

With that, Committee is recessed.

[Whereupon, at 2:05 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Mike Coffman, Chairman

Good morning. This hearing will come to order.

I want to welcome everyone to today's hearing titled "Waiting for Care: Examining Patient Wait Times at VA."

We should always be working to ensure veterans have timely access to quality care. However, today's hearing is necessary because evidence reviewed by this Subcommittee, the Government Accountability Office, and VA's own Inspector General shows little improvement in that area.

GAO recently completed its study that was appropriately titled "Appointment Scheduling Oversight and Wait Time Measures Need Improvement." Despite claims of improvement under higher standards, we will hear today about a lack of reliable information when VA is measuring patient wait times. VA's own testimony supports that premise as it discusses what it sees as no reliable standard and an inability to accurately measure what constitutes a patient wait time.

While the topic of patient wait times may sound like a very narrow issue, the problems in accurately monitoring and improving wait times for veterans at VA facilities is spread throughout the whole Department of Veterans Affairs. Schedulers at the facilities themselves have to use a cumbersome system that creates a significant chance of error. The problem runs all the way up to the Veterans Health Administration, which has an unclear policy on patient scheduling practices, and still seems to struggle to best define its policy on patient scheduling. I understand that defining these policies is not easy, and that perfecting a process for appointment scheduling is a significant challenge, but VA has been well behind in this area for a long time.

However, none of this excuses VA from its obligation to veterans. While I understand a system may not always be perfect, it does not mean that VA shouldn't make every effort to ensure veterans receive necessary care. Backlogs are a fairly common theme at the Department, but that is no reason for VA to game the numbers to simply show better performance instead of providing medical appointments, sometimes for life-threatening conditions.

Sadly, evidence obtained by this Subcommittee clearly shows that, in many cases, VA did not do the right thing. Instead, evidence has shown that many VA facilities, when faced with a backlog of thousands of outstanding or unresolved consultations, decided to administratively close out these requests. Some reasons given included that the request was years old, too much time had elapsed, or the veteran had died.

This Subcommittee asked VA for updates on these consultation backlogs beginning in October 2012. Despite multiple follow-up requests to VA, no information was ever provided, and it was only when this hearing was scheduled that the Department offered a briefing on this subject. I would note that the Subcommittee asked for information, not a briefing. Regardless, we should not be where we are now, and this goes to reinforce that the Veterans' Affairs Committee wants to work with the Department on this and other issues, but that requires a willingness on VA's side to be forthcoming about its problems so that together we can identify ways to solve them.

Prepared Statement of Hon. Ann Kirkpatrick

Thank you, Mr. Chairman, for holding this hearing this afternoon on the Veterans Health Administration's scheduling processes and how that affects patient wait times for veterans.

Improving access to health care is a continuous effort by VHA, and it is not surprising that we are here today.

Excessive wait times and the failures of the scheduling processes have been long-standing problems within the Veterans Health Administration.

The Government Accountability Office has been reporting on this issue for over a decade.

In 2001, the GAO reported that two-thirds of the specialty care had wait times longer than 30 days.

In 2007, the VA Office of Inspector General reported that VHA facilities did not always follow VHA's scheduling polices and processes.

In 2012, the VA OIG reported that VHA was not providing all new veterans with timely access to full mental health evaluations. In that same year, the GAO again examined the issue and found that, among other things, there was inconsistent implementation of VHA's scheduling policy that could result in increased wait times or delays in scheduling timely medical appointments.

In my Arizona district, in the city of Casa Grande, one of my caseworkers recently met with an Iraq veteran who made the brave decision to seek VA mental health care after two years of being back in the U.S. from Iraq.

The VA required a physical exam before this veteran in my district could schedule an appointment with a mental health care provider. Unfortunately, they weren't able to schedule him for the initial physical for six full months. That's six months of waiting before he could even have his initial consultation with a mental health care provider. And this is after two years of not even seeing a doctor.

These situations were able to be resolved by our veterans caseworker in the district, but the point is that veterans should not have yet another hoop to jump through – access to health care should be easy to schedule.

I also understand that VHA is operating with a reportedly outdated system that is cumbersome and slow. GAO reported numerous workarounds that some facilities are using, which may adversely affect timely health care delivery to veterans.

Delayed care is denied care. This is all too evident with the rash of recent consult backlogs experienced at some of VHA's medical centers.

It has been reported that thousands of consults in 2011 and 2012 were backlogged at various facilities which may have resulted in adverse events due to the delays in diagnosis and treatment.

This of course is unacceptable. Veterans deserve timely, accessible, health care.

What I would like to hear about today is a sound plan that will assist VHA in transforming into a 21st Century organization and will eliminate, as much as possible, the needless waits, unclear policies and procedures, and frustrating technology that only serves to slow down progress.

Prepared Statement of Hon. Jackie Walorski

Mr. Chairman, it's an honor to be here today.

I thank you for holding this hearing on an issue that is very important to current and future veteran care.

Indiana's Second Congressional District is home to over 50,000 veterans. [1]

These men and women have served their country and endured the struggles and triumphs that come with wearing the uniform. I am proud of these Hoosiers and indebted to them for their sacrifices.

When the Hoosier veterans were called for duty, they promptly responded. It is saddening and disgraceful that our Veterans Administration fails to respond to the needs of these veterans with the same timeliness. Veteran calls for help should not go unanswered.

I appreciate the time the panelists have taken today. I know my colleagues share the same commitment, as I do, to ensuring the veterans of this great Nation receive the care they have rightfully earned.

Thank you.

Prepared Statement of Hon. Jeff Duncan

It was once said that "the legacy of heroes is the memory of a great name and the inheritance of a great example." In our country, some of our greatest heroes are

[1] There are an estimated 53,318 veterans in IN–02. This data was compiled on 09/30/2012, based on the district lines from the 112th Congress. *http://www.va.gov/vetdata/Veteran—Population.asp*

our veterans; individuals who answered our Nation's call to protect and defend our freedom. Our veterans are one of our Nation's greatest treasures and as such our country has given them a firm promise:

Because of their willingness to protect us through their service, when their service ends we promise to look after them. Unfortunately, when I talk to veterans today, they don't believe that our government is living up to our promises. When we made the commitment to take care of troops when they return home we never said anything about making them jump through hoops or navigate a complicated a bureaucracy. We promised our veterans the moon but instead we have failed in many instances to provide our veterans with the most basic of care.

When I heard this Committee was holding this hearing, my staff reached out to our veterans in our district to hear their perspective. The VA testifies here today that its "wait time goal" is 14 days. Well, I spoke to my constituents. As of Monday, March 4, 2013, the Columbia VA Regional Office has **22,565** claims pending. The current wait time is an average of **282.6** days. Survivor benefits for veteran's spouses can between 10 and 18 months to be dispersed, and sometimes even longer depending on the health status of the beneficiary.

My staff spoke with the Oconee County Veterans Affairs office last week, and they tell me that up until a few weeks ago, the local Veterans Affairs office hadn't been able reach the Columbia Regional Office by telephone since early November. In fact, the staff of this particular Veterans Affairs office told us that they often have to take files home with them, so they can call down to Columbia at 10 or 11 o'clock at night just so they can leave a message, which they aren't even able to get through to do during the day!

Last year, my office assisted a constituent who contacted us because he has had 12 claims pending before the Veteran's Administration which dated all the way back to 2004.

Tommy Wilbanks, a Vietnam and Gulf War Veteran from Oconee County, currently has five cases pending before the VA dating back to June of 2010. He told us that veterans constantly feel like they're getting the run around from the VA.

Another constituent who we've worked with had her claims delayed over 18 months because she has been told by the Veteran's Administration that they didn't have her medical records, this is despite the fact she sent the VA her medical records twice by certified mail.

When we connect these disabilities claims backlogs to the wait times for appointments that veterans are currently experiencing in my district, the lack of doctors and inefficiency in the system, we see a large systemic problem that the VA has failed to address. This is utterly unacceptable.

I've heard frequently from a younger veteran, a marine, who served two tours in Iraq. He's concerned about the cleanliness of the facilities in Columbia, and angered at what he's described as disrespect shown by some of the staff directed towards veterans. He's also deeply troubled by the wait times of support hotlines for veterans with PDST.

The VA has failed our veterans in these ways, and you must do better. You say the problem is resolved. Veterans in my district disagree. You say that you've fixed it. I want to know how. We know that in other facilities you have administratively closed cases, and veterans have died. What are you going to do to fix these problems?

Prepared Statement of William C. Schoenhard

Good afternoon, Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee. Thank you for the opportunity to discuss an important topic that impacts every Veteran's experience with Department of Veterans Affairs (VA) health care services - the reliability and timeliness of outpatient medical appointments. I am accompanied today by Thomas Lynch, M.D., Assistant Deputy Under Secretary for Health for Clinical Operations; Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations; and, Michael Davies, M.D., National Director of Systems Redesign

The Veterans Health Administration's (VHA) mission is to honor America's Veterans by providing exceptional healthcare that improves their health and well-being. Providing timely access to that care is a critical aspect of our mission. Access enables VHA to provide personalized, proactive, patient-driven health care; achieve measurable improvements in health outcomes; and, align resources to deliver sustained value to Veterans. VHA is continually assessing wait times and making adjustments as needed to ensure that Veterans have access to the best care anywhere.

VHA Wait Time Determination: Early Efforts

VHA has been transforming its health care delivery system for two decades, moving from a hospital-based system to an ambulatory care model. The ability of Veterans to access health care at the right time and in the right place is at the heart of keeping our promise to America's Veterans. For this reason, VA's effort to manage timely access is critically important.

We know timeliness of appointments has improved since we began tracking it, but determining a reliable and valid way to measure timeliness has been difficult. In the 1990s, VHA started measuring wait times using capacity measures, such as next available appointment date that are widely used in the health care industry today. VHA found that capacity measures proved inadequate to portray each individual patient's experience because they showed clinic availability rather than what occurred for the individual patient. In the absence of an effective industry standard, VHA has had to develop, test, and refine new methods for measuring wait time that align with our goal to provide patient-centered care. Much of this work has been iterative and is reflected by the numerous wait time measures VHA has developed over the past ten years.

In retrospect, we now know that some of our reporting on wait times was not as reliable as our Veteran patient and stakeholders deserve. For instance, while the information VHA submitted for the President's annual Performance and Accountability Reports did provide the current level of performance against the existing measures, these measures did not accurately capture the experience of Veterans. Measuring outpatient medical appointment wait times was uncharted territory and we relied on the best information and experience available at the time.

In 1999, Veterans waited an average of 60–90 days for a primary care appointment. In 2011, VHA established a wait time goal of 14 days, rather than 30 days, for both primary and specialty care appointments. VHA challenged itself to provide more timely care to increase patient satisfaction since most patients were being seen within the earlier established 30 day goal. Currently, approximately 40% of new patients and 90% of established patients meet this 14 day goal.

Over the past few years, the U.S. Government Accountability Office (GAO) and VA's Office of Inspector General (OIG) have assessed VHA's outpatient medical appointment wait times. OIG made multiple recommendations to improve scheduler accuracy and "establish procedures to test the accuracy of reported wait times." VHA acknowledges the shortcomings in our past approaches and appreciates these findings and recommendations. Through these analyses, we are better able to understand the gaps in our processes and incorporate best practices into future policy and operations.

VHA's Wait Times Study

In 2009, VA commissioned a retrospective study partly in response to concerns raised by GAO and OIG to assess the association between multiple measures of timeliness and patient satisfaction. Using data from 2005 – 2010, researchers obtained and analyzed information from nearly 400 million VHA appointments and over 220,000 patient satisfaction surveys. VHA received the study's results in 2012.

The study showed that new and established patients have different needs and require different approaches for capturing wait times. Also, the data identified that the Create Date, the date that an appointment is made is the optimal method for new patients, since most new patients want their visit or clinical evaluation to occur as close to the time they make the appointment as possible. For established patients, VHA has determined that using the Desired Date is the most reliable and patient-centered approach. Desired Date is the ideal time a patient or provider wants the patient to be seen. Although not perfect, this measure provides the best association with patient satisfaction for established patients. VHA's Wait Time Study, consistent with the literature in this area, shows that shorter wait times are associated with better clinical care and positive health outcomes. Armed with evidence that the Create Date and the Desired Date best predict patient satisfaction and health outcomes for new and established patients respectively, VHA adopted these methods on October 1, 2012.

In December 2012, GAO issued its report urging VA to improve oversight of the reliability of reported outpatient medical appointment wait times and scheduling for outpatient appointments. VA concurred with GAO's findings and their four recommendations that are important to improving VHA's wait time measures. We will discuss in more detail VHA's action plan to address GAO's recommendations below.

The Way Forward

With the recent evidence from our wait time study, ongoing VHA performance measures, as well as findings and recommendation from oversight entities, VHA be-

lieves it now has reliable and valid wait time measures that allow VHA to accurately measure how long a patient waits for an outpatient appointment. VHA's action plan is aimed at ensuring the integrity of wait time measurement data so that VHA has the most reliable information to ensure Veterans have timely access to care and high satisfaction.

VHA is focused on implementing new wait time measurement practices, policies, and technologies along with aggressive monitoring of reliability through oversight and audits. VHA is working to implement the action plan and expects to have the majority of the efforts in place in the next 12 months. Following is a discussion of VHA's efforts to implement reliable measures so that we can ensure that Veterans receive the care they need when they need it.

In response to the first GAO recommendation, identifying weaknesses in scheduler procedures for accurately and reliably establishing the patient's desired appointment date, VHA is both establishing more accurate wait time measures and revising its scheduling policy. The old scheduling policy relied on the scheduler to ascertain and correctly record the Desired Date for established patients. The new policy requires the provider to record the patient-provider decision on the projected next appointment date. This 'Agreed-Upon-Date' (AUD) process provides clear documentation and will improve the reliability of the recorded desired appointment date. AUD also includes the patient actively in the decision-making process and more accurately portrays the patient expectation. VHA piloted these new procedures and found them to be feasible to implement.

In order to improve the accuracy of wait time measures, VHA is using methodology that relies on recorded time stamps. For new patients, VHA will report the length of time that elapses between appointment creation and completion. For established patients, VHA will report the time between the AUD and the scheduled appointment. The VA's wait time study that began in 2009 demonstrated that of all possible measure combinations, these particular methods best reflect patient satisfaction.

Regarding GAO's second recommendation to improve scheduling policy and procedures for the use of the Electronic Wait List (EWL), VHA is updating policy and training. Also, VHA is ensuring all staff with access to the Veterans Health Information Systems and Technology Architecture (VistA) appointment scheduling system completes required training. The EWL is used to keep track of patients waiting to be scheduled with a provider in Primary Care, Specialty Care, or Mental Health. When the new process goes into effect within the next year, only new patients will be placed on an EWL if they cannot be scheduled within 90 days. In the past, VHA did not specify the 90-day standard. Patients on the EWL will continue to have their wait times tracked from the time they are entered on the list. Standardizing all clinics to this procedure will allow managers to better understand clinic operations and resource needs.

VHA has updated its training program for the more than 50,000 staff that uses the VistA scheduling system. Schedulers are trained on how to properly record the AUD in VistA. VHA acknowledges that the VistA scheduling system is outdated and inefficient. Schedulers must open and close multiple screens to check a providers' availability. It can take a scheduler between 30 seconds and five minutes and many keystrokes to make an appointment in VistA, compared to a point and click process in modern scheduling programs. This cumbersome process leads to user error. To optimize scheduler efficiency, VHA requires training of schedulers making appointments. VA medical centers are able to track schedulers' compliance with training requirements.

While training ensures that staff know the proper scheduling procedures, VHA also requires audits to ensure compliance with these procedures. The implementation of new AUD procedures enables more comprehensive auditing capabilities. In the future, supervisors will have the capability to electronically audit proper entry of the AUD by the scheduler. For a typical Patient Aligned Care Team (PACT) practice, this could range from 1,000 to 2,000 appointments per year for every provider. Supervisors will not need to pull and review charts, but rather more efficiently retrieve reports from central databases. This process will audit appointment requests generated internally from health care providers, where the majority of appointments are made. These procedures do not apply to patients who call-in or walk-in from "outside" the practice. VHA will continue to require manual audits of these cases.

Complying with GAO's third recommendation, to ensure adequate scheduling staff is present in VHA facilities, VHA is working to ensure that each medical center has adequate scheduling staff. Schedulers are entry-level positions with high turnover rates and may have multiple responsibilities. VHA has launched efforts to study and select the best way to track staff occupying these positions. In addition, VHA has made progress in developing analytical tools that will help schedulers and managers

select the best methods to manage access based on individual clinic patterns of operation. For instance, clinics have differing amounts of no-shows, cancellations, and different utilization and revisit rates.

GAO's fourth recommendation to VHA is to improve responsiveness to Veterans accessing services by phone. To improve telephone service for Veterans calling into health care facilities for appointments, VHA will require facilities to complete a standardized telephone assessment and implement improvements. VHA will monitor the progress quarterly and align resources as needed.

In addition to actions taken to comply with GAO's recommendations, VHA continues to develop technology for improving the scheduling system. VHA has completed programming for version 1.0 of the Veteran Appointment Request Application that is currently being pilot tested. This "App" resides on a Veteran's handheld device or desktop computer and accepts up to three preferences for each appointment request. VHA databases will capture the Veteran-entered first choice as the Desired Date. VHA has also contracted for the development of a Scheduler Calendar View. This "overlay" to the VistA scheduling system is envisioned as a way to decrease user error that can occur during the scheduling process. The Scheduler Calendar View will be a more user-friendly, point-and-click interface. VHA continues to pursue efforts to replace VistA scheduling with a commercial off-the-shelf product. The Department has issued a challenge on Challenge.gov for a medical patient scheduling solution.

Conclusion

In conclusion, VHA is aggressively addressing access for patients in many ways. In 2011, VHA raised the bar for the industry by setting a wait time goal of 14 days for both primary and specialty care appointments. Last year, VHA added a goal of completing primary care appointments within 7 days of the Desired Date. The intent is to come as close as possible to providing just-in-time care for patients. The ultimate goal is same day access. VHA is making improvements in delivering timely care to our Veterans and in the reliability of reporting wait time information. We have identified the issues and are taking steps to address them. We recognize that there is more to do, and we will continue to make this a priority.

VA is committed to honoring America's Veterans by providing them the health care they have earned and deserve. Thank you for the opportunity to speak to you about this issue. My colleagues and I are ready to respond to any questions you might have.

Prepared Statement of Debra A. Draper

Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee:

I am pleased to be here today to discuss improvements needed in the Department of Veterans Affairs' (VA) outpatient medical appointment scheduling oversight and wait time measurement.[1] In fiscal year 2011, the Veterans Health Administration (VHA), within VA, provided nearly 80 million medical appointments to veterans through its primary and specialty care clinics, which are managed by VA medical centers (VAMC).[2] Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, long wait times and inadequate scheduling processes at VAMCs have been persistent problems, as we and the VA Office of Inspector General have reported.[3] Most recently, in December 2012, we reported that VHA's medical appointment wait times are unreliable and problems

[1] Throughout this statement, we will use the term "medical appointments" to refer to outpatient medical appointments.

[2] Outpatient 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 orthopedics, dermatology, or psychiatry.

[3] See GAO, VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress, GAO-01-953 (Washington, D.C.: Aug. 31, 2001). See also Department of Veterans Affairs, Office of Inspector General, Audit of the Veterans Health Administration's Outpatient Waiting Times, Report No. 07–00616–199, (Washington, D.C.: Sept. 10, 2007). Finally, see Department of Veterans Affairs, Office of Inspector General, Veterans Health Administration: Review of Veterans' Access to Mental Health Care, Report No. 12–00900–168, (Washington, D.C.: Apr. 23, 2012).

with VHA's oversight of outpatient medical appointment scheduling processes impede VHA's ability to schedule timely medical appointments. [4]

VHA has a scheduling policy designed to help its VAMCs meet its commitment to scheduling medical appointments with no undue waits or delays. [5] The policy establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. It includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement. [6] For example, the policy requires schedulers to record appointments in VHA's Veterans Health Information Systems and Technology Architecture (VistA) medical appointment scheduling system; schedulers also are to record the date on which the patient or provider wants the patient to be seen—known as the desired date. [7]

At the time of our review, VHA measured 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. According to VHA central office officials, VHA measures wait times based on desired date in order to capture the patient's experience waiting and to reflect the patient's or provider's wishes. In fiscal year 2012, VHA had a goal of completing primary care appointments within 7 days of the desired date, and scheduling specialty care appointments within 14 days of the desired date. [8] VHA established these goals based on its performance reported in previous years. [9] To help facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance measures—in its Veterans Integrated Service Network (VISN) directors' and VAMC directors' performance contracts [10] and VA includes measures in its budget submissions and performance reports to Congress and stakeholders. [11]

My statement today highlights key findings from our December 2012 report that describes needed improvements in the reliability of VHA's reported medical appointment wait times, scheduling oversight, and VHA initiatives to improve access to timely medical appointments. [12] For that report, we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times and interviewed VHA central office officials responsible for developing them. [13] 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 manage and improve med-

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[4] GAO, 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).

[5] VHA 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.

[6] 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. VHA Directive 2007–033, Telephone Service for Clinical Care (Oct. 11, 2007).

[7] VistA is the single integrated health information system used throughout VHA in all of its health care settings. There are many different VistA applications for clinical, administrative, and financial functions, including the scheduling system.

[8] In 2012, VA also had several additional goals related to measuring access to mental health appointments specifically, such as screening eligible patients for depression, post-traumatic stress disorder, and alcohol misuse at required intervals; and documenting that all first-time patients referred for or requesting mental health services receive a full mental health evaluation within 14 days of their initial encounter. As noted earlier, in its Report No. 12–00900–168, the VA OIG found that some of the mental health performance data were not reliable. VA is dropping several of these mental health measures in 2013.

[9] In 1995, VHA established a goal of scheduling primary and specialty care medical appointments within 30 days to ensure veterans' timely access to care. In fiscal year 2011, VHA shortened the wait time goal to 14 days for both primary and specialty care medical appointments. In fiscal year 2012, VHA added a goal of completing primary care medical appointments within 7 days of the desired date.

[10] Each of VA's 21 VISNs is responsible for managing and overseeing medical facilities within a defined geographic area. VISN and VAMC directors' performance contracts include measures against which directors are rated at the end of the fiscal year, which determine their performance pay.

[11] VA 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.

[12] GAO-13-130.

[13] We 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.

ical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with scheduling policy, and problems staff experience 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 VISNs for the sites 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. We performed this work from February 2012 through December 2012 in accordance with generally accepted government auditing standards.

In brief, we found that (1) VHA's reported outpatient medical appointment wait times are unreliable, (2) there was inconsistent implementation of certain elements of VHA's scheduling policy that could result in increased wait times or delays in scheduling timely medical appointments, and

(3) VHA is implementing or piloting a number of initiatives to improve veterans' access to medical appointments. Specifically, VHA's reported outpatient medical appointment wait times are unreliable because of problems with correctly recording the appointment desired date—the date on which the patient or provider would like the appointment to be scheduled—in the VistA scheduling system. Since, at the time of our review, VHA measured medical appointment wait times as the number of days elapsed from the desired date, the reliability of reported wait time performance is dependent on the consistency with which VAMC schedulers record the desired date in the VistA scheduling system. However, aspects of VHA's scheduling policy and related training documents on how to determine and record the desired date are unclear and do not ensure replicable and reliable recording of the desired date by the large number of staff across VHA who can schedule medical appointments, which at the time of our review was estimated to be more than 50,000. During our site visits, we found that at least one scheduler at each VAMC did not record the desired date correctly, which, in certain cases, would have resulted in a reported wait time that was shorter than the patient actually experienced for that appointment. Moreover, staff at some clinics told us they change medical appointment desired dates to show clinic wait times within VHA's performance goals. Although VHA officials acknowledged limitations of measuring wait times based on desired date, and told us that they use additional information, such as patient satisfaction survey results, to monitor veterans' access to medical appointments, reliable measurement of how long veterans wait for appointments is essential for identifying and mitigating problems that contribute to wait times.

At the VAMCs we visited, we also found inconsistent implementation of certain elements of VHA's scheduling policy, which can result in increased wait times or delays in scheduling timely medical appointments. For example, four clinics across three VAMCs did not use the electronic wait list to track new patients that needed medical appointments as required by VHA's scheduling policy, putting these clinics at risk for losing track of these patients. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy was inconsistent across the facilities we visited. Specifically, certain VAMCs did not ensure the completion of scheduler training by all staff required to complete it even though officials stressed the importance of the training for ensuring correct implementation of VHA's scheduling policy. VAMCs also described other problems that impede the timely scheduling of medical appointments, including VA's outdated and inefficient VistA scheduling system, gaps in scheduler staffing, and issues with telephone access. The current VistA scheduling system is more than 25 years old, and VAMC officials reported that using the system is cumbersome and can lead to errors.[14] In addition, shortages or turnover of scheduling staff, identified as a problem by all of the VAMCs we visited, can result in appointment scheduling delays and incorrect scheduling practices. Officials at all VAMCs we visited also reported that high call volumes and a lack of staff dedicated to answering the telephones impede the scheduling of timely medical appointments.

VHA is implementing or piloting a number of initiatives to improve veterans' access to medical appointments that focus on more patient-centered care; using technology to provide care, through means such as telehealth and secure messaging between patients and their health care providers; and using care outside of VHA to reduce travel and wait times for veterans who are unable to receive certain types of outpatient care in a timely way through local VHA facilities. For example, VHA is piloting a new initiative to provide health care services through contracts with

[14] In October 2012, VA announced a contest seeking proposals for a new medical appointment scheduling system from commercial software developers.

community providers that aims to reduce travel and wait times for veterans who are unable to receive certain types of care from VHA in a timely way. Although VHA collects information on wait times for medical appointments provided through this initiative, these wait times may not accurately reflect how long patients are waiting for appointments because they are counted from the time the contracted provider receives an authorization from VA, rather than from the time the patient or provider first requests an appointment from VHA.

In conclusion, VHA officials have expressed an ongoing commitment to providing veterans with timely access to medical appointments and have reported continued improvements in achieving this goal. However, unreliable wait time measurement has resulted in a discrepancy between the positive wait time performance VA has reported and veterans' actual experiences. More consistent adherence to VHA's scheduling policy and oversight of the scheduling process, allocation of staff resources to match clinics' scheduling demands, and resolution of problems with telephone access would potentially reduce medical appointment wait times. 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.

To ensure reliable measurement of how long veterans are waiting for appointments and improve timely medical appointment scheduling, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to (1) improve the reliability of its medical appointment wait time measures, (2) ensure VAMCs consistently implement VHA's scheduling policy, (3) require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources, and (4) ensure that VAMCs provide oversight of telephone access and implement best practices to improve telephone access for clinical care. VA concurred with our recommendations and identified actions planned or underway to address them.

Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you or other members of the subcommittee may have at this time.

For questions about this statement, please contact Debra A. Draper at (202) 512–7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Bonnie Anderson, Assistant Director; Rebecca Abela; Jennie F. Apter; Lisa Motley; Sara Rudow; and Ann Tynan.

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Highlights

VA HEALTH CARE

Appointment Scheduling Oversight and Wait Time Measures Need Improvement

Why GAO Did This Study

VHA provided nearly 80 million outpatient medical appointments to veterans in fiscal year 2011. Although access to timely medical appointments is important to ensuring veterans obtain needed care, long wait times and inadequate scheduling processes have been persistent problems.

This testimony is based on a December 2012 report, VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement (GAO–13–130), that described needed improvements in the reliability of VHA's reported medical appointment wait times, scheduling oversight and VHA initiatives to improve access to timely medical appointments. To conduct that work, GAO made site visits to 23 clinics at four VAMCs, the latter selected for variation in size, complexity, and location. GAO also reviewed VHA's policies and interviewed VHA officials.

What GAO Recommends

In its December 2012 report, GAO recommended that VHA take actions to (1) improve the reliability of its medical appointment wait time measures, (2) ensure VAMCs consistently implement VHA's scheduling policy, (3) require VAMCs to allocate staffing resources based on scheduling needs, and (4) ensure that VAMCs provide oversight of telephone access and implement best practices to improve telephone access for clinical care. VA concurred with GAO's recommendations.

What GAO Found

Outpatient medical appointment wait times reported by the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), are unreliable. Wait times for outpatient medical appointments—referred to as medical appointments—are calculated as the number of days elapsed from the desired date, which is defined as the date on which the patient or health care provider wants the patient to be seen. The reliability of reported wait time performance measures is dependent on the consistency with which schedulers record the desired date in the scheduling system. However, aspects of VHA's scheduling policy and training documents for recording desired date are unclear and do not ensure consistent use of the desired date. Some schedulers at VA medical centers (VAMC) that GAO visited did not record the desired date correctly, which, in certain cases, would have resulted in a reported wait time that was shorter than the patient actually experienced for that appointment. VHA officials acknowledged limitations of measuring wait times based on desired date, and described additional information used to monitor veterans' access to medical appointments; however, reliable measurement of how long patients are waiting for medical appointments is essential for identifying and mitigating problems that contribute to wait times.

While visiting VAMCs, GAO also found inconsistent implementation of certain elements of VHA's scheduling policy that impedes VAMCs from scheduling timely medical appointments. For example, four clinics across three VAMCs did not use the electronic wait list to track new patients that needed medical appointments as required by VHA scheduling policy, putting these clinics at risk for losing track of these patients. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. VAMCs also described other problems with scheduling timely medical appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler staffing, and issues with telephone access. For example, officials at all VAMCs GAO visited reported that high call volumes and a lack of

staff dedicated to answering the telephones impede scheduling of timely medical appointments.

VHA is implementing a number of initiatives to improve veterans' access to medical appointments such as use of technology to interact with patients and provide care, which includes the use of secure messaging between patients and their health care providers. VHA also is piloting a new initiative to provide health care services through contracts with community providers that aims to reduce travel and wait times for veterans who are unable to receive certain types of care within VHA in a timely way.

Prepared Statement of Roscoe Butler

A veteran in crisis, suffering from mental health problems, became so furious with the telephone delays he faced while trying to make a mental health appointment at the VA, assaulted his wife and dog after being repeatedly placed on hold. Veterans are struggling to access their healthcare across the country, and in Richmond, Virginia appointments for mental health (PTSD) issues are at least a six to eight month wait. Further, when calling for assistance, veterans are placed on hold before being asked whether the call is regarding an emergency, or whether the veteran is currently a danger to them self or to someone else.

Chairman Miller, Ranking Member Michaud and distinguished Members of the Committee: On behalf of National Commander James Koutz and the 2.4 million veterans of The American Legion, thank you for the opportunity to address this critical issue affecting veterans across the nation.

In VISN 21, a veteran has informed us that it takes approximately twelve weeks to obtain primary care appointments at the VAMC. Addressing wait times within VA is nothing new to The American Legion. Our System Worth Saving Task Force, the renowned third party oversight of VA medical facilities, was created, in part, as a response to growing wait times at VA facilities. When Past National Commander Ronald F. Conley of Pennsylvania became National Commander in 2002, he helped create two initiatives: First was the year-long "I Am Not A Number" campaign which sought to put faces on the veterans waiting months and years for appointments and service from VA, and second was the annual System Worth Saving report – designed to address the fact that, as Commander Conley noted,

"Among veterans, I heard profound gratitude voiced for the quality of care they receive. But from nearly everyone, I also found acute frustration over the lack of timely access to VA health care."

That year the System Worth Saving Report found that over 300,000 veterans were waiting for health care appointments. Of those, over half were waiting more than eight months for primary care appointments. At Bay Pines, Florida the VA Medical Center had a list of 14,000 veterans waiting longer than six months for an appointment, and 14,000 was a celebrated improvement!

It's been more than 10 years, and The American Legion continues to make System Worth Saving Task Force visits to dozens of medical facilities across the country every year. We have determined that many of these scheduling problems remain, and veterans are still being delayed and denied access to otherwise excellent care. VA needs to begin implementing real solutions to its problems and these solutions need to start with an improved appointment scheduling system.

Unfortunately, the only metric we have to track whether veterans are being seen on time relies on self-reporting from VA, and according to the Government Accounting Office (GAO), VA is a poor barometer of whether or not they are meeting appointment time guidelines. GAO specifically noted problems with VA schedulers repeated erroneous recording the "desired date" for appointments, and explained " . . . schedulers changed the desired date based on appointment availability; this would have resulted in a reported wait time that was shorter than the patient actually experienced."[1] Because the figures are being manipulated by employees to look better, statistics such as VA's reported 94 percent of primary care appointments within the proper period, mean very little.

The real measure, of whether VA is meeting the needs of veterans is how long the ACTUAL veterans have been waiting for appointments. For example, a veteran in VISN 18 told the Legion that they were waiting more than 8 months for a primary care appointment, and when he finally went in for the appointment, he was

[1] GAO–13–130, Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, December 2012

not seen, but rescheduled to return a month later. A three quarter of a year wait for a primary care appointment is not meeting the needs of veterans.

As we are now a decade into the 21st Century, The American Legion believes that VA should also begin implementing 21st Century solutions to its problems. In 1998, GAO released a report that highlighted the excessive wait times experienced by veterans trying to schedule appointments, and recommended that VA replace its VistA scheduling system.[2] To address the scheduling problem, the Veteran's Health Administration (VHA) solicited internal proposals from within VA to study and replace the VistA Scheduling System, with a Commercial Off-the-Shelf (COTS) software program. VA selected a system, and about 14 months into the project they significantly changed the scope of the project from a COTS solution to an in-house build of a scheduling application. After that, VHA ended up determining that it would not be able to implement any of the planned system's capabilities, and after spending an estimated $127 million over 9 years, The American Legion learned that VHA ended the entire Scheduling Replacement Project in September 2009.[3] We believe that this haphazard approach of fits and starts is crippling any hope of progress.

It has now been over three years since VHA cancelled the Replacement Scheduling Application project, and as of today, The American Legion understands that there is still no workable solution to fixing VA's outdated and inefficient scheduling system. In 2012 The American Legion passed Resolution number 42 that asked the VA to implement a system "To allow VA patients to be able to make appointments online by choosing the day, time and provider and that VA sends a confirmation within 24 hours". Last December, VA published an opportunity for companies to provide adjustments to the VistA system through the federal Register – all submissions are due by June 2013. While this is laudable attempt to address the problem, it hardly seems sufficiently proactive given that the problem has been identified for over fifteen years, and the persistence of excessive wait times still experienced by many veterans across the nation.

The American Legion recognizes that over the past decade, VA has taken some steps aimed at to improving its scheduling and access to care, we believe that there is still much to be done. In order to adequately address the problems of veterans, The American Legion believes VA should adopt the following steps towards a solution:

1. Devote full effort towards filling all empty staff positions. The problems with mental health scheduling clearly indicate how a lack of available medical personnel can be a large contributing factor to long wait times for treatment. Despite VA's efforts to hire 1,600 new staff, as recently as last month VA was noting only two thirds of those positions had been filled. This does not even address the previous 1,500 vacancies, and stakeholder veterans' groups are left to wonder if VA is adequately staffed to meet the needs of veterans.

We believe they are not.

If VA needs more resources to address these staffing needs, The American Legion hopes they will be forthright and open about their need, and ask for the resources they need to get the job done. The Veteran Service Organizations and Congress have been extremely responsive to get VA the resources they need to fulfill their mission, but VA must be transparent about what their real needs are.

2. Develop a better plan to address appointments outside traditional business hours. With the growing numbers of women veterans who need to balance family obligations and other commitments hamper our veterans' abilities to meet appointments during regular business hours. The American Legion believes VA can better address the community's needs with more evening and weekend appointment times. American Resolution number 40 calls on the VA to provide more extended hour options, and believes VA should recruit and hire adequate staff to handle the additional weekend and extended hour appointments for both primary and specialty care.

3. Improve the IT solution. Last year The American Legion also passed resolution number 44 , that called on the VA to create a records system that both VBA and VHA could share to better facilitate information exchange. A common system could even synchronize care visits in conjunction with compensation and pension examinations. We had hoped such a system might be included in the improvements brought

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[2] U.S. Medicine Magazine, VA Leadership Lacks Confidence in New $145M Patient Scheduling System, May 2009

[3] GAO–10–579, Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System, May, 2010

by the Virtual Lifetime Electronic Record, however VA and DOD appear to be content to pursue individual legacy systems for that project, so veterans must continue to contend with VBA and VHA systems that do not communicate as well as they should. In any case, as VA looks outward for a solution to their scheduling program, all can agree that the current system is not serving the needs of veterans and needs to be updated.

Tragically, the end result is that although VA has a truly first rate standard of care, veterans aren't able to access it with anywhere near the ease with which they should. Even the best care in the world is of little service to veterans if they cannot easily schedule timely appointments. If these problems with scheduling and appointments can be remedied, and veterans can access the care VA is delivering through the system, there would be little to complain about.

The American Legion thanks the committee for their diligence to pursue these failings of oversight, and while these are solvable problems, the solutions will require the participation and input from all community stakeholders. The outstanding care veterans receive in VA is, and should be, a point of national pride. Let's not tarnish the good work the VA accomplishes because we insist on wrestling with legacy IT systems.

For additional information regarding this testimony, please contact Mr. Shaun Rieley at The American Legion's Legislative Division, (202) 861–2700 or *srieley@legion.org*.

List of attachments;

Attachment A Statements from veterans as reported to us through our Department Service Officers

Attachment B The American Legion Resolution #40

Attachment C The American Legion Resolution #42

Attachment D The American Legion Resolution #44

Attachment A:

Statements from veterans as reported to us through our Department Service Officers

VISN 1

Generally the access to healthcare in the VISN is excellent when everything goes right, weather and vacations hamper the process though and there are a few issues. Scheduling continues to be tricky for certain specialties and the clinics are cancelling appointments if the veteran is not checked in prior to the assigned time. In the winter months that is tricky . Vets (including myself) were listed as missing an appointment on the day of the big snow storm earlier in the month. My rheumatology clinic was rescheduled four months from now. VHA has expanded the capacity at one of the CBOC's as it has moved to a larger facility and they have in turn brought on additional providers. This eases the strain at the VAMC's, although I cannot say without checking the numbers if they are seeing more veterans then last year at this time, or if the load has been spread out across more providers. Mental Health Care at the CBOC's is getting good reviews , both on access and availability to Psychologists and Psychiatrists. In VHA the problem appears to be, as was mentioned at the Washington Conference in DC, that only about half of the enrolled vets are using the services. I cannot say what the functionality would be if 80–90% of enrollees began to actively seek health care, or if a higher percentage of eligible veterans enrolled.

VISN 6

Appointments for Mental Health, i.e Ptsd. Veterans are having to wait at least 6–8 months to be seen. When calling this clinic for assistance, you are immediately placed on hold, before being asked "Is this an Emergency" Are you in any danger to yourself, or someone else. One Veteran, after he was placed on hold, became so furious, he beat his dog and wife, then they both went to the emergency room outside the VA.

Another concern is Veterans being sent for QTC exams, and because the doctors are not clear as to the test VA wants, they are given options to decline the tests.

Female Veterans are not seeing, nor getting the treatment, or time spent as males are. Story- Two married veterans with Diabetes. Her husband (takes pills only), VA doctor took 20 minutes with him, observed his feet, spoke to him about nutrition, shoes, socks medication and so on. Her doctor, crossed his legs, asked what can he do for her, took 10 minutes, made one or two notes, and said I refilled your medi-

cines and I will see you in six months. This veteran is Insulin dependent, takes Medformin (pill), had recently stepped on a thumb tack, and her feet and ankles were swollen. She asked him to check her feet, doctor asked why, what's going on and reminded her that other patients are time slotted, she may have to reschedule. Last - VHA -Interns are telling the veteran, they are not experienced enough to write nexus letter to support claim, diagnoses or justify conditions. They are telling the veteran, it's in their records, tell who ever is processing your claim to read it.

VISN 8, 10, 18

I've been enrolled in three different VISN's and health care facilities in the last twenty some odd years. The first was at the VA OPC, in VISN 8. The care there was second to none and I could get appointments within two to three weeks. My second experience was with A medical center in VISN 10. Although overcrowded, I received excellent care and appointments within two to three weeks. I am now residing in VISN 18. It took me eight months to get my initial appointment, when I arrived, they had given me the wrong time and cancelled the appointment. It took another four or five weeks to reschedule their error. My appointment was in early January. They were supposed to set up upper-GI and audiology appointments. Also, I asked for more pain medications (non-narcotic) for my service connected back. I am still waiting for the appointments and the meds. I do not intend to go back to this medical center. It appears to be poorly managed. I should not have had to wait 8 months for my first appointment, and they should have made arrangements to see me that day when I reported late for the appointment, as it was their error which caused me to be late. I lost one hour of sick leave because of their error.

VISN 10

Treatment – The mental health department seems to have a cookie cutter method for treating all veterans. As a result veterans have stopped seeking Mental Health treatment. This makes veterans not want to seek help.

VHA Phone – When you do get through on the phones, you are transferred to the wrong department or told you will be called back, and never get a call back.

VISN 17

We do not receive too many complaints and about my facility in VISN 17, but a few more complaints about another VAMC in VISN 17 with regard to scheduling appointments. Some of the veterans indicate that it is a bit difficult to schedule an appointment, especially with the outpatient clinics. Most of the complaints seem to center around being timely notified of the date and time of the appointments. Additionally, there have been complaints about the length of time it would take to get into a specialty clinic, especially PTSD at the clinics. Of course, the majority of the complaints about the VA healthcare facilities come from those individuals using the medical center.

VISN 18

Here in VISN 18 we have a great VA hospital. However, medical personnel is an issue. We have a great women's clinic but because of staff shortages it takes sometime for our women veterans to have an appointment. In addition, the east side CBOC is also experiencing staff issues. One primary care physician at a medical center in VISN 18 has not been replaced and since his departure last summer, his patients have a difficulty being seen.

VISN 19 & 22

Another major issue is having to wait up to 12 weeks to get a primary care appointment. Fortunately, the individual can go to triage for emergent issues but we don't want triage to become primary care. Another issue would be obtaining a diagnosis of PTSD or mental health issue. It can take weeks for a WWII or a Viet Nam vet to get a diagnosis as the only priority care for PTSD issues is the OEF/OIF office. Now these WWII and Viet Nam and Korea vet who begin to experience issues at this later time in life after retirements etc, have to first get to primary care (12 weeks) and then obtain a referral to mental health which can take weeks to months due to loading.

While I hear great things about the staff and care in VISN 19 AND 22, the wait times and availability for appointments and issues are approximately 8–12 weeks out.

We are not considered 'rural' but 'frontier', which means we are even more remote than rural. We have an approximate population of 50K and are 4 hours drive from the nearest VAMC. The local CBOC does not have a full time nor even part time doctor on site which means 4 hour trips one way. Emergency and urgent care and coordination there of for veterans seems to be an issue with the local hospital also.

VISN 23

One of the biggest complaints I hear time and time again is when a veteran wants to call in (or the doc has asked them to contact them) and they call up the Clinic to leave message or etc and they cannot be connected to the doctor. Either they get a triage nurse or someone in another clinic and they are not sure the provider even got the message to start with. This is a huge problem. Many times the vets get seen in the ER or the doc says call me and let me know and they can't get that message back to them. This makes the vets feel like they have no connection to the doctor they just saw.

My other issue is this: I am soooooo tired of getting a provider and 2 months later having to start from scratch with yet another provider. I hate hashing and rehashing my medical concerns time and time again or something that was so far in the past that it's no longer an issue but since we are starting from scratch we have to go back to it. That means the quick appointment I thought I was going to get to refill my meds now takes 2 hours and there is absolutely no reason for it.

We hear a lot about the inability to provide certain medications for veterans as they are not authorized on the list. For example certain medications for Diabetes control.

Attachment B

NATIONAL EXECUTIVE COMMITTEE OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA

OCTOBER 17 – 18, 2012

Resolution No. 40: Extended Hours & Weekends for Veterans' Health Care

Origin: Veterans Affairs and Rehabilitation Commission

Submitted by: Veterans Affairs and Rehabilitation Commission

WHEREAS, The Department of Veteran Affairs' (VA) mission is to provide for those who have borne the battle; and

WHEREAS, Veterans employed in the civilian workforce may require more flexible hours to meet their health care needs, because they have not accrued an adequate amount of personal leave to use for health care appointments; and

WHEREAS, Eligible veterans should not be denied access to VA healthcare due to a lack of flexible health care appointments; and

WHEREAS, Veterans with children also may require flexible hours to meet their health care needs; and

WHEREAS, Extended hours such as early mornings, evenings and weekend appointments should be made available at all VA facilities to include primary and specialty care; and

WHEREAS, Offering extended hours for veterans may reduce no-show rates by providing flexible appointments; and

WHEREAS, Additional clinic hours are not possible due to chronic short staffing; and

WHEREAS, Staffing limitations would affect patients from receiving health care on a timely basis; and

WHEREAS, The VA's premium and overtime compensation should be competitive with the private sector for employees who contribute overtime and weekend work; and

WHEREAS, The Veterans Health Administration developed Directive 2012–023, Extended Hours Access For Veterans Requiring Primary Care Including Women's Health and Mental Health Services At Department Of Veterans Affairs Medical Centers And Selected Community Based Outpatient Clinics on September 5, 2012; and

WHEREAS, The directive was rescinded on September 11, 2012 by VHA Notice 2012–13; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on October 17–18, 2012, The Department of Veteran Affairs (VA) provide extended hours and weekend appointments for both primary and specialty care at all VA medical facilities in addition to their regular hours of operation; and, be it finally

RESOLVED, That the VA recruits and hires additional staff to accommodate the rising need of weekend and extended hours for appointments in both primary and specialty care.

Attachment C

NATIONAL EXECUTIVE COMMITTEE OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA

OCTOBER 17 – 18, 2012

Resolution No. 42: Virtual Lifetime Electronic Record

Origin: Veterans Affairs and Rehabilitation Commission

Submitted by: Veterans Affairs and Rehabilitation Commission

WHEREAS, On April 9, 2009, President Obama provided direction to the Department of Defense (DoD) and Department of Veterans Affairs (VA) to develop a Virtual Lifetime Electronic Record (VLER), which would create a unified lifetime electronic record for members of the Armed Services; and

WHEREAS, The VLER plans to include administrative and medical information for service members from when they first join the service throughout their lives until they are laid to rest; and

WHEREAS, The VLER plan seeks to expand the departments' health information sharing capabilities by enabling access to private sector health data as well; and

WHEREAS, VLER is a federal, inter-agency initiative to provide portability, accessibility and complete health, benefits and administrative data for servicemembers, veterans and their beneficiaries; and

WHEREAS, DoD and VA for years have yet to fully implement a bilateral medical record between both agencies with no target end date in sight; and

WHEREAS, Approximately 2.1 million members of the military have served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn and are returning home in unprecedented numbers needing care for their injuries and illnesses sustained in service to our nation; and

WHEREAS, Failure to implement a bilateral medical record and VLER to date has caused significant delays in the veterans' treatment process from DoD to VA because the VA treatment team does not have full access to the patient's DoD records and have to rely on a patient's self report of their medical history and symptoms; and

WHEREAS, Servicemembers and veterans are forced to make copies of their records at their last duty station or submit a request to the National Personnel Records Center in St. Louis, which can take months to process; and

WHEREAS, Veteran service organizations, such as The American Legion, have not been invited to VLER meeting to provide stakeholder input and sharing of mutual concerns; and

WHEREAS, The American Legion has over 2,000 accredited department (state) and county veteran service officers that will continue to need access to Veteran Benefit Administration databases in order to file for VA benefits and claims for those claimants represented; and

WHEREAS, The American Legion is concerned that within VA's three branches – Veterans Health Administration (VHA), Veterans Benefits Administration, and National Cemetery Administration – there are numerous computer-based programs that are inoperable between these branches which are not addressed in the VLER plan; and

WHEREAS, Because a bilateral medical record is not currently available, there is not an ability for a patient's record to be flagged at the time of injury/illness occurred during military service, which makes it difficult and more time-consuming for DoD/VA physicians and raters to find proof of service connection; and

WHEREAS, Currently VA has the ability to send patients encrypted email messages and a VHA program, Myhealthyvet, allows patients to refill their VA prescriptions, view their labs and receive VA wellness reminders but does not allow VA patients to schedule appointments online; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on October 17–18, 2012, That The American Legion urge Congress to provide oversight to the Department of Defense (DoD) and Department of Veterans Affairs (VA) to ensure that the Virtual Lifetime Electronic Record (VLER) is fully implemented by Fiscal Year 2013; and, be it further

RESOLVED, That The American Legion urge DoD and VA to implement VLER no later than FY 2013 to ensure returning servicemembers' medical records are able to be accessed by both agencies which will improve the timeliness and delivery of VA health care and claims benefits; and, be it finally

RESOLVED, That The American Legion recommend the following be included in design and implementation of VLER:

- **Include veteran service organizations, such as The American Legion, in VLER meetings to offer stakeholder input and sharing of mutual concerns;**
- **Allow servicemember records to be flagged at the time of injury/illness in the military to speed up processing of VA benefits (health care and claims) during and after discharge;**
- **Ensure computer systems and programs within the Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration are interoperable and able to communicate with each other;**
- **Allow VA patients to be able to make appointments online by choosing the day, time and provider and that VA sends a confirmation within 24 hours.**

Attachment D

NATIONAL EXECUTIVE COMMITTEE OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA

OCTOBER 17 – 18, 2012

Resolution No. 44: Decentralization of Department of Veterans Affairs Programs

Origin: Veterans Affairs and Rehabilitation Commission

Submitted by: Veterans Affairs and Rehabilitation Commission

WHEREAS, The Department of Veterans Affairs (VA) has been gearing towards a centralized model of decision-making within the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA); and

WHEREAS, Centralization of contracting has created problems for individual facilities such as a two-day pileup of hazardous waste outside a Boston VA Medical Center (VAMC) due to a lapse in contract that could have been prevented by local contracting officers; and

WHEREAS, Centralization of Internet Technology (IT) removed the ability of individual facilities to be flexible with their programming needs; and

WHEREAS, Centralization of information leads to siloing among the Administrations; for example when processing a claim, the VBA and the VHA do not have the ability to access or view the other administration's records in their entirety; nor can the Appeals Management Center (AMC) view images in records that might be useful in rating decisions; and

WHEREAS, According to an article published in the Annual Review of Public Health in 2009 called "Extreme Makeover: Transformation of the Veterans Health Care System" by Drs. Kizer and Dudley, centralization of decision-making authority markedly slows down the process; and

WHEREAS, Centralization fosters animosity between agencies that are forced to compete for IT funding; for example the Office of Research and Development (ORD) reported that it was unable to finance select projects because all resources went to the VBA claims IT program programs; and

WHEREAS, The VistA computer program that the VHA uses to track medical records was created by doctors at local facilities, and is now regarded as one of the best IT systems in the world; and

WHEREAS, If the VBA and VHA shared a common appointment scheduling system for Compensation and Pension (C&P) exams, their respective employees would be able to schedule and reschedule appointments as needed; and

WHEREAS, If VBA liaisons were placed within VAMCs, communication between administrations, namely the communication between raters and physicians, would be increased, therefore reducing error and turnaround time for processing claims; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on October 17–18, 2012, That The American Legion supports decentralization of programs associated with the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA); and, be it further

RESOLVED, That the Department of Veteran Affairs (VA) decentralizes its decision making, accompanied by a demarcation of responsibilities and a plan for holding its decision-makers accountable; and, be it further

RESOLVED, That the VA restores contract-making authority and Internet Technology programs to VA Medical Centers at the local level and Regional Offices (ROs); and, be it further

RESOLVED, That VBA and VHA structure their relationship using a bottom-up approach similar to Baldrige's Model of Excellence, which will allow for a rapid model of change to occur at the operator level; and, be it finally

RESOLVED, That VBA and VHA share a common records system and increased access to one another's programs in order to facilitate information exchange and process claims more efficiently.

○