TRUE TRANSPARENCY? ASSESSING WAIT TIMES FIVE YEARS AFTER PHOENIX

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COMMITTEE ON VETERANS' AFFAIRS
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Wednesday, July 24, 2019

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

The Committee met, pursuant to notice, at 10:00 a.m., in Room 210, House Visitors Center, Hon. Mark Takano [Chairman of the Committee] presiding.

Present:Representatives Takano, Brownley, Lamb, Levin, Brindisi, Rose, Pappas, Lee, Cunningham, Cisneros, Peterson, Allred, Underwood, Roe, Radewagen, Bost, Dunn, Bergman, Banks, Meuser, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good morning. I call this hearing to order.

This year marks the 5-year anniversary of a watershed moment for VA and for this Committee: the 2014 VA wait time scandal. Whistleblowers from the Phoenix VA health care system exposed an elaborate scheme by supervisors and senior leaders to conceal the amount of time veterans were waiting to receive health care. Some patients' conditions deteriorated, while other veterans died after waiting too long for VA appointments.

After months of hearings and independent investigations, we concluded that serious appointment scheduling improprieties and delays in veterans' access to care were not limited to Phoenix, but were occurring at dozens of other VA facilities nationwide. And this had been going on for years.

To address this, Congress passed the Veterans Choice Program in August 2014 with the goal of helping veterans' access more timely health care by sending them to community providers.

Five years ago today, we held a hearing with VA's then- Acting Secretary, Sloan Gibson, and leaders from several veteran's service organizations, to learn how VA planned to restore the trust of veterans, Congress, and the American people.

In his statement for that hearing, Mr. Gibson presented a stark, but honest assessment of VA's challenges. Three of the main challenges he identified are on this chart behind me: widespread scheduling improprieties, inadequate IT resources, and a culture of fear and retaliation.

Honestly, after reviewing our witnesses' written testimony and several articles that have appeared recently in the national media, I am alarmed that too much of what Acting Secretary Gibson observed 5 years ago still rings true today. This is, frankly, just unac-

ceptable. We simply cannot put veterans' lives at risk while they wait for care.

Today, it is time to assess VA's progress in earning back the trust of veterans, Congress, and the American people.

Within the last couple of months, several media outlets published articles where whistleblowers allege that VA is still keeping secret waiting lists. This doesn't come as a surprise.

Our Committee staff also have been approached by several whistleblowers with these allegations, and some have faced retaliation after raising their concerns with VA. They allege that VA has mass-canceled pending requests for certain types of care without sufficient clinical review, and that front-line employees have been ordered to schedule veteran patients in imaginary clinics as a means of concealing wait times.

Some of these whistleblowers recently testified before our Committee. Yet, as we learned from the whistleblower hearing that wrapped up yesterday, VA's Office of Accountability and Whistleblower Protection is failing to protect whistleblowers.

We rely on whistleblowers to speak truth to power and hold VA accountable. OAWP must do its job and immediately end the toxic culture of retaliation at VA.

Dr. Boyd, you claim in your written statement that, quote, "no veterans were harmed," end quote, as a result of being on wait lists like those mentioned in the news. You also state that VA is operating with, quote, "unprecedented transparency," end quote. Those are two very bold statements.

With the MISSION Act, more and more veterans will be eligible for community care. However, as you will hear from some of our witnesses today, VA has never reliably tracked or reported veterans' wait times for community care, yet there is evidence that wait times in the community are often longer than wait times for VA care. VA's own data on wait times for appointments at VA facilities remain incomplete and unreliable.

The policy goal of the Choice Act and the MISSION Act was to reduce wait times for veterans and increase access.

Therefore, the lack of accurate information on wait times at VA hospitals and with community providers should cause us all to question whether the policy to send more veterans to community care providers is sound or even if it is working.

Veterans have a right to make informed choices about where to receive care; however, that choice is dependent on transparent and accurate information about wait times. This Committee will not allow our veterans to be harmed by the same deceptive practices that led to the Phoenix VA scandal.

I look forward to engaging our witnesses and my colleagues in this conversation, and with that, I will recognize Ranking Member Dr. Roe for 5 minutes for any opening remarks that he may have.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman.

A little over 5 years ago, as the Chairman stated, on April 14th, 2014, this Committee held a hearing very similar to this one on "Access to Care for Veterans in the Department of Veterans Affairs."

During that hearing, then-Chairman Miller disclosed that a Committee investigation had uncovered a secret list, a waiting list at the Phoenix VA Medical Center, and that as many as 40 veterans on that list had died waiting for care. That disclosure embroiled VA in a nationwide access-and-accountability crisis that is still reverberating across the VA health care system today.

We would be remiss if we do not take a moment to acknowledge the many ways in which access to care for veterans has improved since 2014. VA is seeing more veteran patients today than ever before.

Last year alone, VA completed more than 1 million more appointments than it had the year before. In many cases, those appointments occurred faster within VA than they would have in the private sector, according to the Journal of the American Medical Association. We should all be proud of those achievements, particularly the thousands of VA employees across the country whose hard work is what led us to that.

However, despite how far VA has come in the last 5 years, there is no doubt that VA has further still to go. While I was preparing for this hearing yesterday morning, the VA Inspector General released an alarming report about delays in care for veterans seeking mental health appointments at the Albuquerque VA Medical Center. That report paints a heartbreaking picture of why we must continue to focus on access to care for our Nation's veterans, until we are assured that every veteran, every time, receives the care that they need when they need it.

In a system as large and dynamic and as evolving as VA, there will never be a perfect way to measure access; it is as much of an art as it is a science. That is why I am grateful to have the experts from VA and the Government Accountability Office, and the private sector, here with us today to discuss not only how access has improved for veterans over the last 5 years, but also how it can continue to improve for veterans over the next 5 years.

I am particularly grateful to have Dr. Kenneth Kizer with us. Dr. Kizer is a veteran of the United States Navy, a physician with a long and distinguished career as a public health leader in government, the private sector, and academia. He also served as Under Secretary for Health in the mid-'90s during the last critical transformation period for the VA health care system.

Thank you, Dr. Kizer, for taking time out of your busy schedule to share your expertise with us this morning. I am very much looking forward to your testimony and that of your fellow panelists.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

With us today are Dr. Debra Draper, Director of the Health Care Team at the U.S. Government Accountability Office, otherwise known as the GAO. We have also Dr. Teresa Boyd, Assistant Deputy Under Secretary for Health for Clinical Operations, accompanied by Dr. Susan Kirsh and Dr. Clinton Greenstone.

We also have with us the Honorable Kenneth Kizer, Chief Healthcare Transformation Officer and Senior Executive Vice President of Atlas Research, Incorporated.

And with that, I will begin with Dr. Draper for her opening statement.

STATEMENT OF DEBRA A. DRAPER

Dr. DRAPER. Chairman Takano, Ranking Member Roe, and Members of the Committee, thank you for the opportunity to be here today to discuss VA's medical appointment wait times on the 5th anniversary of this Committee's hearing following the Phoenix wait times crisis in 2014. While Phoenix was the epicenter of the crisis, the identified problems were widespread, affecting the entire VA health care system.

Access to timely health care is critical for veterans seeking needed medical care; however, long wait times and weaknesses in the schedule system have been persistent, and have hindered veterans' ability to access care. For the past 20 years, we have conducted an extensive body of work on veterans' access to care. We have reported significant and wide-ranging weaknesses that contributed to the addition of veterans' health care to the GAO's high-risk list for the first time in 2015 and where it remains today.

In 2012, we conducted a comprehensive review of VA's outpatient medical appointment scheduling policy and processes. We found that the medical appointment wait times reported by VA were unreliable, in part because VA did not ensure consistency in how schedulers recorded dates that provided the basis for measuring wait times. We found these dates to be subject to interpretation and prone to scheduler error. We recommended that VA clarify its definition of these dates. VA concurred and has taken some actions since 2012 to improve wait time measurement, such as improved oversight through ongoing audits of schedulers.

VA provided us new information related to this recommendation on July 12th. Once we have had the opportunity to fully review this information, we will be able to determine what additional actions and information are needed. However, at this time we continue to be concerned that VA has not sufficiently addressed the reliability of its wait time data.

For example, in its first internal audit in August 2018, VA was unable to evaluate the accuracy or reliability of its wait time data, data posted to its website or used by veterans.

In 2012, we found that the medical appointment wait times reported by VA were also unreliable because VA did not ensure the schedulers received the required training. We recommended that VA ensure consistent implementation of a scheduling policy and ensure that all schedulers complete the required training. VA concurred with this recommendation and has taken action since 2012 to update its scheduling policy and complete training for schedulers.

We believe that these actions, along with the additional information VA provided us earlier this month, sufficiently address this recommendation.

While improvements to the VA's scheduling policy and processes will help ensure veterans timely access to health care, it is important to acknowledge that there are also other factors that may affect access that are not currently reflected in VA's wait time data. For example, we have found that VA's wait times do not capture the time it takes the Department to enroll veterans in VA health care benefits, which we found could be quite lengthy.

Issues with appointment scheduling have not been limited to VA's internal delivery of care, but have also existed for its community care programs. Our prior work on appointment scheduling in VA's Choice Program found weaknesses resulting in recommendations to address the lack of timeliness goals and reliance on incomplete and inaccurate wait time data.

In June 2018, for example, we found that the data VA used to monitor the timeliness of appointments for the Choice Program captured only a portion of the total appointment-scheduling process. Although VA had a wait time goal of 30 days under this program, the timeliness data did not capture certain processes such as the time taken to prepare veterans' referrals and send those to a third party administrator. We found that, if those processes were accounted for, veterans could wait up to 70 days to see a provider.

As of July 2019, our recommendations in this area have not been implemented. VA officials told us that these recommendations would be addressed by the tools and systems created for the new Veterans Community Care Program. According to VA officials, for example, one of the new systems that will support the management and monitoring of referrals, appointment scheduling, and authorizations will be fully implemented across all VA medical facilities in fiscal year 2021.

In closing, we have identified weaknesses in VA's wait time measurement and scheduling processes over the years, affecting not only VA's internal delivery of care, but also that provided through community care providers. We have made a number of related recommendations. We are pleased that VA has taken actions to address some of these recommendations, but additional work is needed.

The implementation of enhanced technology such as a new scheduling system is crucial and will provide an important foundation for improvements; however, this is not a panacea for addressing all of the identified problems. Moving forward, VA must also continue to ensure that its policies clearly delineate roles and responsibilities; oversight and accountability remain front and center; and training is ongoing and effective.

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

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

The CHAIRMAN. Thank you, Dr. Draper.

I will now turn to Dr. Teresa Boyd.

STATEMENT OF TERESA S. BOYD

Dr. BOYD. Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. I appreciate the opportunity to discuss VA's current practices for measuring veterans' access to health care and to provide a clearer picture concerning wait times in light of the 5-year anniversary of the issues in Phoenix.

I am accompanied today by Dr. Susan Kirsh, Acting Assistant Deputy Under Secretary for Health for Access, and Dr. Clinton Leo Greenstone, Deputy Executive Director, Clinical Integration, Office of Community Care.

VHA has undergone a tremendous transformation since 2014, operating with a renewed focus, unprecedented transparency, and increased accountability. We recognize that there are still challenges ahead of us, but it is important to keep in mind that veterans continue to receive the highest quality care, often with shorter wait times than in the private sector.

As in the community, most VA patients come to us for routine or elective care. For established patients, VA's average wait times for primary care and mental health care appointments are under 5 days and 7 days for specialty care. To ensure that veterans with more urgent needs are accommodated appropriately, as of 2017 the VA began offering same-day services for mental health and primary care at all VA medical centers and community-based outpatient clinics across VA.

So what does that mean? Well, it means that when a veteran contacts us seeking same-day services for primary care and mental health care, we address the need that day with perhaps an appointment, if that's appropriate; by refilling a prescription; answering a question over the phone or by secure messaging; or even scheduling clinically appropriate follow-up care.

We have also simplified the consult management process and resolution of these referrals has made it easier for veterans to be seen in a timelier manner. When in 2014 it took an average of 19 days to complete a stacked consult, we are now completing these referrals in under 48 hours, which is the industry target.

Listening to our employees and sharing strong practices across the enterprise, as well as lessons learned from implementing the Veterans Access, Choice, and Accountability Act of 2014 were among the reasons we have seen these improvements, and we expect continued success under the implementation of the MISSION Act of 2018.

As a learning organization, VA encourage employees who have ideas or concerns to report them; VA will not tolerate efforts to retaliate against employees for doing so.

In January, VA Assistant Secretary for Accountability and Whistleblower Protection, Dr. Tamara Bonzanto, was sworn in, and for the last several months she and her team have been working closely with the VA Inspector General to ensure her office is operating as Congress has intended and with maximum efficiency.

When it became apparent that VHA needed to improve the scheduling process, we created the Office of Veterans' Access to Care, or OVAC, to lead VA's new approach, which has included updated scheduling software, standardized national processes, national audits, and scheduler trainings at the local level. More than 58,000 VHA employees, including medical support assistants, clinicians, nurses, and health care technicians have completed this training, which includes technical and customer service skills, as well as in-depth training on standard processes and procedures per VHA's scheduling directive.

Over the last 5 years, we have transformed how we deliver care, and our success has been realized due to strategic planning and cooperative implementation efforts across the enterprise; once again, listening to our staff, our veterans, and their families.

Recently, OVAC implemented a three-phase initiative to improve capacity, efficiency, and productivity to help facilities and our national teams better understand demand and increased access to care at specific sites. So, overall, this work has helped us to improve access to high-quality care for our Nation's veterans, more closely aligning capacity to meet demand.

We also recognize that quality care comes from having adequate levels of staff available to provide and coordinate that care. Today, there are more than 200,000 health care professionals, including doctors and nurses, who treat veterans in the VA system.

VHA values what veterans have to say, and we know that, ultimately, it is our veterans who will determine whether we are meeting their expectations as health care partners. To better understand that perspective, VA has moved to the industry standard for assessing patient satisfaction, the Consumer Assessment of Health Providers and Systems Survey.

Based on survey results, veterans are telling us we are moving in the right direction. VA has seen improvement in patient satisfaction scores across every category related to veterans getting care when they needed it. More than 77 percent of those who responded to the survey said they were treated as a valued customer during their most recent VA encounter, and three in four veterans say they trust VA with their health care.

Placing veterans at the center of their care helps ensure they receive that care when and where they need it, and is fundamental to all we do. We have made significant progress and are committed to earning the trust of our veterans and the American people. We will continue to improve veterans' access to timely, high-quality care from VA facilities, while also providing veterans with more choice to receive community care where and when they want it. Your continued support is essential to providing this care for veterans and their families.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.

[THE PREPARED STATEMENT OF TERESA S. BOYD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Boyd.

I now recognize Secretary Kizer for 5 minutes.

STATEMENT OF KENNETH W. KIZER

Dr. KIZER. Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for the opportunity for allowing me to offer some comments about assessing and tracking wait times and timely access to care, and also to comment about what timely access to care means or the evolving nature of what that means today.

You have my written testimony, so I am going to take the 5 minutes I have here just to highlight a few points that were made there. And I would note also that my comments here are informed by more than 40 years of experience in a variety of health care roles, from being a practitioner to managing the largest health care system in the United States, to being a researcher and a variety of other perspectives on issues related to access.

Perhaps the first point I would make is that, while assuring timely access to care is widely recognized as an important dimension of high-quality health care and has been a priority for American health care for many years, consistently achieving timely access to care continues to be a challenge throughout American health care. Unfortunately, long wait times for care are all too common for patients and families everywhere, although especially for those who are on publicly-funded insurance such as Medicaid.

I think the problems related to long wait times are known and I won't go into that. Suffice it to say that when patients have to wait weeks or months to see a physician, bad things tend to happen.

There are multiple reasons why we have problems in timely access to care in this country, much has been written about this and I won't take the time now to delve into all of those reasons. I would just note that one of the problems simply is the lack of national standards about what constitutes timely access to care in the variety of settings in which patients receive care.

I would also comment that wait times, while seemingly a straightforward or simple thing to measure, actually, technically, turns out to be exceedingly complex and difficult to capture, all the variables that go into wait times. And I would also note that even if wait times were accurately measured, they have many limitations. They are just one dimension of looking at access and access is a multi-dimensional issue that includes many factors other than just wait times.

I was gratified to hear that VA has moved to using HCAHPS as a patient-reported measure of timeliness of access. I would note that leading health care systems around the country are increasingly looking to patient-reported measures of timeliness of care in addition to looking at wait times, but they find that patients' perceptions of the timeliness of care is very revealing as to how well their health system is functioning. And we can talk more about that later, if there is interest.

I think I would be remiss if I didn't also take the opportunity here to comment that in considering timeliness of care and how accessibility to care should be measured, we need to ask a basic or very fundamental question about what access to care means in an era of enhanced connectivity through all of the information and communication technologies that exist today that, candidly, 10, 15, 20 years ago were simply not available.

In a time when a large proportion of the population accomplishes many critically important and sensitive activities, such as their banking through the Internet, we need to ask ourselves why do we continue to view access to care only or primarily through the lens of face-to-face visits. And, indeed, I would posit that measuring access to care simply by counting face-to-face encounters is increasingly anachronistic and really does not promote patient-centered care. We know that 70 to 80 percent of patients when queried would like to be able to take care of their health care needs just like they take care of their banking and shopping and other needs through technology-enabled devices, and when those folks are queried, more than 90 percent of them say that they are satisfied

and happy with their interactions through telehealth and health, other technology-assisted ways.

And I would just perhaps, recognizing that the clock is running out, note that while VA is an acknowledged leader in telehealth and virtual care, I believe that it is has only scratched the surface of what could be done to enhance access to care through technology-assisted means. And I offer in my written comments a number of suggestions for where I think VA could go and should go to enhance access to care using technology-enabled means and engaging entities like the National Academy of Sciences, Engineering, and Medicine, and the National Quality Forum, to help them address some of the technical issues attendant to getting there.

With that, let me close, and I am happy to respond to your questions.

[THE PREPARED STATEMENT OF HONORABLE KENNETH W. KIZER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Secretary Kizer. I now recognize myself for 5 minutes.

Dr. Boyd, I will begin with you. Where can veterans go to find out about the wait times to see a community provider?

Dr. BOYD. So currently the VA does not have a roll-up or even a provider's specific information about a specific community care provided.

The CHAIRMAN. Okay, so the VA doesn't currently provide that, so there's no way for a veteran right now to be able to assess how long it will take to see a community provider.

When a veteran makes an appointment, is that veteran given information about the wait time to see a VA provider versus a community provider, so they can make an informed decision about which is better?

Dr. BOYD. So that is a great question and as I—and I was remiss in not mentioning this, but all three of us, the physicians here from VA, practicing physicians within the VA at some time—

The CHAIRMAN. I only have so much time. I'm sorry, Doctor, I don't mean to be rude. But—

Dr. BOYD. So I will answer that for you, I will answer that for you.

The CHAIRMAN [continued]. —it would seem to me that since you can't find out any times for a wait time for a community provider that a comparison tool is also not possible; is that correct?

Dr. BOYD. What I will answer is this. In my conversation with my patient, which is very sacred, I do mention what our eligibility wait times are within the VA and by the MISSION Act. And I do discuss with my patient, you need to be seen within X, Y, and Z time. So it is the patient preference to go out to the community, knowing when that needs to be done, or stay within the VA.

The CHAIRMAN. But, nevertheless, there is not really a tool or information available to say this is how long it will take for the VA, this is how long it will take to go to the community, you don't have that capability right now?

Dr. BOYD. We have that within what we call our Decision Support Tool that was rolled out on June 6th that all of our providers

use when they meet with their patient and they discuss their options for care.

The CHAIRMAN. We have—so that—but that is not available generally to the veteran outside on a website someplace, right?

Dr. BOYD. That is correct.

The CHAIRMAN. And we haven't seen this tool independently tested for the accuracy of these comparative wait times?

Dr. BOYD. Well, I could pass off to Dr. Greenstone, who is—

The CHAIRMAN. So, wait, does—

Dr. BOYD.—effectively the developer of that.

The CHAIRMAN [continued]. —does the tool actually show wait times?

Dr. BOYD. The DST does.

Dr. GREENSTONE. So, Mr. Chairman, the tool actually shows average wait times within the VA and we are now beginning to collect data that we intend to put into the tool to show comparative data in the community.

The CHAIRMAN. So an average over how long, an average over 30 days?

Dr. GREENSTONE. Yes, it is a rolling 30-day average that we actually show.

The CHAIRMAN. So, at the point of consultation, there is no real-time comparison, you know, within that day or the week for that veteran to know the real-time wait time at the facility, at the VA, or in the community?

Dr. GREENSTONE. That is correct. So that is determined at the time that a scheduler is working with a veteran.

The CHAIRMAN. So real-time wait times are not available. The average is available in a limited sense.

Dr. GREENSTONE. That is correct.

The CHAIRMAN. VA uses the Consumer Assessment Health Care Providers and Systems Survey, mentioned earlier, to collect data on whether a veteran received care when they need it and it is the health care industry standard. Why isn't this information made easier for veterans to find and why isn't VA publishing this same data from its community providers, so veterans know if they can expect to receive care in the community when they need it? Dr. Boyd.

Dr. BOYD. So, currently, our veterans are able to look online. We have Access to Care website that our veterans can go online and look for their specific medical center or their CBOC as well.

The CHAIRMAN. I understand that, but I specifically asked you about the Consumer Assessment Health Care Providers and Systems Survey data. My understanding is that VA does not publish this for community care providers.

Dr. BOYD. That is correct.

The CHAIRMAN. Yeah. So and why aren't we publishing that data?

Dr. BOYD. That is—I could pass it off to Dr. Greenstone, who is more informed about that particular part.

The CHAIRMAN. Dr. Greenstone, go ahead.

Dr. GREENSTONE. Sure. So we do not have the specific HCAHPS data on the community providers. We have data on the veterans' experiences when those veterans go and see providers in the com-

munity, and we ask them the question about how satisfied were they with their community care experience with a provider they—

The CHAIRMAN. But I have heard testimony here that these consumer reports are actually a pretty good way to figure out how timely the service is.

Dr. Kizer, did you want to comment on this?

Dr. KIZER. Well, a couple things I would say is, one, the private providers, community providers are not routinely required to report wait time data the same way that the VA is, and in the instances where some of that information is available, it certainly has not been subjected to the scrutiny for its accuracy and validity as has the VA data.

The information on HCAHPS, while that could be gleaned from various sources and made available, that does tend to lag behind. Whether it is available in realtime or close to realtime may be more difficult to achieve, but some of that information is reported to the CMS and other bodies and one could basically mine those data sources to get some of that information.

The CHAIRMAN. Well, thank you, Dr. Kizer.

Dr. Roe, you are recognized for 5 minutes.

Mr. ROE. Thank you, Mr. Chairman.

Dr. Boyd, I guess one of the questions I have is that why does it take 3 months to enroll somebody in the VA health care system?

Dr. BOYD. So I am not aware of a standard time for enrollment. We have multiple entryways for veterans to be enrolled; they can walk into a medical center, to the eligibility center, and sign up.

Mr. ROE. Well, it says—I mean, I read the script today and the data in here and it said that—let me ask another question.

And I read something in your testimony that I have a hard time believing—and I hope it is true, but I just have a hard time believing it is true, is if you call up, you can get an appointment that day for mental health or for primary care at any CBOC and at any VA medical center, 172 of them in the country.

Let me just ask you this question: if a patient calls up and says I am having real problems coping and I am concerned about my safety, what does the scheduler tell this person and what do they do? Do they get in that day? And, if that is true, then what is going on in Albuquerque?

Dr. BOYD. Okay. So that is a great question, it is about same-day services. So in that particular case, when that veteran calls in to that clinic, the scheduler is not clinical. That would be handed off to a clinical person who would assess the needs with the veterans, is this something that can be taken care of on the phone, with another health care provider through telehealth, a video-connect session, or is it of an urgent need and the veteran needs to go more of an urgent care center or to an ER.

So, we assess the needs, and it is at very VA medical center and at every CBOC.

Mr. ROE. Well, my bet is that I will call before the end of the day that refutes that, that would be my bet.

Dr. BOYD. And, Dr. Roe, if I may add? Twenty percent of our completed appointments every single day—and we look at this every morning at 7:45—so 20 percent of our completed appoint-

ments every day are same-day appointments. So it is those same-day service requests that actually go on to making an appointment.

Mr. ROE. Oh, I think it is a noble goal, I mean, I absolutely do, it is just hard for me to believe it can be carried out.

Now, the VA is seeing over a million more patients in '18 or '17, which is remarkable—or appointments, I should say—how does that occur? Is it new hires or are they not seeing a doctor, maybe they are seeing a nurse practitioner or a PA or something? How has that occurred? And then I have got a follow-up question.

Dr. BOYD. So I will be brief then; so, in a myriad of ways. We look at efficiencies of the actual clinics and to make sure that our grids are open, that is how we schedule patients, to making sure that we are effectively supporting a provider, whether it be a nurse practitioner, PA, or a physician. And so we have found efficiencies, we have found some extra time in there for bookable hours, if you will. So that is part of it.

The other part is, you know, what we heard about telehealth, we have different modalities with which to actually see patients, if you will, to complete those appointments as well.

So in some areas we have increased staff, because there was an increased demand and high-growth areas, and also using the actual team around say our primary care team or our mental health team, not always having to be just the provider.

Mr. ROE. I guess the thing that I have looked at—and, Dr. Kizer, I would like to have—you are absolutely right, I don't know that we ever measured wait times; I know I didn't in our practice. And if one of the measurements is somebody calls in to get a refill, boy, I did really well with that, if you look at those—that is the standard that you are using, because I didn't even look at that as a contact with somebody that day. And typically, how a private—and I'm sure it does at the VA too works—you know, at the end of the day I would have 15 to 30 phone calls that I would make to patients and contact them. Talk about telehealth, I used to telephone. We didn't have Internet then, but I did that, and I guarantee Dr. Kizer has done the same thing.

Going forward—and I want to commend the VA for it has absolutely improved since 2014, there is no question about that. It has been a Herculean effort to do right by our Nation's veterans, there is no question about that. And I have got, Dr. Draper, just a couple of very quick questions. My time is about expired, but if you had today to improve the accuracy and consistency of this, what would you have the VA do today?

Dr. DRAPER. Well, I think they need not to consider this as a one-off like training. This needs to be consistent. I mean, one of the issues is that the schedulers are among the top ten highest turnover positions in the VA. So, you know, there is constant turnover, there is, you know, really educating those schedulers and making sure that they are consistently implementing the scheduling policy, that is one big thing.

Oversight and accountability, you know, we continue to find pockets of that where that is not so effective, and that really needs—as I said in my oral comments, that needs to be front and center and just on the mind, you know, pervasive on everything that they do.

And I think that the—you know, the new scheduling system that is expected to roll out in the next couple of years, that will be very helpful, but that will not solve all the problems. You still have to, you know, as I said, have training, oversight and accountability, and other things that, you know, together.

Mr. ROE. Just one last comment. The two most important people in my office was the first person to answer the phone when the patient called in to make that appointment and the person that greeted them when they came in, because if they had a bad experience there, it was going to be hard to get a good clinical experience.

So I would encourage you to do exactly that, is train those folks that are doing the scheduling and meeting people. They are the front line, they are the face of the VA.

I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

I now recognize Mr. Allred for 5 minutes.

Mr. ALLRED. Well, thank you, Mr. Chairman and Ranking Member Roe for holding today's hearing. I want to thank our witnesses for being here.

Wait times for veterans in North Texas are too long. Every day, 40 to 80 veterans are in temporary care awaiting a bed at a VA facility, and that is why I led a bipartisan letter with my colleagues in North Texas to ask the VA to work with us in facilitating the acquisition of a donated hospital in Garland to help us meet the growing demand. This hospital is an easy solution to growing access problems and will help North Texas address the gaps in our capacity to provide for a growing number of veterans.

So I will ask you, Dr. Boyd, to take that back to your colleagues in the VHA and the VA. Secretary Wilke has appeared before us in this Committee and has said that he is interested in doing it, the Dallas VA wants to do it, the City of Garland wants to do it, and I am a little bit frustrated at the amount of time that this is taking for us to move forward. It is something that we critically need to meet our capacity and it is I think the smart thing for the VA, for our veterans, and will save us a lot of money as well.

Dr. BOYD. So, if I could just briefly comment. In many meetings recently there is an urgency with this discussion, so I just want you to know it is front and center. It is being discussed at all levels of VA and VHA. As you can only imagine, it is a very complex—it sounds easy, but it is a complex discussion, but no doubt we want to do the right thing for veteran care. So, just so you know, we are working it.

Mr. ALLRED. Good. I am glad to see that it is getting discussed. It is a matter of urgency, I think, and I am glad that you all are recognizing that.

Texas is proud to be home to the most women veterans of any state, and yet wait times for women's health care services can be longer than wait times for other services, and I want to ask if you have a specific plan to address wait times for our women veterans.

Dr. BOYD. So, roughly, in working with our National Program for Women Veterans, Dr. Patty Hayes, we are absolutely accelerating the footprint with which, if you will, the capacity for women-specific providers in all of our areas.

And the other thing, just so you know—and I am a Texan, by the way—the other thing is that when we recruit providers now, it is not a perhaps do you want to do women's health, it is going to be something that is part of the recruitment package. So I think that is another thing that we will do, but absolutely we are very well aware of that.

Mr. ALLRED. Well, that is good to hear, because I think that we are going to have to continue to change and grow our VHA services to deal with our new community of veterans and especially here in Texas with us having the most women veterans, it is a big issue for us.

I want to also talk about community care, and I want to talk about how we are going to monitor this. I think you addressed it briefly, you could go into a little more what the plans are, where we are in the implementation of that, and how we in Congress can help you oversee how the community care system is being enacted.

Dr. BOYD. So I will hand that off to Dr. Greenstone, who can speak very eloquently about that.

Dr. GREENSTONE. Yes, certainly. Thank you very much.

So, as you know, we have undergone a great deal of transformation overall in our programs, that is with new technology, new legislation under MISSION, we have new contracts that have been awarded and are now coming on line, and a significant amount of change in our business processes for overseeing community care. That means we have the ability to now, which we never had before, using new technology in identifying the time that it takes for us from when a colleague or a provider, like Dr. Kirsh or myself or Dr. Boyd, places a consult, a request for care, the time that care actually takes place in the community and every important step along the way.

And that way we will have an opportunity to measure what matters, that means measuring that veterans are getting appropriate, timely, high-quality care, and when they are not, we have an idea now of where the problems are taking place. How can you really drill down and make the appropriate changes to actually improve upon the work that all of our staff are working on to improve getting veterans timely care. So that is going to be one of the ways we have the opportunity to oversee that data now.

Mr. ALLRED. Well, I hope you understand that this Committee wants to work with you on it. We want this to be a success. I don't want it to also take away from our initial mission at the VHA, providing and improving the care we are providing there, as I said, to address our diversifying community of veterans.

So I hope that you will stay in touch with us. I hope that we have a productive conversation around this, because I have heard from some of our VSOs a lot of concerns about how this is going to be implemented. And so it is certainly going to be a focus for us here in the Committee and I look forward to staying in touch with you on it.

And, with that, I yield back.

Dr. GREENSTONE. Absolutely. Thank you.

The CHAIRMAN. Thank you, Mr. Allred.

Mr. Bost, you are recognized for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman.

This is for Dr. Draper and Dr. Kizer both. The Journal of American Medical Association released a study in January, and they found the VA generally outperformed the private sector with respect to wait times. Are you both familiar with that study—

Dr. DRAPER. Yes, I am.

Mr. BOST [continued]. —and do you agree with the findings?

Dr. DRAPER. Well, this is what I would say. It is really a piece of the story, because it looked at 15 major metropolitan market areas and we know across VA's 172 medical centers there is great variation. And a lot of the access issues are more prominent for rural markets or rural—less urban markets. So I think it is important to really understand the implications or what happens in those markets as well, because, as I said, there is a great deal of variability, as we all know, across medical centers. So I think it is a piece of the story.

I think it also has implications for community care, because the wait times are really—if they are worse in the private sector, then, you know, that suggests that VA is more able to provide care within its own facilities. But I would say the variability piece and particularly looking at rural markets is really important to consider.

Dr. KIZER. Yes, sir. I am familiar with the paper, although it has been a while since I looked at it. I think it was a sound study, good results. If I recall correctly, in the paper it did discuss some of the limitations that it has and some of which have been alluded to already.

But I would also take this occasion or opportunity to comment on something that Dr. Roe made, as well as the person before you, and that one of the predictable and foreseeable problems that VA is going to have in assessing community wait times is the fact that there is no standard way of assessing wait times in the private sector. There are no national standards, there is no widely-accepted or single way of doing this. So, even though they may procure lots of information, there is no certainty that there is going to be apples-to-apples type comparisons, and so there is going to be difficulty comparing the information that is made available from community providers.

Mr. BOST. Thank you.

And, Dr. Boyd, you know, during the period of 2014, following the scandal of Phoenix, have veterans' satisfaction ratings increased or decreased with the VA or do you think the wait times are—is wait times a factor in that?

Dr. BOYD. With regards to the tremendous increase in the satisfaction scores with our veterans, I think the wait times have a piece of that, but really going back to what Dr. Kizer was really—it is meeting their needs. So whatever that means, and that is—you know, it is an individual. It may be different. And it could be, as Dr. Roe said, it could be because they had a great experience, too, an appropriate experience.

But no doubt our satisfaction scores are going up, and I do think that that is a piece of it. It absolutely is.

Mr. BOST. Well, let me just say that as Members of the Committee, all of us are wanting the VA as a whole to succeed and to do their job to the best of its ability.

That being said, each one of us have our own districts and see the particular VAs in our districts and we use the scientific studies that we have, which is how many complaints come and say how bad is our local VA in comparison to how many say, hey, they are doing a great job.

And so as we do that, as we move forward, I hope that we find some kind of system which we can truly make that judgment call. I am the state legislator in the State of Illinois, and this is a scientific—we have a deer season. And the deer season and the amount of permits is released based on the amount of people who call in and say, there are too many deer in comparison that there is not enough. And that is how they issue the amount of permits.

I am afraid that when we move forward with our veterans, that that is not the real—really the best way. What the best way would be is truly find a way to track the numbers. And right now I am concerned that we are not able to track those numbers. And I hope we can get through that.

So with that, Mr. Chairman, I yield back.

The CHAIRMAN. I now recognize Mr. Brindisi for 5 minutes.

Mr. BRINDISI. Thank you, Mr. Chairman.

Dr. Boyd, I recently had a meeting of my veterans' advisory council back in my district and one of the issues that was raised by several of the veterans who attended the meeting was about the committee providers under the Mission Act, being able to search them on the VA's website.

But in an area like mine, which is very rural, and where high speed internet is spotty at best, and cell phone service is almost non-existent in certain areas, if you don't have access to a website or can't pull up the VA's website on your phone, how does a veteran go about searching what community providers are available under the Mission Act?

Dr. BOYD. So just a couple of things for that.

First of all, before we rolled out, you know, the June 6th Mission Act, we ensured that every VA medical center had the capability from the incoming phone lines to press 6 for more mission information. That is the one thing. But what you are asking is something that has a different twist to it as well.

Veterans need to engage with their facility, with their VA clinic, their provider in order to get into that system. There is no direct reaching out to the committee providers. And that discussion then will be had at the VA center.

And if Dr. Greenstone has anything to add on that because he truly is in that area.

Dr. GREENSTONE. Thank you.

It is a very important question, reaching out to our rural veterans who may not have access. And so clearly, you know, like Dr. Roe mentioned, the telephone is going to be one way that you can certainly get information. And if you contact someone, we can actually go to our directory and find out where that veteran lives and what kind of providers are in their sort of neighborhood, if you will, or close to them.

But then as Dr. Boyd mentioned, in order to access those providers in the community, it has to be initiated by a request for care from a provider within the VA. So that would be one thing.

And then at that time, anytime you are working directly with a provider and a veteran, that provider has access to see the providers in the community, the average wait times in the VA, and eventually we plan on being able to demonstrate the average wait times in the community for a comparison to take place at that point in time.

Mr. BRINDISI. Okay. So and another question I wanted to ask was about the same day services initiative. I wanted you to just expand a little bit on that initiative. Does that always mean a face to face appointment? Are there other areas where you can get help, telehealth? What does that exactly mean?

Dr. BOYD. You are absolutely right. And I will let Dr. Kirsh answer that. It is from her office. But you are absolutely right, and that is a super question.

Dr. KIRSH. Thank you for that question.

And I wanted to provide some further detail in that this has been a pretty robust effort over the last couple of years to ensure that primary care, mental health, substance use disorder, that we have the ability for a veteran to contact us and for us to take an action, essentially.

While as we heard previously, 20 percent of the time it may result in a face to face appointment, we know, as has been pointed out previously, that this can be addressed through fulfilling a medication or assessing the patient and determining that that patient needs to be seen for some knee pain in 2 weeks as the appropriate follow up.

So it really is about addressing the need of the veteran that day, ensuring that there is not something urgent that is happening, and then ensuring that that happens in the way the veteran wants that, whether it is in a text message follow up or if it is in a phone call follow up. That is our goal is to be veteran-centric.

Mr. BRINDISI. And just to follow up on that a little bit, in the written testimony GAO said that ongoing staffing and space shortages have created challenges for implementing and sustaining same-day services.

What are you doing to help those facilities with that challenge?

Dr. KIRSH. So overall since 2013 we have increased staff very significantly by approximately 50,000 staff. And 63 of that percentage, 63 percent has been an increase in schedulers specifically.

Our office was engaged with GAO and I think the report is not yet final, but the recommendation was really only around measuring what we do. As you heard previously, having a telephone follow up or a secure messaging follow up is not as easy to measure and to roll that and understand how we are doing in that area.

And to that end, I have been engaged with the National Quality Forum to help assist us in understanding the best way to measure a same-day service.

Mr. BRINDISI. Thank you.

I see I am out of time, so thank you for your responses.

The CHAIRMAN. Thank you, Mr. Brindisi.

Dr. Dunn, you are recognized for 5 minutes.

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

Dr. Kizer, I read your resume, very impressive. You have a great depth of experience. I, too, am a physician. I appreciate your insightful comments on your opening statement there.

So just doctor to doctor here, what do you think is the value of wait time measures as we are performing them in the VA given the inherent technical problems in doing those measures, and are we guilty of an overly microscopic focus on a set of macroscopic problems?

Dr. KIZER. Let me try to answer you in a couple of ways. I think wait times are an important metric to assess and to track. I think they, what many private or leading private health systems find is that they are more useful for quality improvement purposes. There are targets to try to achieve. That from an accountability or compliance point of view, just the technical issues make it very difficult.

So while they are an important metric to track, they are but one metric. As I said before, it is a uni-dimensional way of looking at a multi-dimensional issue. Access is much more complicated than just wait times, and as Dr. Roe—

Mr. DUNN. I appreciate you saying that, and I wanted you to underscore that because I think it is important that we don't get too far chasing down wait times.

But on the same subject, are you aware of any wait time measure that is immune to faulty interpretation or scheduling errors?

Dr. KIZER. No, I am not.

Mr. DUNN. Yeah. I am not either. Dr. Draper, are you?

Dr. DRAPER. Well, one thing that has greater accuracy is the create day. So that has, that is the time stamp that the system creates, and it doesn't allow manipulation of days like some of the other days.

Mr. DUNN. Good. I think there is a lot of things we could look at in the VA besides just wait times.

Dr. Boyd, your testimony notes that the Choice Act, now the Mission Act, is a large factor behind many improvements. And the Department has made far access, recognizing that the implementation of the Mission Act really just started a few weeks ago. What impact do you think it has had on access so far and what impact do you think it will have going forward?

Dr. BOYD. So in several areas. And you are right. We just started. But it seems like we have been living it now, you know, in preparation.

The access portion is that when we look at community care, our new community care network, as a senior leader when I am looking at the world of capacity of where my veteran patients can go is a combination of my internal systems and my integrated outside network. So that is huge, and it gives veterans choices. There are—no one, no 2 veterans are the same with regards to where they live and so forth.

The part of the mission that I wanted to thank the group for is that we have certain authorities now that will improve our ability to not only recruit, but to retain our employees. So that to me, those 2 big things just stand right out.

Mr. DUNN. So, also, Dr. Boyd, on this note, the VA now provides many more appointments than it did back in '14. What do you at-

tribute that capacity do, and what role do you think the community care plays in that?

Dr. BOYD. So currently we—year to date we have had 1.75 million more completed appointments. That is amazing.

Mr. DUNN. Year on year.

Dr. BOYD. That is internal.

Mr. DUNN. Is that year to year comparison?

Dr. BOYD. Yes, sir.

Mr. DUNN. Okay.

Dr. BOYD. Yes, sir. So we are already 1.75 million ahead. And a couple of things as I had mentioned earlier. One is our attention to detail with regards to efficiencies. I, too, came from the private sector and we didn't have a lot of fluff. You know, people needed to have a good working environment, to have the good support so everyone could practice up to the top of their licensure.

So we have paid really close attention to that through Dr. Kirsh's office with regards to efficiencies and productivity. That is a big piece of it.

But, also, I also want to believe that it is the regaining the trust of our veterans as well.

Mr. DUNN. Well, that's good. And, specifically, sort of following the end of that question was the community care. What does it do for that, increasing your ability to give appointments?

Dr. BOYD. Okay. So having the options for our veterans in the community, especially for services that may be in some areas, they just don't have.

Mr. DUNN. Yeah. In rural areas like mine.

Dr. BOYD. Rural areas. Yeah. Exactly.

Mr. DUNN. Yeah.

Dr. BOYD. Or there is not enough volume to support that service internally. We have a partner now in the community that we can coordinate that care and that is that continued mode of care that we promise our veteran patients.

Mr. DUNN. I appreciate that. So in my remaining 20 seconds, Dr. Draper, what do you think is our single biggest opportunity to improve access to care and what do you think the biggest barrier to improving access to care is?

Dr. DRAPER. One of the biggest barriers I think is to have the sufficiency of providers to see patients. I mean, that has been an ongoing issue with VA, their recruitment and retention.

Mr. DUNN. But we sort of solved that with the community care, right?

Dr. DRAPER. Well, it depends on the community, I think. Some communities probably—

Mr. DUNN. Fair enough.

Dr. DRAPER. You know, I think it—

Mr. DUNN. And the opportunity?

Dr. DRAPER. Opportunity for the biggest improvement?

Mr. DUNN. Yeah. What's the biggest barrier? Well, I guess barrier and opportunity. I'll take that as an answer to both questions. Thank you very much, Dr. Draper.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Dunn.

Ms. Underwood, you are recognized for 5 minutes.

Ms. UNDERWOOD. Thank you, Mr. Chairman, and thank you to all the witnesses for joining us today.

I recently surveyed veterans in my district outside of Chicago and learned that the vast majority of respondents are satisfied overall with the care that the VA provides, including the wait times to see a physician at a local facility like the Level Healthcare Center.

Despite these local success stories, nationwide wait times remain a serious concern. Veterans prefer VA for many reasons, and we owe it to them to provide convenient, patient-centered access to quality care.

Dr. Patricia Hayes, VA's chief consultant for women's health services said in February that a "small, but persistent disparities' exist for women veterans accessing care at the VA. Overall, she said "women veterans are still waiting longer for appointments than males."

And so I know my colleague, Congressman Allred touched on this, but women are a growing proportion of the veteran population. And Dr. Boyd, I believe it was Dr. Boyd, you said that—or maybe—okay. Yes. That the VA is "accelerating the footprint in all areas for women veterans."

I was wondering if you might be a little bit more specific about the timeline to closing the gap on wait times.

Dr. BOYD. I wish it was, you know, said and done yesterday. But the reality is that with the enhanced recruitment capabilities, the authorities that we have within Mission, that will get us a little further.

But as Dr. Hayes I am sure has probably testified before, we continue to accelerate the many residencies and to stay on top of women's health needs and their special concerns.

Ms. UNDERWOOD. Right.

Dr. BOYD. And so we are not losing focus on that. And we are actually integrating that even into our mental health world as well to make it an actual crosswalk, to make it part of the fabric as well.

So we do have work to do. And I wish I had an exacting timeline, but as you know, Dr. Hayes, she will not let us, you know, at all lose urgency on this one. And, in fact, we just recently set up another governing board, if you will, that is primarily focused on women veterans and some—to keep that fresh and also to keep the opportunities in line and on our mind with leadership as well.

Ms. UNDERWOOD. Sure. I appreciate those steps. Are there any kind of internal goals or metrics that you all are working towards?

Dr. BOYD. I would have to get back to you on that specifically and speak with her office on that.

Ms. UNDERWOOD. Okay. Please do.

Dr. BOYD. I would sure be glad to.

Ms. UNDERWOOD. Connecting veterans to timely care at the VA is especially important, as you said, regarding mental health and addressing the veteran suicide crisis.

Some of our veterans will not self-report their suicidal ideations which could limit the benefits of same day care. Right. They have to proactively say that they need to come in because they are having these kinds of thoughts.

So, Dr. Boyd, does the VA collect data on average wait times for veterans specifically seeking mental health care treatments?

Dr. BOYD. Yes, we do.

Ms. UNDERWOOD. Okay. Mental health care is one of the several critical risk factors in addressing the suicide crisis. According to the CDC, access to effective clinical care for mental, physical and substance abuse disorders can help protect people from suicidal thoughts and behaviors.

Dr. Boyd, does the VA collect data on wait times for veterans waiting to be seen for pain management, substance abuse disorders or other chronic medical conditions?

Dr. BOYD. Yes, we do.

Ms. UNDERWOOD. Oh, that's good.

Okay. My last set of questions is in both the GAO and the VA testimonies, the need for consistent and comprehensive training of VA staff was highlighted. I commend the steps that you have taken to increase scheduling training completion rates and would like your perspective on how that was achieved.

Dr. Boyd, how do you track the completion rates for staff who require scheduling training?

Dr. BOYD. I will ask that Dr. Kirsh answer that for you. She has the specifics for that.

Ms. UNDERWOOD. Thank you.

Dr. BOYD. You are welcome.

Dr. KIRSH. Thank you for that question.

Our office oversees scheduling policy, standardizing processes, trainings and audits. And the trainings have been very robustly engaged with our 58,000 staff out there who do schedule.

Ms. UNDERWOOD. So how do you track the rates?

Dr. KIRSH. We have our talent management system through the employee education system. It is trackable across all sites. You have to log in as a VA employee and complete trainings.

But more important or in addition to that is really when anything, a nuance is brought up or there are bi-communication calls every week—

Ms. UNDERWOOD. Yeah.

Dr. KIRSH [continued]. —with the scheduling community.

Ms. UNDERWOOD. Can I ask one other follow up question? Is there an incentive to complete the training?

Dr. KIRSH. It is an expectation as a component of your job that you complete the training, if that is in your job description as a role.

Ms. UNDERWOOD. So it is in like your PDP?

Dr. KIRSH. Yes, it is.

Ms. UNDERWOOD. I see. Okay. Thank you so much.

The CHAIRMAN. Thank you, Ms. Underwood.

General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

Thanks to all of you for being here. This is complex to say the least. You know, putting my airline pilot hat on from decades, you know, at one point we were graded on how much we supported our passengers to make sure they didn't miss their flights. The next time you turn around we are being graded on our on-time performance.

And as an airline captain, I had the challenge to decide what do we do. The gate agents wanted to close the door even though there were passengers running between flights because they were going to get a ding on their record because of the fact that they didn't shut that door on time.

My plan was and is always the passenger first. I said I will take the hit. If someone wants to call me as to why the flight left three minutes late, they can deal with me and don't worry. I will take you off the hook.

So as we look at what we are trying to do here, which is not only identify wait times, but to accommodate our veterans who need care, it is going to be, again, a complex challenge to make sure that nobody gets hung out to dry for the wrong reasons. So it is the accountability and the structure all the way up and down the line.

But having said that, Michigan's first district, my home, is a combination of small towns, rural, and remote. So when—and you noticed that I didn't say urban or suburban. That doesn't fit. So when you think about wait times and what it means with the combination of services that we would have in our district with one small VA hospital in Iron Mountain, but the accommodation of the CBOC or a community care, it is kind of a microcosm of all other, not that big organized system that is within Uber distance. In fact, we don't have really much Uber in our district at all.

Are we in some cases—and by the way, anybody can answer this? Are we in some cases comparing apples and oranges when we try to talk about wait times at a VA hospital, wait times at a CBOC, wait times in community care? I mean, are we just—we have separate silos here and are we trying to compare, again, apples and oranges? Anybody want to take a shot at that one?

Dr. BOYD. I will start off. So when we go into the access to care website, you know, where our veterans can go on and look, if you go on and click onto Michigan, it will be bring up the VA medical Center and then all the clinics. And they will have posted a 30-day average, and it is an average, of the wait times, if you will. And so it is specific geographically and to that particular area.

So I am not sure if that answers your question.

Mr. BERGMAN. Well, it does kind of in a way. Its kind of basically means that the comparisons, if you don't have big VA hospitals and you don't have your—you may fall outside of the 80 percent norm of that bell curve. Okay. I mean, that is—I mean, we are trying to make here an 80 percent solution. If we can get 8 out of 10 right. Think about even Ted Williams only hit 400. You know, if we could hit 800, we would be doing very well.

I would like to go down a different road here for a second. Can VA solve the problem that we are trying to deal with her, the wait times, can they solve it from within? In other words, does VA have that capability or, said a different way, is there a model, Dr. Kizer, that already exists somewhere outside of the VA that we can modify, again, to the 80 percent level to make it work? We are open to anything that will work to make sure the veterans are realistic about what the wait times are where they live and for the condition they have, and we also want the VA and the CBOCs and the community providers to be realistic about what they can provide

and not—you know, I would rather have them under promise and over produce.

Dr. KIZER. Yes, sir. A few things.

One, there is no model. No one has solved this problem. There is no single model out there that the VA could just modify and adapt. There are glimpses of what are what we might call promising practices and I am encouraged to hear that VA has implemented and is pursuing a number of those, such as same-day service and what they have done in that regard. Certainly, expanding telehealth and other technology assisted options which may be particularly useful in rural and underserved areas.

But I also want to go back to your first point underscoring the complexity of this issue and the need that exists for standards that are setting specific, whether that is primary care or specialty care, a hospital, a clinic. All of the different settings really have—we should be thinking about different standards for those settings of care.

And there may be opportunities for the VA to engage with entities like the National Quality Forum or with the National Academy of Sciences to help solve or at least address some of the technical issues that may provide better answers for where we need to go in that regard.

Mr. BERGMAN. Thank you. And I appreciate your answer.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, General Bergman.

Mr. Pappas, you are recognized for 5 minutes.

Mr. PAPPAS. Well, thank you, Mr. Chairman. Thank you to the Ranking Member, and to our panel. I appreciate your testimony here today.

I want to take a step back. We are marking 5 years since Phoenix. We are here having these discussions, talking about some steps that have been taken forward because of whistleblowers.

And I noted, Dr. Boyd, in your testimony you said, "due to the recent media reports of a whistleblower indicating issues with the electronic wait lists, we conducted a top to bottom review." And I think that is great.

But let's unpack that a bit. You say, "due to recent media reports." And I am wondering why it took media reports and not a disclosure from a whistleblower with valuable information to spur that review.

Dr. BOYD. So at the facility level where this may have occurred, there is always—that is just the practice. That is the ongoing practice is to always look at harm, unintended harm if you will.

And it should not take a media, a piece of paper, you know, a story in the media to call our attention. We should be very responsive to when, as I mentioned, when employees or any staff—I don't care where they work or hat their role is— comes forward and says, something doesn't look right.

So this is an ongoing practice at facilities to look at things that rise to the top. So it should not take a media story.

Mr. PAPPAS. Well, I appreciate that.

Dr. BOYD. Sure.

Mr. PAPPAS. And we are working. As the oversight and investigation subcommittee we have done a couple of panels on whistle-

blower issues. We want to ensure that they are heard, that we improve processes to protect their rights and prevent retaliation which we have seen.

We recently heard from a few whistleblowers in our June 25th session who raised some serious concerns that have a connection to the wait time issue that we are talking about today. The whistleblowers told us that they saw 12,000 canceled radiology orders in Iowa City, "imaginary opioid clinics in Baltimore set up to hide wait lists," and 400,000 plus consults opened over 90 days across 5 districts.

I am wondering what steps the VA is taking to identify and curtail any sort of practice of hiding and masking the problem that exists with wait times.

Dr. BOYD. So it is multi-fold. One thing that is, I think, at the core is changing the culture. When I go around to sites, one of the first things that I do is meet with various staff, usually at town hall, frontline staff. I don't want leadership there, don't want supervisors there, to get a feel for is there a good culture there, is there a culture of, I will raise my hand and stop the line.

So I think it really, it goes to us as senior leaders to walk the talk and to make sure that our facility leadership does that as well because without that we could have every possible process in place, but no one is going to feel comfortable raising their hand because no process is perfect. We want people to put holes in it. So it is all about changing that culture.

Mr. PAPPAS. Well, thank you. You know, reading some of the terms that have been used with scheduling, I can understand why there has been some confusion. We are talking about terms like patient-indicated date, desired date, preferred date, clinically indicated date. Is there a difference between these terms or are they interchangeable?

Dr. BOYD. I will have Dr. Kirsh answer that one. Thank you.

Dr. KIRSH. Thank you for your question.

And you bring up an important point that is that names have changed over time. The patient indicated date was a decision made a few years ago really with an emphasis and focus on that it is about the patient preference in the equation.

As a doctor, when I make a follow up appointment for a patient, and that is what patient indicated date is used for, it is a clinical timeline when the patient should be seen and then when the patient as well can—is agreeable to the appointment within a certain amount of time. That is what the patient indicated date is. It has evolved after the clinically indicated date and preferred date. It is now the replacement for follow up appointments.

Mr. PAPPAS. Okay.

Dr. KIRSH. I hope that answers your question.

Mr. PAPPAS. Yeah. And I think that the GAOs indicated some improvement here at logging these terms. 18 percent improvement in manually entering dates, but also there still exists an error rate that is of some substance that has an impact.

So I am wondering in terms of the GAOs perspective on this, how are we doing and are they on track to be in compliance?

Dr. KIRSH. Well, since our implementing our recommendation, the VA has taken a number of actions. One is bi-annual audits of

schedulers. And the most recent, in 2018 they audited about 667,000 appointments and they found an 8 percent error rate. So that effected about 53,000 appointments.

So there is improvement. There is more work to be done, definitely, and I think that as we talked about in our written statement, you know, a lot of the scheduling, the terms are pretty, they are pretty much the same. They are just different names. The patient indicated day is basically, it is a, you know, the schedule, we used a clinically indicated date if a provider provides one. And if not, in the absence of that they will use the veterans preferred date, which is essentially the same as the desired date.

So not much difference—

Mr. PAPPAS. Thank you.

Dr. KIRSH [continued]. —between the terms.

Mr. PAPPAS. Thank you, Mr. Chair.

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

Mr. BANKS. Thank you, Mr. Chairman.

Well, I am encouraged by the Jamma study published earlier this year that found VA has significantly shorter wait times for primary care than private doctors. I remain concerned about VA's ability to provide urgent mental health services to our veterans in crisis.

Dr. Boyd, in your testimony you discuss how VA began offering same-day appointments for mental health at every VA medical center in CBOC in 2017. According to VA, when veterans request a same-day appointment, they are assessed for the level of urgency and either provided a form of consultation or a future appointment.

I have a constituent veteran who had quite a different experience last year and I would like to take a moment to quickly summarize his story for you.

This veteran was having a mental health episode and was found walking down the highway by police. The veteran was turned over to his mother who picked him up and was instructed by a county VSO to immediately drive him to our local VA medical center for a mental health assessment.

The VSO called ahead, but was informed that the local VA medical center didn't have room or a doctor that could see the veteran at the time. The VA medical center recommended that they go to the next closest VA facility which was over an hour away.

Upon arrival, this VA medical center also refused to see him due to "lack of space." 2 police officers were in the waiting room and saw that something was wrong with the veteran and told the hospital staff that the veteran must be admitted, and yet they refused. The officers then went on and got a court order from a judge to mandate that the veteran be admitted.

Dr. Boyd, this situation may very well be an outlier or an anomaly. And for all intents and purposes I really hope that it is. But can you explain what VHA is doing to ensure that veterans in crisis are not being turned away and that these mental health assessments are available and consistent across all VA medical centers?

Dr. BOYD. First of all, I want to make a comment. If, in fact, we have not looked at that particular case, I would appreciate that, if your staff could get that to us.

Mr. BANKS. Indeed.

Dr. BOYD. If it happens one time, that is one time too many. Okay.

With regards to the process, we do have oversight of how patients are triaged and by what discipline. And when I mean that, I mean by social work, a licensed social worker, or a psychologist or a psychiatrist. So our central office or our national program office meets regularly with the field, and when I say the field, I mean their regional leads who know exactly what is going on in facilities.

So do I know for certain that there is not another one out there like that, I do not. That would be—it would be perfect if we did. But we make every intent to ensure that the urgency is assessed first. And so I have a lot of concern with what—with the story that you just relayed to me. It doesn't fit with what we expect and what we see when I go out.

Mr. BANKS. Yeah. Very well.

Dr. Draper, I understand that GAO has studied the availability of same-day services within VA and we can expect the findings and recommendations of the reports to be released soon.

That being said, can you shed any light on how frequently situations like what my constituent experienced occur and, if so, do you have any recommendations for us on how VA can better prevent situations like this from happening in the future?

Dr. DRAPER. Well, according to the information based on our work, the same-day services are available to anyone who comes into the VA and presents. You know, I think there is some expectations on veterans because it was really intended for those with more urgent needs or more immediate needs. But we have heard from the facilities that we visited that basically any veteran can show up and request same-day services.

So it seems out of character for what you are talking about, but, I mean, I can't explicitly talk about that particular case because I am not familiar with it.

But one of the things I do want to clarify that I know that there has been information about that 20 percent of all appointments are same-day services. There is a lot of noise in that information, in that data. So, for example, it could include like a veteran—a provider will call in sick and his appointments are canceled, his or her appointments are canceled for the day and then they get rescheduled with another provider. That looks like a same-day services when, in fact, the veterans may have been waiting quite some time to see the provider.

So that is one instance. So that number is not as clean as—you know, it is not necessarily that 20 percent of all appointments are truly same-day services.

It is also, I think, that there is some confusion about what same-day services are. It is not just a face to face with a provider, but it could be a nurse providing education. It could be medication refills. It could be scheduling a future appointment.

None of those other than the provider, face to face with the provider, none of those types of activities are captured. So we don't really know how much, what those different activities are and how frequent they happen. We did visit one VA medical center who had a pretty sophisticated group of staff who were able to set up a system, so they were able to track it. But that was just one facility

that we saw that was able to provide information about the different types of same-day services.

Mr. BANKS. Thank you. My time has expired.

The CHAIRMAN. Thank you, Mr. Banks.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman.

Dr. Boyd, you know, like Mr. Pappas said, we have had several hearings, you know, regarding the whistleblowers and those coming forward and how they have been treated after they come forward. And some of those whistleblowers were talking about the secret wait list that are being held at—you know, that has happened. And I guess Phoenix is our big example of what has happened there.

In your opinion, what can be done to increase transparency culture, and you talked about the culture a little bit, and policy in the VA so that its recurrence of secret VA wait lists doesn't keep resurfacing?

Dr. BOYD. Well, first of all, I want to be really clear. We are not 5 years ago. There is no secret wait lists. What we have are tools that are getting, are somewhat obsolete in their tracking capabilities that can be misinterpreted. And really, so they don't fit the mold of what we had said back 5 years ago that truly were the wait list. And we don't need to go back and re-litigate and re-talk about all of that.

But what can we do moving forward? I think we are on a really good path moving forward. And I know it is the soft stuff, but we are on a journey of high reliability. And you may have already heard about this, where we are really focusing on a just culture, and for 0 harm, and for raising your hand, stopping the line. Those who are the surgeons in the room or have been in the OR, that is extremely important, or even on the aircraft. Right. Stop the line. Something is not right.

So it is a matter of doing that, of developing that through all of our 18 regions, our facilities and in central office where we all live. It is a matter of providing that environment for folks to raise their hand and for us to say, it is okay.

Mr. CISNEROS. You know, I get that, and I keep hearing that, right, how we need to adjust the culture at the VA.

Dr. BOYD. We do.

Mr. CISNEROS. And there is a lot of work. You know, people are going to talk to the individuals, those that are working at the VA. You said it yourself. You are having town halls with those individuals.

But what are we doing to talk to the supervisors at the facilities? They are the ones that are conducting the culture. They are the ones that are overseeing it all. How are we changing their mindset and what is being done there?

Dr. BOYD. And that is an extremely good point since I did come from the field within the VA after private sector.

We have not traditionally done a great job of setting our supervisors and mid-managers up for success. And you are absolutely right. There is a gap in there. And so part of this education or this journey that we are on is to give our supervisors, many of them

new, and our mid-managers the tools and the skillsets with which to be a successful supervisor, to be a servant leader.

It is a rigorous program that we are embarking on and you really touched on what I am seeing in the field more and more. There is that mid-management gap. You are right.

Mr. CISNEROS. Now the other thing you mentioned, too, was that your tracking methods are behind. How are we going to update these? What needs to be done? How can we in congress help you bring your systems up to date, so we don't have these, you know, archaic systems that are like 15, 20 years old and we are still trying to track things that way? How do we modernize?

Dr. BOYD. So I am going to let Dr. Greenstone talk about it because we are transitioning, as we went from Choice where you are purchasing care and had a much different process. And so we were using a tracking tool, a software. I will let him talk about where we are going.

Dr. GREENSTONE. You know, one of the things, you know, that you raised is so important about, you know, secret wait lists and not having wait lists and having old, archaic systems. So we are moving to new technology that allows us to actually put people, when we are using administrative lists, be able to have triggers automatically.

Helping schedulers have triggers so when—in my realm of community care when we are buying care in the community for veterans and coordinating that care, we have new commercial off the shelf Cots products that we have configured to work with our old systems so as not to lose integrity, but to have those new systems help our schedulers, for example, more effectively and efficiently get veterans care in the community and have little reminders that come up and the like, and drive those schedulers to follow policy. They can't go outside of their realm.

And so eliminating things like the electronic wait list, so it is not even available is things that we have done in the Chairman's district recently to make sure that no one gets put erroneously on a list because we eliminate the list altogether. You can't even use it. And the technology allows us now moving forward to do those kinds of things to have more guidance and more support, and give the people the tools they need to be successful.

Mr. CISNEROS. I want to thank you all for your testimony today. My time is expired. Thank you.

The CHAIRMAN. Thank you, Mr. Cisneros.

Mr. Roy, you are recognized for 5 minutes.

Mr. ROY. I thank the Chairman. Thank you all very much for your time and thanks for being here today.

One quick question maybe for you, Dr. Boyd, and then maybe you, Mr. Kizer, as well. And I realize that we have had a number of hearings on this topic and will likely have more with respect to electronic health records.

But a question because it is something that I have raised to me all the time at Audie Murphy and San Antonio as well as in Kerrville, Texas is the extent to which the trouble with accessing records is interfering with, well, I will say Choice, now Mission, and the ability to go get the care that veterans are seeking and because there is some difficulty in dealing with records. How much

is that impacting wait times? I mean, we talk about wait times statistically. But in practice for a veteran, right, who is going in and saying, well, I want to get care, and he can't get care because they are going to seek care and then they are having to get kicked to the VA and they are kind of in an infinite do loop. What can you say about that as its impact on wait times?

Dr. BOYD. So I will let Dr. Greenstone comment on that, but that is an extremely critical observation.

Dr. GREENSTONE. Yeah. Really important. So one of the thing that we were able to create in terms of new information technology is, it was taking our staff about 20 minutes on average to compile all the medical records that might be appropriate for a provider in the community to have access to in order to appropriately care for a veteran.

We created a new tool we called, you know, the referral document tool which allows the staff with several clicks to grab that information and put it all together in one document. And it actually saved 15 minutes of their time on average to be able to do that.

And then how do you get it to them. So we have a new referral and authorization system that is essentially a portal. So the providers in the community, web-based, can log in and they can actually see the entire medical record of a veteran for the duration of the episode of care. So that is called our community viewer.

So we have created ways in which we can facilitate getting the providers in the community a medical information. We also need to get those records back. And so that inter-operability is something that we are working on diligently, and one of them is using the health information exchange. So if a provider in the community actually uses these new electronic records, they have the opportunity to create a computer readable and human readable document that the VA can actually pull and see readily, right, without having to worry about faxes and mail and all these other things.

So they can use our portal. They can use the health information exchange, the information back to us, and vice versa. So we are really trying to enhance this issue because it is a very important issue for us.

Mr. ROY. So you all would agree that has been a part of delays and wait times in the past?

Dr. GREENSTONE. I would say it would contribute. So if I am a scheduler in the VA, I can see the exact schedule. So my scheduler can see my next available appointment. When I am scheduling in the community, it may take longer because I may need to call 3 different cardiologists in the community. So it takes me longer to make that one appointment for a veteran in the community. So I can get fewer amount of schedules done in a day. So that does attribute somewhat to that process.

Mr. ROY. I appreciate that. Let me move on really quickly because of limited time.

Dr. Boyd, in your prepared statement you noted that veterans often face shorter wait times in VA than in the private sector. Are there any regions of the country and/or clinical specialties where VA is particularly challenged with respect to wait times compared to the private sector? And forgive me if you already answered that question.

Dr. BOYD. Oh, that is okay. I would have to roll that up all for you. But, absolutely, there would be pockets—well, we already heard from a few of the Committee Members. There are areas where we just don't have that expertise in-house and there is a very limited amount within the community as well.

So we do have a fix for that. We have a solution and that is going to be telemedicine is all through our clinical resource hubs. But you are right. But I don't have that off the top of my head, a long list.

Mr. ROY. Okay. That would be great if we could get that in response to the hearing.

Dr. Draper, a quick question for you. In your testimony you reference, you know, findings and some of the recommendations that go back, you know, a number of years, you know, going back to 2012 and so forth.

Obviously, the VA health system has changed quite a bit over this last 6, 7 years since that point. Are those findings and recommendations relevant today and how would you comment on that?

Dr. DRAPER. Yes. Absolutely. They still remain relevant. So our recommendations from our 2012 work was to really improve the reliability of the wait time measurement and ensure consistent implementation of the scheduling policy and scheduler training. So those were 2. Those were 2 that we have subsequently identified as priority recommendations.

And then a third recommendation was something that Dr. Roe had eluded to about telephone access. We have found telephone access to be problematic and, you know, VA had a set of best practices that they never implemented. So that remains an open recommendation.

And then the fourth one is to really identify the scheduling resources needed and allocate them appropriately based on need.

So all those recommendations still remain open. And I will say we are going to close one of the priority recommendations, but it took 7 years to close. And so we are still moving forward with, you know, we still have 3 that are open that are open for at least 7 years.

Mr. ROY. Thank you, ma'am.

Thank you, Chairman.

The CHAIRMAN. Thank you, Mr. Roy.

Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Dr. Boyd, you stated in your written testimony anyway that the VA in a RAND study it concluded that the VA performed similarly or even better than non-VA systems. And so I went back to find that report. And so first I want to say, I want to applaud the VA because I think that data point is consistent with what I hear from veterans all the time is once I am in the VA and getting my health care, I am very satisfied.

But this report had nothing to do with wait times. And I just want to make that clear.

A few months ago I had a town hall in my district and the greater Los Angeles people came into my local town hall and they read statistics on wait times for veterans in my district. And the whole room erupted in laughter. And I think the reason they erupted in

laughter is because the definition of wait time from a veteran's perspective is polar opposite to how the VA defines wait time and how they measure it.

A veteran or any average citizen would think wait time means from the time I called to ask for an appointment to when I receive the appointment. That would be what—their parameters of wait time. But yet in the VA system, in a typical situation the veteran will call and ask for an appointment. 6 or 7 days later the VA gets back to them and says, yes, you know, we want to see you, what is your preferred date. They give the preferred date and then the preferred date can't be met.

So, you know, let's say on day 8 they said my preferred date is on the 13th. They can't meet the 13th, but the next available appointment is on the 18th. But the way the VA calculates that wait time is from day 13, the day that they wanted the appointment and the day that they got it. So they say that's a 5 day wait time as opposed to all of the preceding days which were, you know, 10, 11, 12 days before they were actually able to state their preferred time.

So I think this is—you know, that's why my veterans erupted in laughter because they were coming from a completely different perspective.

So I just want to ask a very simple question. And I hope I can get a very simple answer. Why is it that the VA makes this so complicated and not just measure it from the time the veteran calls to the time he or she gets her appointment?

Dr. BOYD. That is a good question. And Dr. Kirsh is here from that office. I would be more than happy for her to take a stab at that one.

'Dr. KIRSH. Thank you for that question.

I want to make sure that I am understanding whether it is a new patient or a follow up patient.

Ms. BROWNLEY. Okay. I understand a follow up patient can be a little bit different. Okay. And so in this case probably it is more relevant to a new patient. But I don't want anybody who is listening to this meeting think that there is a huge difference between one and the other.

But go ahead.

Dr. KIRSH. I appreciate that.

So for a new patient calling in to get an appointment, that patient then, the scheduler accommodates that patient if they are on the phone and they are ready to make that appointment. The time that the scheduler goes into the system—

Ms. BROWNLEY. No. No. No. I know how the system works.

Dr. KIRSH. Okay.

Ms. BROWNLEY. And I am just asking why is it that you don't measure from the time, whether it is a new patient or an existing patient, why don't you measure wait times from the time the veteran asks for an appointment and the time he or she receives an appointment? That is the only answer I want. Why is that you don't measure it that way?

Dr. KIRSH. If the veteran calls and the appointment is made that day and until the completed time, that is the same measurement. I think there are some factors in there about requests in a follow up appointment where it is requested and the time to reach to the

veteran, call them, get back to them, determine when they want to be seen. There can be some variability in that component.

Ms. BROWNLEY. Okay. Well, my time is up. And I just don't feel like I have gotten an answer. But I personally think going to Dr. Kizer's point and his comment saying that we lack national standards with regards to wait times, I would love to have a longer conversation with you about what that should look like. But I just don't understand why it is not simple.

Everybody keeps saying, it is hard to answer your question because it is so complicated. But I feel like the VA has made it so complicated when it is really very simple, from the time they call to the time they receive their appointment.

I know I am over time. I yield back, Mr. Chair.

The CHAIRMAN. Thank you, Ms. Brownley.

Ms. Radewagen, you are recognized for 5 minutes.

Ms. RADEWAGEN. Thank you, Chairman Takano, and Ranking Member Dr. Roe for holding this hearing. And I want to thank the panel for being here today.

First off, I just simply want to associate myself with the concerns that were just raised by Ms. Brownley because in my home district of American Samoa I go through this with our veterans all the time. And I am very accessible to our veterans. As a matter of fact, many of them think nothing of calling me at 3:00 in the morning to tell me about their wait time definition that was misinterpreted or whatever.

But at any rate I do hope that sometime in the future VA is able to find a way to simplify a very simple problem rather than doing it with a complicated kind of a definition.

Anyway, so, Dr. Kizer, I understand that as the co-chair of the National Quality Task Force you recently participated in a conversation with some of the country's top health experts about access to care in 2019 and how our increasing reliance on technology is changing how access is defined and measured.

What were the key conclusions of that conversation and how do they apply to our conversation today regarding access to care for veterans within the VA health care system?

Dr. KIZER. Thank you for that question.

I think if I were to distill down what was a perhaps several hour conversation to a couple of points it was this. One is that all of the utilization measures that are used to measure wait times have problems and are technically difficult. And as a result many health systems are increasingly moving to patient-reported outcomes and what the patient perceptions are as to whether they got in in a timely manner and how they were handled.

And that while these health systems are not abandoning using wait times, they are using then in perhaps a different way, but putting increasing reliance on what the patients feel about the timeliness of the accessibility of care.

The second point was the need to increasingly use technology enabled means to facilitate access of care, whether it is telehealth or Mhealth or secure e-mail or a variety of other tools that are now available that simply weren't available not that long ago. And that, you know, for example, Kaiser Permanente, a system that sees more than 100,000 million outpatient encounters a year, are now

accomplishing more than half of those encounters through various telehealth means.

Los Angeles County, as another example, has gone to using e-consults to support its community based clinics and has dramatically reduced wait times for specialty consultations by using, again, technology enabled means.

So I think if I, again, were to distill down a several hour conversations, it would be to those 2 points about using patient reported measures and using telehealth and other technology means to facilitate access to care.

Ms. RADEWAGEN. Thank you.

Dr. KIZER. Which has particular relevance to your district.

Ms. RADEWAGEN. Yes. And going back to this definition of wait times, my veterans and I are extremely honored that Secretary Wilke and I will be flying down in a few days to American Samoa. I am sure he is going to get it in the neck about the definition of wait times.

Dr. Boyd, please respond to allegations made by a VA employee, Jeremy Whiteman, in a June 3rd Washington Post article regarding the electronic waiting list. Are you familiar with that?

Dr. BOYD. Yes, I am. Peripherally, that is an ongoing, active investigation at this time, very complex, and if there were any other specifics, it is not a closed case yet.

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

The CHAIRMAN. Thank you, Ms. Radewagen.

Ms. Lee, you are recognized for 5 minutes.

Ms. LEE. Thank you, Mr. Chairman, and thank all of you for the service you provide to our veterans and, Dr. Kizer, for your leadership, Dr. Boyd as well, and GAO, of course, for your shining the light on this issue.

Dr. Kizer, while you were at the VA you no doubt saw challenges that the organization experienced with technology modernization. And as of now the VA has many modernization projects in process, including this transition to the electronic health record from the Vista program.

And it is our understanding that this transition will entail implementing Cerner's scheduling software which will replace the current antiquated scheduling system.

But this is going to happen nationwide at first despite the fact that the Cerner rollout is going to be a step by step rollout over a 10 year period. And based on your past experience, Dr. Kizer, what is your view of this transition and what do you think the impact it will have on wait times and quality of delivery?

Dr. KIZER. Thank you for the question. And I would certainly give the colleagues, my friends here from the VA, the opportunity to respond after I try to address your comments.

I think there are 2 aspects of what you are asking. One has to do with the scheduling, the new scheduling system, the underlying scheduling system that is being implemented concomitant with the implementation of the overall new Cerner electronic health record.

I am encouraged by what I have seen so far with the scheduling system. I was particularly encouraged by the fact that the VA reached out to the National Academy of Medicine to hold a work-

shop on what should be the key operating characteristics and functionalities of that scheduling system. That workshop was held a couple of months ago. The report is, I got the draft actually of the report this week and it should be released soon. And I think it will provide a lot of useful guidance to the VA as they implement this new scheduling system.

As far as the rollout of the overall electronic health record, again, based on what I know and what I have heard from colleagues, and I do keep some presence in the IT sector, I have to confess that I have rather serious concerns about the implementation of the entire rollout and whether either the VA or the vendor is ready to accomplish all that needs to be done in the timeframes that have been laid out.

Ms. LEE. Thank you. I would love to chat with you more about those concerns as well.

Would anyone from the VA like to comment?

Dr. KIRSH. I would like to address the Cerner stand-alone scheduling.

As you know that was a request last fall from the congress about VHA's plan, VA's plan in accelerating the scheduling component of our electronic health record. And we since had purchased Cerner, spoke to the vendor about the capability and our collaborating with the Office of Electronic Health Record, VA OI&T and Cerner, about accelerating that program.

We believe that there will be benefits gained in efficiencies there and plan to begin that next June.

Ms. LEE. Okay. Thank you.

I just wanted to talk to Dr. Boyd, or it might be Dr. Greenstone, on your written testimony you cite the use of an online scheduling app. Are you referring to Myhealthyvet app? Is that what is being referred to?

Dr. GREENSTONE. So I can speak to that. Sure. Thank you.

So there is VA online scheduling. We call it VAOS, and that allows veterans to actually go in and if they are established within a VA medical center to request appointments and actually go in and make their own appointments in the grids of their primary care providers and even mental health.

We have created a similar capability for community care. So using Mission Act eligibility criteria, we allow veterans to go into the VA online scheduling. It shows their ability to use this for community care if the system knows that that veteran has eligibility: They live in the state or territory with no full service VA; they were a grandfathered in under Mission.

Ms. LEE. So is that done through this app? I am—

Dr. GREENSTONE. Yes.

Ms. LEE. Yes. So it is—

Dr. GREENSTONE. Through the app.

Ms. LEE [continued]. —done through—

Dr. GREENSTONE. So you can access it through Myhealthyvet.

Ms. LEE. Okay. And I just want to, do you have any idea about the utilization rate of this app by veterans and what are the demographics of the veterans using it?

Dr. GREENSTONE. Dr. Kirsh may have that for internally. I don't have those data, but we can get those for you as we have just rolled

it out for community care. But for internal VA, Dr. Kirsh may have some information.

Dr. BOYD. No. I agree with that. If we could get that information back to you because—

Ms. LEE. Yeah. That would be great.

Dr. BOYD [continued]. —it is very telling for us as well.

Ms. LEE. Good. And I would love if you could also, any information you have about the satisfaction and the effectiveness of the use of that app would be helpful.

Dr. BOYD. Certainly.

Ms. LEE. Thank you.

I yield the remainder of my time.

The CHAIRMAN. Thank you, Ms. Lee.

Mr. Meuser, you are recognized for 5 minutes.

Mr. MEUSER. Thank you, Mr. Chairman. Thank you all very much for being here. It is appreciated. Certainly, we are very encouraged by your work, what the Mission Act, I believe, has also helped improve. There is always more to do and certainly our shared goals are to take care of our country's veterans to the best of our abilities with the highest level of quality health care.

The number of VAs, Mr. Kizer, I will direct these questions to you, please. About 170 VA hospitals and 1,063 outpatient sites, are they all monitored for wait times?

Dr. KIZER. I think it might be best that someone from the VA respond to that question.

Mr. MEUSER. Oh, all right. Would somebody like to respond to that, please?

Dr. KIRSH. Absolutely. The accesstocare.va.gov website, veteran or family member can go in and look at wait times in primary care, mental health and 10 other specialties for a new patient appointment.

Mr. MEUSER. Okay. Dr. Kirsh, I will continue then my questioning with you.

And is the rating system, is it the 4 star or 5 stars, how do you set a rating system?

Dr. KIRSH. So the rating system applies to in-patient hospital care and this access to care website is around receiving outpatient new appointments.

Mr. MEUSER. Is there a percentage of the VA hospitals, let's say, that are rated the best? Is there 5 percent that are in the top echelon for wait times?

Dr. KIRSH. We can identify which sites because all sites do have wait times in primary care, mental health and if they offer specialty services. We have wait times for every facility available and we can provide that information for you and your staff.

Mr. MEUSER. Okay. I would actually like to see that. And do you believe that the Mission Act has helped?

Dr. KIRSH. Absolutely. I think one of the biggest drivers in my role in leading the internal access office has been to think about increasing our capacity, efficiency and productivity really over the last year in preparation. We want to be able to offer veterans an opportunity to stay in the VA if that is their preference or then provide an integrated, expanded network.

Dr. GREENSTONE. And, Congressman, the other value to the Mission Act is the provision for urgent care. We have had over 14,000 veterans that we think have actually received urgent care under the Mission act. So that is another way that we have expanded the capacity for veterans to be seen when they think they actually need care.

Mr. MEUSER. All right. Great.

And I do know the Mission Act, the Lebanon VA, which is in my district, Pennsylvania's 9th, does a fantastic job and they are improving all the time. And they also get a tremendous amount of feedback from their veterans. I don't know if that is a customary practice in other Vas, Dr. Boyd?

Dr. BOYD. Yes. With the Veterans Experience Office we have an amazing tool now where it is called Vsignals. I mean, we can call it most anything. But we get realtime feedback, comments, congratulations, positive things, but we also concern from veteran's realtime, whether they are an in-patient or they are maybe that housekeeping didn't come in at a certain time, or they have concerns about medications, most anything.

And we are—and we rapidly—well, the Veterans Experience Office rapidly gets those down to your site, down to your medical center and your folks there, your leadership there tend to that and address that. So they close that loop. We don't have to wait months for something to kind of fester. So we do realtime owning that moment.

Mr. MEUSER. Okay. Great.

Are there certain model VAs? I mean, there must be that when it comes to wait times or maybe it is many of the pieces of the overall operation that 1 VA or 10 VAs do better and you identify the reasons why, people, process, technology, whatever it might be and obviously do our very best to model the other VAs after them? Either one would be fine. Thank you.

Dr. BOYD. So we do have. We call those best practices. I tend to call them good practices. And we want to socialize those rapidly, vertically and horizontally throughout our enterprise. And the way to do that is as we are going forward with our VHA modernization plan, which I would be glad to talk about that at some other time, where we are linking together like programs, like services, clinical services, and the facility all the way on up to the national offices so we can help spread those practices. We don't have to wait for 2 years for a policy to come out, but share those things.

So we do encourage that.

Mr. MEUSER. Well, thank you all for your service. And, Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Meuser.

Mr. Levin, you are recognized for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman. I want to thank you for holding this important hearing, and thank you to our witnesses for the work that you do to serve our veterans. I particularly want to thank the folks at the VA back home in my community in La Jolla and in Oceanside for the excellent work that they are doing. There is always room for improvement, and with that in mind I wanted to ask a few questions.

Our veterans deserve clear information when making decisions about where to seek care, and Congress needs more reliable measures to understand veterans' access to care in our districts and districts across the country.

Dr. Kizer, can you speak to best practices for patient access measures across the U.S. health care system and how commonly are wait times used as opposed to the CAPS survey or other measurements?

Dr. KIZER. As I indicated previously, there currently are no industry wide or sector wide standards that are used to assess wait times which makes it difficult for an entity like the VA health care system to compare itself to community providers because in the community a variety of different methods may be used and certainly they don't receive the same degree of oversight or scrutiny as to the rigor with which their data has been collected or how valid are the methods they are using.

So there is some difficulty there. And in my written testimony one of the suggestions that I offered is that the VA might want to work with the National Quality Forum to try to establish some national standards about what would be appropriate access standards or time limit standards for the different settings of care, whether that be primary care or specialty care of different flavors as well as hospital care and post-acute care, et cetera.

Mr. LEVIN. Thank you. And I appreciated that suggestion. I am sure we will follow up.

Dr. Boyd, you also noted in your testimony that VA uses the CAP survey to assess patient satisfaction for primary care and for mental health care.

Has VA explored the possibility of expanding this survey to other aspects of specialty care and, if so, can you walk me through the cost benefit analysis?

Dr. BOYD. I will let Dr. Kirsh answer that. But we have some great answers for that.

Mr. LEVIN. Okay.

Dr. KIRSH. So mental health and other specialty clinics have been added in the last few years, so we can get information and we do feed that information back through our group practice manager program. As a result of VACAA 303 legislation, we have a practice manager much like private sector who is in charge of and really the point person for access of every single medical center. There are 238 practice managers that report to leadership there.

So they really are overseeing and governing and looking at things like the Vsignals and the CAHPS information. I can get you some specifics and follow up for you and your staff around specialty care, cardiology, mental health, et cetera, and what are some of the questions asked and those responses nationally or locally.

Mr. LEVIN. Thank you. I would appreciate that.

I wanted to go back to this question about how dates are determined. As the GAO, Inspector General and even VA's own internal audits have found, patient indicated dates are often entered incorrectly resulting in inaccurate wait time data.

Dr. Boyd, I would like to ask you a few follow ups on this to kind of understand better how these dates are determined.

You described the patient indicated data as the appointment date agreed upon by the patient and provider. So what happens when the patient and provider disagree?

Dr. BOYD. It goes with the patient's preferred date then.

Mr. LEVIN. Okay. How—go ahead.

Dr. BOYD. Because it is all about veteran preference. It really is.

Mr. LEVIN. That is what I was going to ask next. So how does the veteran's personal preference such as a work or vacation schedule factor into the determination?

Dr. BOYD. It does. And if I could just elude, being from Texas, although I practiced up in Maine up in the VA as well, and it was not uncommon for me to try to be able to convince a veteran that, oh, you really do need to be seen in 45 days. Oh, no. That was salmon running time up in the river, so couldn't do it then.

So I use that because it was a reality to me that that was the important, that was important to that veteran. So we would push out the appointment and went to Option B. So we do go with veteran preference.

Mr. LEVIN. Okay. Thanks for that clarification.

Dr. Kizer or Dr. Draper, are there any other factors that you think VA should clarify?

Dr. KIZER. Well, again, in my written comments I suggested that the VA work with the National Academy of Sciences to try to define what access means in this era that we live in now of increased connectivity through advanced communications and information management technology.

What access meant 10 years ago, certainly 15 years ago, is different than what it means today. And the fact that we can accomplish so many of our day to day important and sensitive activities through technology enabled means has not carried over into health care. And there is much that we need to do to move health care as a sector into the same status, say, that banking and some other sectors have moved to as far as using the internet as a vehicle to enhance communication to services or a connection with services.

Mr. LEVIN. Thank you. And I am out of time, but I want to thank the Chairman again for his attention to this important matter. And thank you all again for your testimony.

The CHAIRMAN. Thank you, Mr. Levin.

Dr. Roe, you are recognized for any closing remarks you might have.

Mr. ROE. Well, thank you very much, Mr. Chairman. It has been good, and I am going to close by remembering a conversation I had over four decades ago when I started my medical practice. And this was an old country doctor. He sat down and he said, son, he said, I am going to tell you how to be a successful doctor. And I said, how is that, and he said, I am going to give you the three A's of practicing medicine. A Number 1 is availability. A Number 2 is affability, and A Number 3 is ability. And he said you get those 3 rights, if they don't like you or if they can't get in and they don't know how good you are, if they don't like you, they are not going to come back.

So that is a challenge that we all have. It is very simple, but it still works today. And like I said at the very beginning, you can do all these measurements if you want to, but when somebody calls

in and they have a bad experience calling in to make an appointment, when the person that comes in to greet them, when they come into the VA or into my office makes them mad I spend the first 10 or 15 minutes trying to get everybody calmed down so I can actually find out why are you here today.

So I think you can take those things in training and do that, whether it is in the private or the public sector.

And, secondly, Dr. Kizer made several great points. And we do have huge challenges in rural America where I live in practicing medicine. We know there are going to be huge shortages in the practice, and that is one of the things this Committee did when we wrote the VA Mission Act.

And it struck me when I was out in Greg Walden's district in Oregon a little less than 2 years ago when he said, my congressional district has more square miles than the State of Tennessee does. And it does by several thousand more square miles, just one congressional district. So we had to put together a replacement of choice with something that worked in urban America and also tried to work in rural America, which is why you have to partner with the private sector.

And one of the reasons for that in we know that the estimates are there will be as many as 100 to 120,000 fewer physicians or lack of physicians in 2030 than there are today. And if we start training these doctors today, if you are a freshman in college today, you are not going to be ready to go live until the early 2030s to get your training done. So it was a huge problem.

We also added in the Mission Act residency and how to pay for it. We know that medical debt is a huge—or debt, student loan debt, I mean, is a huge problem. So we put that in there.

A lot of things. So if you can't get your appointment at the VA in a timely fashion, can you get it out in the community where you live? If you live 5 hours from the VA and the doctor is sick that day, you don't want to drive 5 hours down there and find out you don't have an appointment and then turn around and drive 5 hours back. So those are the things that we tried to remedy making this right in the Mission Act.

I think that the VA—as a matter of fact I can unequivocally say that between when I came on this Committee in 2009 and now, the VA is doing a much better job. I really believe that. I think you are more attentive. And I believe that the solution to the problems is local leadership. If I am a local VA hospital administrator, assistant administrator, and I don't have the doctors, the personnel to take care of the patients that are going to be coming to my facility, I am going to be recruiting those people.

Number 2, if I can't get them, I am going to go out in the community and recruit the community providers. I am going to go out and say to them, to the cardiologists, hey, we are short here, can you help us out.

And then what I am going to do because of the tools we gave you in the Mission Act, I am going to pay you promptly so you will continue to see VA patients.

So I think it is a lot of things. But it has to be done not at the 30,000 foot level where we are right here today. It has got to be done at the local level, at the local CBOC. When I was out in—and

one of the visits I made, as a Chairman we do in many of these, I realized that the incentives were different for a VA provider than they were for me in private practice. If I hired someone, I got an extra night or two off call a week, a month. So that was a little more sleep that I got. I was highly motivated to recruit a new obstetrician, believe me. And our overhead didn't go up much. We could keep our overhead down.

So those motivations are different. But the primary goal for all of us is to provide the best quality of care that you can possibly provide for that patient and a veteran. And to me, I am agnostic about it. If it is in the VA system, I am perfectly happy with that. If it is out in the community, I am perfectly happy with that. It is—I want the best care for the veteran.

I thank all of you all certainly for taking your time and being here today, and, Mr. Chairman, thank you for having this hearing. I really appreciate it.

The CHAIRMAN. Thank you, Dr. Roe.

Well, let me just say that we know that the VA, echoing Ms. Brownley's remarks about the RAND study, we know that the VA offers excellent care as compared to private sector care. And so, you know, I am not quite as agnostic. I believe the VA offers great care. The problem was access.

The VA wait list scandal posed serious, serious doubts about access to care and that scandal brought to light accessibility and manipulation of wait lists across the country. In response to that, we had put in place a piece of legislation, the Choice Act, that was intended to address these wait list scandals and accessibility.

As Dr. Roe mentioned, we included medical residencies. We included money to hire people at competitive salaries. But persistent, what seems to be persistent is, frankly, a lack of transparency for the veteran in terms of being able to assess what are the wait times in realtime at VA facilities. And there is no ability currently to really assess wait times at private sector community care facilities. And looming over all of this is what Dr. Kizer had mentioned is a lack of any national standards or a common understanding of what wait times mean in the context of today's medicine.

So I believe we have an opportunity for the VA to play a leadership role in terms of helping to set those standards. If the VA can get that right, make it simple for veterans to understand, I believe we will do not only veterans a great service, but we will do the American people a great service by setting these standards that the private sector, I think, will have to adopt, as community care provider networks will have to also be just as transparent as VA health care.

I remain concerned that we pay attention to building and maintaining the internal capacity of the VA to deliver the care that independent studies have said is excellent care. And we need to pay attention to efforts to increase accessibility to that internal care, and to rely on our community partners to supplement what the VA cannot do internally.

With that, I thank all the witnesses for their testimony today. I thank you for your hard work. All Members will have 5 legislative days to revise and extend their remarks, and include extraneous material.

Again, thank you for appearing for us today. And this hearing is now adjourned.

[Whereupon, at 11:39 a.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Debra A. Draper

Why GAO Did This Study

The majority of veterans utilizing VA health care services receive care in VA- operated medical facilities, including 172 VA medical centers and more than 1,000 outpatient facilities. For nearly 20 years, GAO has reported on the challenges VA medical facilities have faced providing health care services in a timely manner. When veterans face wait times at VA medical facilities, they may be able to receive services from VA's community care programs, which VA estimates will be 19 percent of its $86.5 billion in health care obligations in fiscal year 2020.

This testimony focuses on GAO's large body of work on veterans' access to care and the status of VA's efforts to address GAO's recommendations, including those from GAO's June 2018 report on VA's community care programs and from GAO's December 2012 report on VA's scheduling of timely medical appointments that VA has provided information on through July 2019. It also includes preliminary observations on related ongoing work.

What GAO Recommends

GAO has made a number of recommendations to VA to address timely scheduling and reliable wait-time data for outpatient appointments and through community care. VA generally agreed with GAO's recommendations. As of July 2019, VA has taken actions to fully implement one recommendation discussed in this statement. GAO continues to believe that all of the recommendations are warranted.

What GAO Found

GAO has issued several reports recommending that the Department of Veterans Affairs (VA) take action to help ensure its facilities provide veterans with timely access to medical care. VA has taken a number of steps to address GAO's recommendations to improve wait-time measurement and its appointment scheduling policy. However, additional actions are needed to fully address most of GAO's recommendations.

- GAO found in 2012 that outpatient appointment wait times reported by VA were unreliable because VA did not ensure consistency in schedulers' definitions of the dates by which wait times were measured. GAO recommended that VA clarify these definitions. VA concurred and has taken a number of actions in response, including improved oversight through scheduling audits. However, VA's first internal audit in August 2018 was unable to evaluate the accuracy and reliability of its wait-time data due to the lack of business rules for calculating them, indicating that additional efforts are needed to address this issue.
- GAO also found in 2012 that not all facilities GAO visited used the electronic wait list to track new patients that needed medical appointments, as required by VA's scheduling policy. This put patients at risk for being lost for appointment scheduling. GAO recommended VA ensure consistent implementation of its policy, and that all schedulers complete required training. VA concurred, and with the information VA provided in July 2019 GAO considers VA's actions, including updating its scheduling policy and completing scheduler training, sufficient to fully address the recommendation.
- While improvements to VA's scheduling policy and processes will help ensure veterans receive timely access to care, there are other factors that may also affect access that are not currently reflected in VA's wait- time data. For example, GAO found instances in which the time it took the agency to initially enroll veterans in VA health care benefits was more than 3 months.

GAO has also made recommendations to improve appointment scheduling and ensure timely access to care from non-VA providers in VA's community care programs that remain unimplemented. GAO found in June 2018 that the data VA used to

monitor the timeliness of the Veterans Choice Program's appointments captured only a portion of the total appointment scheduling process. Although VA had a wait-time goal of 30 days, VA's timeliness data did not capture certain processes, such as the time taken to prepare veterans' referrals and send them to a third-party administrator. GAO found that if these were accounted for, veterans could potentially wait up to 70 calendar days to see a community care provider. VA officials stated that most recommendations will be addressed with new program tools it plans to implement. For example, VA is implementing a system for referral management and appointment scheduling expected to be available in all VA medical facilities by fiscal year 2021. While technology may be an important tool, VA will also need clear and consistent policies and processes, adequate oversight, and effective training to help avoid past challenges.

Chairman Takano, Ranking Member Roe, and Members of the Committee:

I am pleased to be here today to discuss our work on appointment wait times for veterans seeking care provided by the Department of Veterans Affairs (VA) and for those veterans referred to non-VA providers through VA's community care programs. Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. In particular, access to timely primary care appointments is essential as a gateway to obtaining other health care services such as specialty care.

The majority of veterans utilizing health care services delivered by the VA's Veterans Health Administration (VHA) receive care in VA-operated medical facilities, including 172 VA medical centers and more than 1,000 outpatient facilities. For nearly 20 years, we have reported on the challenges VA medical facilities have faced providing health care services in a timely manner.[1] Since 2000, we have issued several reports recommending that VA improve appointment scheduling, ensure the reliability of wait-time and other performance data, and improve oversight. Implementing these recommendations would help ensure VA medical facilities provide veterans with timely access to outpatient primary and specialty care, as well as mental health care. Due to these and other concerns about VA's management and oversight of its health care system, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015, with updates in 2017 and 2019.[2]

Serious and long-standing problems with veterans' access to care were also highlighted in a series of congressional hearings in the spring and summer of 2014, after several well-publicized events raised additional concerns about wait times for appointments at VA medical facilities.[3] Legislation subsequently enacted in 2014 and 2018 established new community care programs, where veterans have the option to receive hospital care and medical services from a non-VA provider if certain conditions are met.[4] VA estimates that community care programs will be 19 percent of its $86.5 billion in health care obligations in fiscal year 2020. The length of VA outpatient appointment wait times is one of the eligibility criteria for several community care programs, and in fiscal years 2015 and 2016 about half a million veterans were referred to one of these programs under the wait-time eligibility criteria.

You asked GAO to testify today on appointment wait times at VA medical facilities and through community care programs, including the wait-time information the agency makes available to veterans and the reliability of these data. My remarks focus on

1.our work on VA outpatient appointment scheduling and the status of VA's efforts to address our recommendations;

2.our work on community care program appointment scheduling and the status of VA's efforts to address our recommendations; and

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[1] See, for example, 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); and 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).

[2] GAO, High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas, GAO–19–157SP (Washington, D.C.: Mar. 6, 2019); High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others, GAO–17–317 (Washington, D.C.: Feb. 15, 2017); and High-Risk Series: An Update, GAO–15–290 (Washington, D.C.: Feb. 11, 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

[3] In some cases, delays in care or VA's failure to provide care reportedly have resulted in harm to veterans.

[4] Pub. L. No. 113–146, 128 Stat. 1754 (2014); Pub. L. No. 115–182, tit. I, 132 Stat. 1393 (2018).

3.our ongoing work on one of VA's efforts to improve access to care.

My remarks today are based on our extensive body of work on veterans' access to care, including our December 2012 report on VA's scheduling of timely outpatient medical appointments and our June 2018 report on VA's community care programs, as well as department information through July 2019 in response to recommendations that we have made.[5] For a list of our previous work in this area, see the Related GAO Products page at the end of this report. Those reports provide further details on our scope and methodology. This testimony also includes preliminary observations from our current review assessing VA's efforts to offer veterans access to routine care without an appointment (known as VA's same-day services initiative). That review is based on our review of VA's policies, guidance, and requirements related to same-day services, and interviews with various officials, including from relevant VA offices and six VA medical centers and affiliated outpatient clinics.

We conducted all of the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Scheduling Outpatient Appointments in VA Medical Facilities

Enrollment is generally the first step veterans take to obtain health care services, within VA or through community care. VA's Health Eligibility Center manages the process of accepting applications, verifying eligibility, and determining enrollment, in collaboration with VA medical centers. VA requires veterans' enrollment applications be processed within 5 business days of receipt, including pending applications that require additional information from the applicant to process.[6]

Once enrolled, veterans can access VA health services by scheduling an appointment. VA's scheduling policy establishes the procedures for scheduling medical appointments, as well as sets the requirements for staff directly or indirectly involved in the scheduling process (e.g., training). A scheduler at the VA medical facility is responsible for making appointments for new and established patients (i.e., patients who have visited the same VA medical center in the previous 24 months), which are then recorded in VA's electronic scheduling system. VA scheduling policy requires patients who have requested an appointment and have not had one scheduled within 90 days to be placed on VA's electronic wait list. VA determines wait times at each facility based on outpatient appointment information from its scheduling system.

If veterans request that VA contact them to schedule an initial appointment on their application, they are placed on the New Enrollee Appointment Request list, and VA medical center staff are required to initiate the scheduling process 7 calendar days after the veteran is fully enrolled.

VA's Public Websites with Appointment Wait-Time Information

VA is required to publish information on appointment wait times at each VA medical facility for primary care, specialty care, and hospital care and medical services, which it does through two public websites. In November 2014, VA began posting monthly wait times for scheduling appointments at all VA medical facilities. One public website provides links to spreadsheets containing data for each VA medical facility, such as the average wait times for primary, specialty, and mental health care appointments and the number of patients on the electronic wait list.[7] In April 2017, VA created a second public "Access and Quality in VA Healthcare" website to post both patient access data and information on VA medical facilities' performance on various quality metrics. This website aims to help veterans find wait times at a specific facility.[8] This information would allow veterans and their family mem-

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[5] See GAO–13–130; and GAO, Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs, GAO–18–281 (Washington, D.C.: June 4, 2018).

[6] If veterans request that VA contact them to schedule an initial appointment on their application, they are placed on the New Enrollee Appointment Request list, and VA medical center staff are required to initiate the scheduling process 7 calendar days after the veteran is fully enrolled.

[7] See https://www.va.gov/health/access-audit.asp.

[8] See https://www.accesstopwt.va.gov/. According to VA's website, average wait times are based on appointments completed at VA medical facilities during the previous month. The Veterans

Continued

bers to use the wait-time data on this website to determine the best option for obtaining timely care.[9]

VA's Community Care Programs

In order to receive needed care in a timely manner, veterans may need to obtain care outside of VA medical facilities through one of VA's community care programs. VA has purchased health care services from community providers through various community care programs since 1945. Veterans may be eligible for community care when they are faced with long wait times or travel long distances for appointments at VA medical facilities, or when a VA facility is unable to provide certain specialty care services.

Since 2014, Congress has taken steps to expand the availability of community care for veterans. The Veterans Access, Choice, and Accountability Act of 2014 provided up to $10 billion in funding for veterans to obtain health care services from community providers.[10] The law established a temporary program-called the Veterans Choice Program (Choice Program)-to offer veterans the option to receive hospital care and medical services from a community provider when a VA medical facility could not provide an appointment within 30 days, or when veterans resided more than 40 miles from the nearest VA facility or faced other travel burdens. VA contracted with two third-party administrators (TPA) to establish networks of community providers, schedule veteran appointments with those providers, and pay those providers for services rendered through the Choice Program.

In June 2018, the VA MISSION Act of 2018 was enacted to further address some of the challenges faced by VA in ensuring timely access to care.[11] The Act required VA to implement within 1 year a permanent community care program-the Veterans Community Care Program (VCCP). The act identified criteria that all veterans enrolled in the VA health care system would be able to qualify for care through the VCCP; for example, if VA does not offer the care or service needed by the veteran or VA cannot provide the veteran with care and services that comply with its designated access standards. The access standards include appointment wait times for a specific VA medical facility; for example, veterans may be eligible for care through the VCCP if VA cannot provide care within 20 days for primary and mental health care, and 28 days from the date of request for specialty care, unless veterans agree to a later date in consultation with their VA health care provider.

VA Has Taken Actions to Address Deficiencies in Appointment Scheduling and Timeliness Identified in Prior Work, but Additional Actions Are Needed

VA Has Taken Steps to Address Our Recommendation to Improve Wait-Time Measurement and Has Implemented Our Recommendation to Improve Implementation of Scheduling Policy

VA has taken a number of actions to address our recommendations regarding deficiencies we found in wait-time measurement and implementation of its scheduling policy. For wait-time measurement, these actions included changes to the wait-time measurement definitions, provision and documentation of scheduler training, and improved oversight through audits, all of which have been in a state of flux for the past 6 years. On July 12, 2019, VA provided us additional updates on efforts to im-

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Access, Choice, and Accountability Act of 2014 required VA to publish the wait times for scheduling an appointment and quality and outcome measures in the Federal Register and on a publicly accessible website.

[9] According to officials, VA does not currently have the necessary data to publicly report wait times for non-VA providers in its community care programs. Officials stated that VA has future plans to measure and report aggregated data for the time elapsed from a veteran's request for care to the time of a community care appointment.

[10] Pub. L. No. 113–146, §§ 101, 802, 128 Stat. 1754, 1755–1765, 1802–1803 (2014). Additional funding for the Choice Program was provided on three separate occasions. Legislation enacted in August and December of 2017 provided an additional $4.2 billion for the Veterans Choice Fund. VA Choice and Quality Employment Act of 2017, Pub. L. No. 115–46, § 101, 131 Stat. 958, 959 (2017) (providing an additional $2.1 billion for the Veterans Choice Fund); An Act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes, Pub. L. No. 115–96. Div. D, § 4001, 131 Stat. 2044, 2052–53 (2017) (providing an additional $2.1 billion for the Veterans Choice Fund). In addition, the VA MISSION Act provided an additional $5.2 billion for the Veterans Choice Fund and authorized VA, beginning March 1, 2019, to use remaining amounts in the Fund for the Community Care Program, along with any other available amounts in other appropriation accounts for such purposes. Pub. L. No. 115–182, §§ 142, 510, 132 Stat. 1393, ** (2018).

[11] Pub. L.No. 115–182, tit. I, 132 Stat. 1393 (2018).

plement our related recommendations. This new information fully addresses one of our recommendations.

VA Wait-Time Measurement

In December 2012, we found that outpatient medical appointment wait times reported by VA were unreliable, and, therefore, VA was unable to identify areas that needed improvement or mitigate problems for veterans attempting to access care.[12] VA typically has measured wait times as the time elapsed between the 'start date'-a defined date that indicates the beginning of the measurement-and the 'end date', which is the date of the appointment. At the time of our 2012 report, VA measured wait times as the number of days elapsed from the start date identified as the desired date-the date on which the patient or health care provider wants the patient to be seen-to the date of the appointment.[13] We found that the reliability of the reported wait-time measures was dependent on the consistency with which schedulers recorded the desired date in the scheduling system, as required by VA's scheduling policy. However, VA's scheduling policy and training documents for recording the desired date were unclear and did not ensure consistency. We observed that not all schedulers at VA medical centers that we visited recorded the desired date correctly. Therefore, we recommended that VA either clarify its scheduling policy to better define the desired date, or identify clearer wait- time measures that are not subject to interpretation and prone to scheduler error. VA concurred with the recommendation, which we have identified as among those recommendations that warrant priority attention.[14]

Actions VA has taken or is taking to address this recommendation include:

- changes to the start date and definitions for wait-time measurement,
- provision and documentation of scheduler training, and
- improved oversight through scheduler audits.

In addition, we are currently assessing new information VA provided in July 2019, which will include obtaining additional evidence and clarification from VA to see whether it has fully addressed our concerns.

VA's Actions to Change Start Dates for Wait-Time Measurement

While the terminology for the start dates of the wait-time measurement has changed several times over the past 6 years, we believe that the current definitions of the start dates are substantively the same as those we reviewed-and found to be deficient-in our 2012 report. VA subsequently introduced new terms with similar definitions-from "desired date" to "preferred date"-without fundamentally addressing the deficiency. See table 1 for the changes to and definitions of the start dates for measuring outpatient appointment wait times and wait-time goals since June 2010.

[12] See GAO–13–130.

[13] The desired date was defined in VHA Directive 2010–027, VHA Outpatient Scheduling Processes and Procedures (June 9, 2010). VA rescinded this policy by memorandum, effective July 31, 2014, and replaced it with interim guidance.

[14] We send letters each year to the heads of key departments and agencies, including VA, that give the overall status of the department's or agency's implementation of our recommendations and identify open recommendations that should be a priority for implementation. In March 2019, we sent the Secretary of VA this year's letter, which identified 30 recommendations as being a priority for implementation. See GAO, Priority Open Recommendations: Department of Veterans Affairs, GAO–19–358SP (Washington, D.C.: Mar. 28, 2019).

Table 1: VA Changes to and Definitions of the Start Date for Measuring and Goal for Outpatient Appointment Wait Times since 2010

Document (date)	Terminology and VA definition of the start date for measuring outpatient appointment wait times		Goal for outpatient appointment wait times
	New patient	Established patient	
VHA Directive 2010-027[a] (June 9, 2010)	**Desired date** Desired date is the date on which the patient or provider wants the patient to be seen. It is defined by the patient without regard to schedule capacity.	**Desired date** Desired date is the date on which the patient or provider wants the patient to be seen. It is defined by the patient without regard to schedule capacity. The provider must document a return-to-clinic date in the patient's electronic health record.	Within 14 calendar days of the desired date (as of fiscal year 2011).
VA Memo (July 7, 2014)	**Create date** Not defined in memo.[b]	**Desired date** Desired date is the date on which the patient or provider wants the patient to be seen.	Not noted
VHA Directive 1230 (1) (July 15, 2016)	**Preferred date** Preferred date is the date the patient communicates they would like to be seen and is established without regard to existing clinic schedule capacity.	**Clinically indicated date or preferred date**, if no clinically indicated date is available. Clinically indicated date is the date an appointment is deemed clinically appropriate by a VA health care provider and documented in the patient's electronic health record.	Within 30 calendar days of the clinically indicated date, or in the absence of such date, the veteran's preferred date.
VA Memo (June 5, 2017)	**Patient indicated date** Clinically indicated date and preferred date will now be called "patient indicated date". Patient indicated date means exactly the same as clinically indicated date and preferred date and the associated scheduling processes will not change.	**Patient indicated date** Clinically indicated date and preferred date will now be called "patient indicated date". Patient indicated date means exactly the same as clinically indicated date and preferred date and the associated scheduling processes will not change.	Not noted

Source: GAO summary of Department of Veterans Affairs (VA) documents. | GAO-19-687T.

(a) VHA Directive 2010–027 was the scheduling directive in effect during our 2012 audit of wait times and scheduling processes.

(b) VA introduced but did not define "create date" in its July 7, 2014, memo; it is specified elsewhere as the date the appointment is created in the scheduling system.

As table 1 shows, for new patients and established patients seeking appointments without a return-to-clinic date specified by their provider, VA changed the terminology of the start date to preferred date in its July 2016 scheduling policy from what it had established in its June 2010 policy. However, the definition of preferred date is substantively the same as the definition of desired date in the previous scheduling policy, the latter of which we found to be subject to interpretation and prone to scheduler error in our 2012 report.[15] We continue to believe that the preferred date is also subject to interpretation and prone to scheduler error, which poses concerns for the reliability of wait times measured using the patient's preferred date.

In its updated July 2016 scheduling policy, VA also changed the terminology of the start date to the "clinically indicated date" for established patients whose provider has documented a clinically appropriate return-to-clinic date in the patient's electronic health record. The clinically indicated date is substantively the same as the definition of desired date for established patients in the previous scheduling directive.

While VA has not clarified the definitions of start dates, VA has taken actions intended to improve the accurate recording of the clinically indicated date in three ways:

1.VA requires clinical leadership (such as the Associate Chief of Staff) at each VA medical facility to ensure that providers enter the clinically indicated date in the electronic health record for future appointments;

2.VA standardized the entry of the clinically indicated date in the electronic health record to improve the accuracy of the date, which was implemented across all VA medical facilities as of July 2018; and

3.VA created a technology enhancement to enable the automatic transfer of the clinically indicated date from the electronic health record to the scheduling system. As a result, the scheduler no longer has to retrieve the date from veterans' electronic health records and manually enter it into the scheduling system. VA reported that this enhancement was implemented at all but three VA medical facilities as of January 2019.

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[15] VHA Directive 1230(1) and VHA Directive 2010–027. See also GAO–13–130.

In July 2019, VA reported to us that the error rate for the patient indicated date (either the clinically indicated date, or in the absence of that date, the patient's preferred date) was 8 percent of about 667,000 appointments audited in the most recent biannual audit cycle, ending March 31, 2019. VA cites an almost 18 percent improvement in reducing the number of errors caused by manual entry of the clinically indicated date due to the use of the technology enhancements.

VA's Actions to Provide and Document Scheduler Training

Although VA updated its scheduling policy in 2016, we believe the instructions, which form the basis for wait-time measurement, are still subject to interpretation and prone to scheduler error, making training and oversight vital to the consistent and accurate implementation of the policy. VA reported that 97 percent of all staff who scheduled an appointment within 30 days completed the required scheduling training as of July 2, 2019. VA stated that the department will closely monitor compliance with scheduler training completion for the remaining staff. Given the high turnover among schedulers, it is important that VA remain vigilant about scheduler training, ensuring all who need it receive it.

VA's Actions to Improve Oversight through Scheduler Audits

VA has taken a number of actions to improve oversight of the scheduling process through biannual scheduling audits at VA medical centers and second level audits, as well as completion of the first system-wide internal audit of scheduling and wait-time data.

Biannual scheduler audits. VA's July 2016 scheduling policy required biannual audits of the timeliness and appropriateness of schedulers' actions and accuracy of entry of the clinically indicated date and preferred date, the start dates of wait-time measurement as identified by the revised scheduling policy. In June 2017, VA deployed a standardized scheduling audit process for staff at VA medical centers to use. As part of our recommendation follow-up in July 2019, VA reported 100 percent completion of the required biannual scheduling audits in fiscal year 2018. As noted above, VA reported to us that the error rate for the patient indicated date (either the clinically indicated date, or in the absence of that date, the patient's preferred date) was 8 percent of about 667,000 appointments audited. While VA asserts that errors in the clinically indicated date have decreased, an error rate of 8 percent still yields errors in more than 53,000 appointments audited. Given these errors, we remain concerned about the reliability of wait times measured using preferred date (one part of the patient indicated date), and have requested additional information from VA about these errors.

- **Second level scheduler audits.** In November 2018, VA implemented a second-level scheduling audit (Audit the Auditors program), which is overseen by the VA integrated service networks tasked with oversight of VA medical facilities within their regions. Each medical center within a network region is paired with another medical center and they audit each other's scheduling audit. Throughout the cycle, medical centers share their findings with each other and the network. The goal is to standardize scheduling audit practices across the network and to ensure reliability of the scheduler audit results. According to VA, the first cycle was completed April 30, 2019, by all VA medical centers.
- **First internal system-wide audit of wait-time data and scheduling.** In its first internal audit completed in August 2018, VA was unable to evaluate the accuracy and reliability of scheduling and the wait-time data. Specifically, VA was unable to determine the accuracy and reliability of the scheduling and wait-time data, databases, and data flow from the electronic health record and scheduling system to the VA Access and Quality website because they were not able to obtain the rules for calculating wait times.[16] Given our continued concerns about VA's ability to ensure the reliability of the wait-time data, we plan to obtain additional information from VA about its methodology and assessment of evidence underlying the audit findings.

Scheduling Policy

In December 2012, we also found inconsistent implementation of VA's scheduling policy that impeded VA medical centers' scheduling of timely medical appointments.

[16] From November 2017 through August 2018, VHA's Office of Internal Audit conducted its first performance audit, which assessed the accuracy and reliability of the wait times published on the VA Access and Quality website. VHA issued the audit report in February 2019, which is an internal report and not publicly available. The methodology included an evaluation of compliance against requirements in VHA Directive 1230 related to the accuracy and reliability of veteran wait times.

Specifically, we found that not all of the clinics across the medical centers we visited used the electronic wait list to track new patients that needed medical appointments as required by VA's scheduling policy, putting these patients at risk of being lost for appointment scheduling.[17] Furthermore, VA medical centers' oversight of compliance with VA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. Scheduler training was particularly important given the high volume of staff with access to the scheduling system-as of July 2, 2019, VA reported there were approximately 33,000 staff that had scheduled an appointment within the last 30 days. We also found that VA medical centers identified the outdated and inefficient scheduling system as one of the problems that can impede the timely scheduling of appointments and may impact their compliance with VA's scheduling policy.[18] We recommended VA ensure that VA medical centers consistently and accurately implement VA's scheduling policy, including use of the electronic wait list, as well as ensuring that all staff with access to the scheduling system completes the required training.[19] VA concurred with this recommendation, which we also have identified as among those recommendations that warrant priority attention.

VA's actions to improve implementation of the scheduling policy, including updated information VA provided in July 2019, fully addresses this recommendation. VA issued an updated scheduling policy in July 2016 that provided clarification on scheduling roles and responsibilities for implementing the policy and business rules for scheduling appointments, such as using the electronic wait list, and required biannual scheduler audits. VA also ensured almost all schedulers received training on the updated scheduling policy and improved oversight through audits, as previously described.

In addition, VA plans to rapidly deploy a single nationwide scheduling system that is intended to simplify the operating environment for schedulers and may mitigate challenges identified in our 2012 report. The new scheduling system will be a resource-based system where each provider's schedule is visible on one screen, instead of requiring the need to toggle through multiple screens as it currently exists. VA plans to roll out the new scheduling system starting in 2020, which is expected to be implemented in coordination with the planned modernization of the electronic health records system across VA facilities. According to VA, the scheduling system will be available for use in advance of the completion of the electronic health record implementation at some sites.[20]

VA Has Taken Steps to Address Our Recommendations to Strengthen Enrollment Processes and Management of Initial Requests for Care That Affect Veterans' Timely Appointments

In addition to the recommendations we made to improve VA's wait-time data and implementation of its scheduling policy, we have also made recommendations to address other factors that affect the timeliness by which veterans obtain appointments. These recommendations have targeted VA's enrollment processes and its management of veterans' initial requests for care. While VA has taken some steps to address these recommendations, they have not yet been fully addressed. For example, we have found that VA's wait-time measures do not yet capture the time it takes the agency to enroll veterans in VA health care benefits, or manage a veterans' initial request for care.[21]

Enrollment Process

In September 2017, we found that VA did not provide its medical centers, who historically receive 90 percent of enrollment applications, with clear guidance on

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[17] VHA Directive 2010–027, in effect during our 2012 audit, defined the electronic wait list as the official VA wait list that is used to list patients waiting to be scheduled, or waiting for assignment to a provider's panel. In general, the electronic wait list is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic).

[18] See GAO–13–130.

[19] We also made two recommendations regarding the allocation of staffing resources to respond to demand for appointment scheduling and the oversight of telephone access and implementation of telephone systems best practices. Both of these recommendations remain unimplemented as of July 2019.

[20] VA does not have an end date for the completion of the scheduling system or electronic health record deployment.

[21] Veterans can request VA contact them to schedule an initial appointment on their enrollment application, and if eligible, they are placed on VA's New Enrollee Appointment Request list. According to VA's scheduling policy, scheduling appointments for veterans on the New Enrollee Appointment Request list must start within 7 days of a veteran being determined eligible for VA health care benefits.

how to resolve pending applications, which led to delays in veteran's enrollment.[22] For example, we found instances in which pending applications remained unresolved for more than 3 months. We concluded these delays in resolving pending applications, along with previously documented delays due to errors in enrollment determinations, may result in veterans facing delays when obtaining health care services or incorrectly denied benefits.

We made several recommendations to address these deficiencies, two of which we determined to be priority recommendations for VA to clearly define roles and responsibilities for (1) resolving pending applications and (2) overseeing the enrollment process. VA has made progress in addressing these priority recommendations by beginning to update, but not yet finalizing, its policies, procedures, and guidance on enrollment processing. In 2017, VA's Health Eligibility Center began conducting secondary reviews of enrollment determinations. However, in fiscal year 2018, Health Eligibility Center staff found that 18 percent of rejected enrollment determinations and 8 percent of ineligible enrollment determinations that underwent secondary reviews were incorrect.[23] These recommendations remain unimplemented as of July 2019.

Initial Requests for Care

Once enrolled, we have found that VA's management of veterans' initial request for care have led to delays; and although VA has clarified timeliness requirements, it has yet to fully capture the wait veterans experience in scheduling initial appointments. In a number of reports from 2015 to 2018, we found instances in which newly enrolled veterans were not contacted to schedule initial primary care appointments, and did not complete initial primary care appointments and mental health evaluations according to VA timeliness requirements.[24] These delays may be understated in VA data, because VA's wait-time measures do not take into account the time it takes VA medical center staff to contact the veteran to determine a preferred date (the starting point for wait-time measurement) from the veteran's initial request or referral. We found that the total amount of time it took for veterans to be seen by providers was often much longer when measured from the dates veterans initially requested to be contacted to schedule an appointment or were referred for an appointment by another provider than when using the veterans' preferred dates as the starting point. See figure 1 for an example of how the two wait-time calculations differ for an initial primary care appointment.[25]

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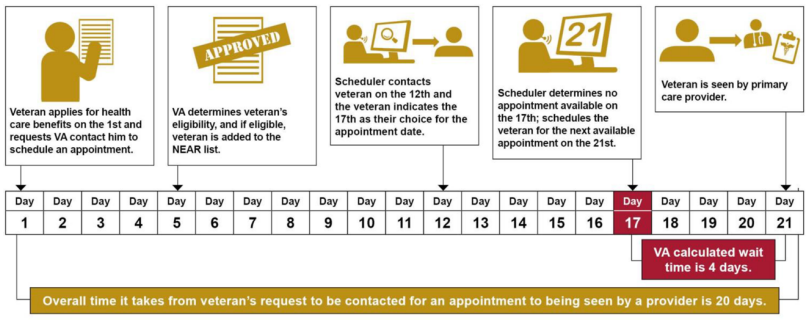
[22] GAO, VA Health Care: Opportunities Exist for Improving Implementation and Oversight of Enrollment Processes for Veterans, GAO–17–709 (Washington, D.C.: Sept. 5, 2017).

[23] We also recommended that VA develop procedures for consistently collecting reliable enrollment processing data. Although VA is working on data systems enhancements and plans to regularly test the reliability of its data, it has not completed those system enhancements or begun to regularly audit its enrollment processing data for reliability. VA did implement our recommendation of clarifying the 5-day timeliness standard for processing enrollment applications.

[24] GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO–16–24 (Washington, D.C.: Oct. 28, 2015); VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care, GAO–16–328 (Washington, D.C.: Mar. 18, 2016); and Veterans Health Administration: Opportunities Exist for Improving Veterans' Access to Health Care Services in the Pacific Islands, GAO–18–288 (Washington, D.C.: Apr. 12, 2018).

[25] We found that although some of the delays may have been attributed to VA medical center staff not being able to contact veterans after repeated attempts, or veterans' preferences to delay treatment, in some cases the delays were caused because VA medical center officials did not initiate contact according to VA requirements, did not complete the required number of contact attempts, or did not have appointments available due to provider and space shortages.

Figure 1: Illustration of How the Time It Takes a Veteran to See a Provider May Differ from the VA's Wait-Time Calculation



Legend: NEAR= New Enrollee Appointment Request; VA = Department of Veterans Affairs.

Sources: GAO summary of VA documents; GAO (illustration). | GAO-19-687T

We made several recommendations to VA, including a priority recommendation to monitor the full amount of time newly enrolled veterans wait to be seen by a provider.[26] VA has taken several steps to address the priority recommendation, including revising an internal report to help identify and document newly enrolled veterans and monitor their appointment request status. The report is intended to help VA and its medical centers oversee the enrollment and appointment process by tracking the total time from application to appointment. However, VA is still in the process of enhancing its electronic enrollment system to capture the application date for all newly enrolled veterans. Until the enhancements are implemented, VA may not consistently capture the start date for newly enrolled veterans, which, in turn, affects the reliability of its wait-time data. The priority recommendation remains unimplemented as of July 2019.

VA Has Not Implemented Recommendations to Address Wait Times and Other Choice Program Issues That Could Affect VCCP Implementation

VA has not implemented several of our recommendations related to the Choice Program that could impact veterans' timely access to care under the VCCP. These recommendations address (1) establishing achievable community care wait-time goals and a scheduling process consistent with those goals, (2) collecting accurate and complete data to systematically monitor veteran community care wait times, and (3) other factors that could adversely affect veterans' access to community care. VA has begun taking steps to address these recommendations as it implements the VCCP.

VA Still Needs to Establish Achievable Wait-Time Goals and a Scheduling Process Consistent with Those Goals to Ensure Veterans' Timely Access to Care under the VCCP

Our review of the Choice Program in June 2018 found that despite having a wait-time goal, VA developed a scheduling process for the Choice Program that was not consistent with achieving that goal. The Veterans Access, Choice, and Accountability Act of 2014 required VA to ensure the provision of care to eligible veterans within 30 days of the clinically indicated date or, if none existed, within 30 days of the veteran's preferred date. However, we found that those veterans who were referred to the Choice Program for routine care because services were not available at VA in a timely manner could potentially wait up to 70 calendar days for care. Under VA's scheduling processes, this potential wait time included VA medical centers having at least 18 calendar days to prepare veterans' Choice Program referrals to TPAs and another 52 calendar days for appointments to occur as scheduled by TPAs.

Based on this finding, we recommended that VA establish an achievable wait-time goal for the VCCP that will permit VA to monitor whether veterans are receiving community care within time frames that are comparable to the amount of time they

[26] We also made recommendations that VA review and revise its process for identifying and documenting newly enrolled veterans requesting appointments, clarify timeliness requirements for scheduling mental health evaluations, and clarify definitions, such as how a new patient is defined, used to calculate wait times. VA concurred with and implemented all of these recommendations.

would otherwise wait to receive care at VA medical facilities.[27] We also recommended that VA should design an appointment scheduling process for the VCCP that sets forth time frames within which (1) veterans' referrals must be processed, (2) veterans' appointments must be scheduled, and (3) veterans' appointments must occur that are consistent with the wait-time goal VA has established for the program. VA agreed with both recommendations, which remain unimplemented, and officials stated that they are in the process of finalizing metrics to capture wait-time performance and designing an appointment scheduling process. Without specifying wait- time goals that are achievable, and without designing appointment scheduling processes that are consistent with those goals, VA lacks assurance that veterans are receiving care from community providers in a timely manner.

VA's Monitoring of Care

under VCCP Could Still Be Compromised by Incomplete and Inaccurate Data

In June 2018, we reported that VA could not systematically monitor wait times for veterans accessing care under the Choice Program due to incomplete and inaccurate data. Without complete and accurate data, VA was not able to determine whether the Choice Program was achieving its goals of (1) alleviating the wait times veterans experienced when seeking care at VA medical facilities, and (2) easing geographic burdens veterans may have faced when accessing care at VA medical facilities.[28] We made three recommendations to address VA's incomplete and inaccurate data related to the Choice Program, and VA is taking steps to implement two of those recommendations.

Incomplete Data

We found that the data VA used to monitor the timeliness of Choice Program appointments captured only a portion of the total appointment scheduling process. Though VA had a 30-day wait-time goal to provide veterans with care under the Choice Program, VA's timeliness data did not capture (1) the time VA medical centers took to prepare veterans' referrals and send them to the TPAs, and (2) the time spent by TPAs in accepting the referrals and opting veterans into the Choice Program. For example, we found that it took VA medical center staff an average of 24 calendar days after the veteran's need for care was identified to contact the veteran, compile relevant clinical information, and send the veteran's referral to the TPAs. For those same authorizations, it took the TPAs an average of 14 calendar days to accept referrals and reach veterans to opt them into the Choice Program.[29]

In 2016, VA also conducted its own manual review of appointment scheduling times and found that wait times could be longer than the 30 days (see fig. 2). Specifically, out of a sample of about 5,000 Choice Program authorizations, VA analyzed (1) the timeliness with which VA medical centers sent referrals to the TPAs, and (2) veterans' overall wait times for Choice Program care. VA's analysis identified average review times when veterans were referred to the Choice Program to be greater- than-30-day wait time for an appointment at a VA medical facility. For example, for overall wait times (i.e., the time veterans' need for care was identified until they attended initial Choice Program appointments), wait times ranged from

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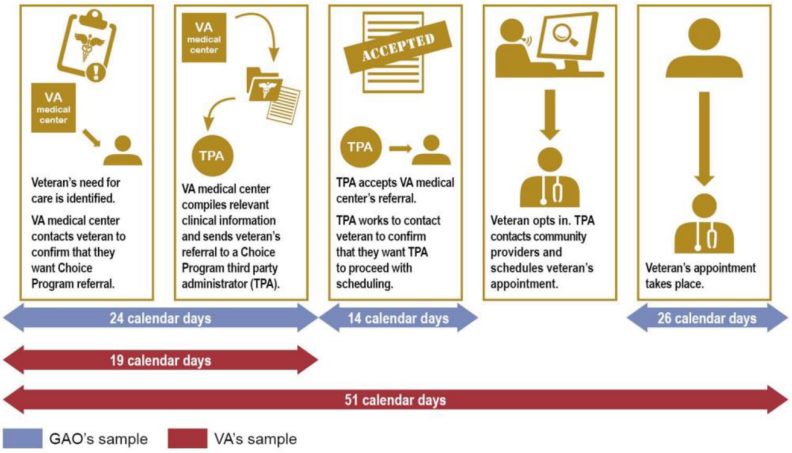
[27] The report in which we made these recommendations refers to the VCCP as the "consolidated community care program VA plans to implement" because at the time of the report, the name of the program had not yet been announced. See GAO–18–281.

[28] GAO selected 6 of 170 VA medical centers (selected for variation in geographic location and the TPAs that served them) and manually reviewed a random, non-generalizable sample of 196 Choice Program authorizations. The authorizations were created for veterans who were referred to the program between January and April of 2016, the most recent period for which data were available when we began our review. The sample of authorizations included 55 for routine care, 53 for urgent care, and 88 that the TPAs returned without scheduling appointments. The sample of authorizations we reviewed included only authorizations for which VA's data indicated there were delays when the TPAs attempted to schedule appointments after the veterans had opted in to the program; however, our analysis of these authorizations indicates that delays occurred at other phases of the referral and appointment scheduling process as well. See GAO–18–281.

[29] Similarly in April 2018, we found that while 20 of 30 veterans accessing specialty care under the Choice Program in the Pacific Islands received care within VA's 30 day wait- time goal, the actual wait time from when the referral was created to when the veteran received care ranged from 19 to 239 days, with the average being 75 days. Our non- generalizable sample included 30 routine Choice Program authorizations that were created from October 2016 through March 2017 by three selected VA medical facilities. See GAO–18–288.

34 to 91 days across the 18 VA integrated service networks. The national average was 51 days.[30]

Figure 2: Average Wait Times for Choice Program Appointments in 2016, According to Separate Non-Generalizable Analyses by GAO and VA



Source: GAO illustration based on GAO and Department of Veterans Affairs (VA) analyses of selected Choice Program authorizations. | GAO-19-687T

Note: GAO excluded from its analysis the amount of time the TPA took to schedule the appointment and the overall wait time because its sample selection methodology differed from VA's in a way that would have skewed these two averages but not the averages from the other segments of the process.

In September 2017, VA began implementing an interim solution to monitor overall wait times, but this solution relied on VA medical center staff consistently and accurately entering data on referrals, a process that is prone to error. In June 2018, we recommended that VA establish a mechanism to monitor the overall wait times under the VCCP. VA agreed with this recommendation, and stated that it is developing a monitoring mechanism that will be incorporated into a new system that will be fully implemented across all VA medical facilities by fiscal year 2021.

Inaccurate Data

We also reported that the clinically indicated dates included on referrals that VA medical centers sent to the TPAs, which are used to measure the timeliness of care, may not have been accurate, further limiting VA's monitoring of veterans' access to care. Our review of 196 Choice Program authorizations found that clinically indicated dates were sometimes changed by VA medical center staff before they were sent to the TPAs, which could mask veterans' true wait times. We found that VA medical center staff entered later clinically indicated dates on referrals for about 23 percent of the 196 authorizations reviewed. We made two recommendations to improve the accuracy of the Choice Program data. For example, we recommended that VA establish a mechanism under the VCCP that prevents clinically indicated dates from being modified. VA agreed with our recommendation, and stated that a new system will interface with VA's existing referral package to allow a VA clinician to enter in a clinically indicated date while restricting schedulers from making alterations to it.[31]

VA Has Not Addressed Other Factors That Could Adversely Affect Veterans' Access to Care under the VCCP

[30] GAO obtained the results of VA's non-generalizable analysis of wait times for a nationwide sample of about 5,000 Choice Program authorizations that were created for selected services between July and September of 2016. Authorizations were for four types of Choice Program care-mammography, gastroenterology, cardiology, and neurology. VA calculated the average wait times across these four types of care for each of the 18 VA integrated service networks.

[31] VA did not agree with one of our recommendations related to urgent care referrals. However, we maintain that our recommendation is still warranted.

In June 2018, we also reported that numerous factors adversely affected veterans' timely access to care through the Choice Program and could affect access under the VCCP.[32] These factors included the following: (1) administrative burden caused by complexities of VA's referral and appointment scheduling processes; (2) poor communication between VA and its medical facilities; and (3) inadequacies in the networks of community providers established by the TPAs, including an insufficient number, mix, or geographic distribution of community providers.

VA has taken steps to help address these factors; however, none have been fully addressed. For example, to help address administrative burden and improve the process of coordinating veterans' Choice Program care, VA established a secure e-mail system and a mechanism for TPAs and community providers to remotely access veterans' VA electronic health records. However, these mechanisms only facilitate a one-way transfer of necessary information. They do not provide a means by which VA medical facilities or veterans can view the TPAs' step-by-step progress in scheduling appointments or electronically receive medical documentation associated with Choice Program appointments. We made five recommendations to VA to address the factors that adversely affected veterans' access to Choice Program care. VA agreed or agreed in principle with all five recommendations and has taken some steps in response to these recommendations. However, our recommendations remain unimplemented.

As It Implements the VCCP, VA Has Taken Some Steps to Address Community Care Wait- Time Data and Monitoring Issues

On June 6, 2019, VA began implementing the VCCP, which created a consolidated community care program. Under the VCCP, VA began determining veteran eligibility based on designated access standards, such as wait-time goals of 20 days for primary and mental health care and 28 days for specialty care and other criteria identified in the MISSION Act.[33] According to VA officials, the implementation of the VCCP also included the use of the new Decision Support Tool-a system that combines eligibility and other information to help veterans, with assistance from VA staff, decide whether to seek care in the community. VA officials previously identified the Decision Support Tool along with another new system-known as the Health Share Referral Management system-as key efforts in addressing many of our recommendations related to VA's community care wait-time data and monitoring issues. VA expects the Health Share Referral Management system, which will manage community care referrals and authorizations as well as facilitate the exchange of health information between VA and community providers, to be fully implemented across all VA medical facilities in fiscal year 2021. We began work in May 2019 to review VA's implementation of the VCCP, including how it will address issues such as appointment scheduling.

Preliminary Observations on VA's Provision of Same- Day Services- Another Access Initiative

In addition to the actions described above, VA has taken other steps to improve veterans' access to care by, for example, offering veterans access to routine care without an appointment. We have ongoing work related to same-day services provided in VA primary care and mental health clinics. In order to improve access, VA implemented the same-day service initiative in 2016, and by 2018 offered same-day services in over 1000 facilities.[34] As part of the initiative, VA medical facility staff are directed to address veterans' primary care and mental health needs that day through a variety of methods, including face-to-face visits, telehealth, prescription refills, or by scheduling a follow-up appointment. Our ongoing work indicates that the six VA medical facilities we visited were generally providing same-day services prior to the initiative; however, according to VA officials, ongoing staffing and space shortages created challenges implementing the initiative. Our ongoing work also indicates that VA does not have performance goals and measures to determine same-day services' impact on veterans' access to care. We plan to issue our report on VA's same-day services initiative in August 2019.

In closing, we have identified various weaknesses in VA's wait-time measurement and scheduling processes over the years. These weaknesses have affected not only VA's internal delivery of outpatient care, but also that provided through community providers. As we have highlighted here, we have made a number of recommenda-

[32] See GAO–18–281.

[33] 84 Fed. Reg. 26278–01 (June 6, 2019).

[34] In January 2018, VA announced that same-day services in primary care and mental health had been achieved not only in all VA medical centers, but also in all of VA's community-based outpatient clinics.

tions to address these weaknesses. VA has taken actions to address our recommendations, but additional work is needed for some. The implementation of enhanced technology, such as a new scheduling system, is crucial and will provide an important foundation for improvements. However, this is not a panacea for addressing all of the identified problems. Moving forward, VA must also continuously ensure that it has clear and consistent policies and processes, adequate oversight, and effective training.

Chairman Takano, Ranking Member Roe, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Debra A. Draper, Director, Health Care 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. GAO staff who made key contributions to this testimony were Sharon Silas (Acting Director), Ann Tynan (Assistant Director), Cathy Hamann, Aaron Holling, Akbar Husain, Kate Tussey, and E. Jane Whipple. Also contributing were Jacquelyn Hamilton and Vikki Porter.

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Prepared Statement of Teresa Boyd, DO

Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. I appreciate the opportunity to discuss VA's current practices for measuring Veterans' access to health care and to provide a clearer picture concerning wait times in light of the 5-year anniversary of the issues in Phoenix. I am accompanied today by Dr. Susan Kirsh, Acting Assistant Deputy Under Secretary for Health (ADUSH) for Access, and Dr. Clinton L. Greenstone, Deputy Executive Director, Clinical Integration, Office of Community Care.

Introduction

VHA has undergone tremendous transformation since 2014, operating with a renewed focus, unprecedented transparency, and increased accountability. We recognize there are still challenges ahead of us, but it is important to keep in mind that Veterans continue to receive the highest quality care, often with shorter wait times than in the private sector. VHA will continue to identify opportunities to share strong practices, standardize processes, educate staff, and provide oversight to ensure these efforts are being effective. Providing Veterans the care they need, when and where they need it, is central to all we do. Even with implementation of the new Veterans Community Care Program through the VA MISSION Act of 2018, Veterans are choosing to stay within VA to receive their care.

Care When It Is Needed

VHA is providing care to more patients than ever. We completed over 1 million more appointments in 2018 than the previous year while wait times continue to decline across VA. In fact, the Journal of the American Medical Association found in a study released in January 2019, that by 2017 VA had significantly shorter wait times for primary care, cardiology, and dermatology than the wait times seen for private doctors. VA had longer wait times for orthopedic care; however, these wait times improved from 2014 and are still improving.

VA offers Veterans same-day services for mental health and primary care when clinically indicated at all VA medical centers (VAMC) and community-based outpatient clinics (CBOC) across VA - an effort completed by 2017. Same-day primary care and mental health services are offered when a Veteran contacts us. Accordingly, we will either address the need that day or schedule appropriate follow up care, depending on the urgency. We may address the health care needed by providing a face-to-face visit, returning a phone call, arranging a telehealth or videocare visit, responding by secure email, or scheduling a future appointment.

VA has improved the average time to complete a stat consult, which is a critically time-sensitive referral to specialist that should be completed in less than 48 hours, from 19.3 days in 2014 to just 1.4 days in 2019, a 90 percent decrease. Simplifying the consult management process and timely resolution of these referrals has made it easier for Veterans to be seen in a timelier manner. A large factor in these improvements was VA's response to the Veterans Access, Choice, and Accountability Act of 2014 and we expect this to continue under the implementation of the MISSION Act of 2018.

Quality Care

In 2018, the RAND Corporation released a study, Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings, that said VA hospitals on average performed the same or significantly better on 21 of 26 measures than private sector hospitals, including inpatient safety and mortality. VA hospitals performed better than commercial and Medicaid Health Maintenance Organizations on 28 of 30 measures. An increased emphasis on patient-centered care is a large contributor to these improvements. Our Veterans Experience Office is constantly assessing our performance throughout VA and giving us the feedback we need to identify and resolve problems.

VHA values what Veterans have to say and have made it an Agency priority. We have been using the industry standard Consumer Assessment of Health Providers and Systems (CAHPS) survey to assess patient satisfaction for primary care and mental health. Through this data, our Veterans have voiced their appreciation with patient satisfaction scores improving in every category related to getting care when they needed it. We also recognize that quality care comes from having adequate levels of staff available to provide the care. Today, there are more than 200,000 health care professionals, including doctors and nurses, who treat Veterans in the VA system. VA has hired more than 14,000 new employees in support of health care since October 2016.

Electronic Wait List

The number of Veterans waiting for clinical care appointments to be made is commonly referred to as the Electronic Wait List (EWL). It is important to note that the EWL is the name of the software used to create reports. Reports include those that track Veterans waiting to schedule an appointment for clinical care, as well as administrative requests. The most common administrative requests are Veterans who are already receiving care and prefer another provider within the same health care facility area such as from a primary care provider at the main facility instead of one at a VA Community Based Outpatient Clinic (CBOC). There is no other

health care system that VA is aware of that tracks transfer requests at a regional or system-wide level, it is tracked locally.

EWL was developed in 2002 by the VHA Office of Informatics and Technology in response to a rapid increase in demand for clinical services. After 2014, VA made the decision to track these administrative requests using EWL software. These administrative requests are not included as part of wait list numbers because these are requests from Veterans who are already receiving care. Due to recent media reports of a whistleblower indicating issues with EWL, we conducted a top to bottom review, and while no Veterans were harmed while on the administrative EWL, this review has allowed us to streamline processes and eliminate confusion for VA staff and Veterans.

We are developing plans to phase out use of EWL altogether by offering Veterans the choice of care in the community or to be scheduled for an appointment that could be more than 90 days (patients waiting this long do not have an urgent clinical need, i.e., waiting more than 90 days for an optometry appointment to get new prescription eyeglasses) in the future. Because we respect and value our patients' preferences, VHA is both implementing new scheduling software that can track these requests and identifying new tools to track transfer requests until the new scheduling tools are in place.

Culture of Accountability and Transparency

Since 2014, VHA established an organizational structure, assigned responsibilities, and delegated authority to ensure multi-level oversight of access objectives. VHA's Office of Veterans Access to Care (OVAC) is the primary responsible program office that provides national oversight and direction for improving access to care. OVAC is headed by a Senior Executive Service-level Assistant Deputy Under Secretary for Health.

VA's Access to Care website (https://www.accesstocare.va.gov/) was created in 2017 to transparently provide helpful information on topics including wait times, patient satisfaction, and quality. Measuring the time a new patient waits for an appointment from the date the appointment request was initiated is a more objective way of measuring patient wait times. For the majority of our appointments, those with established patients, measuring from the date the patient says he or she wants to be seen is a better indicator for patient experience. This information assists Veterans with decisions about where they can receive their care in a timely manner. This is a widely used website with millions of hits.

Additionally, VHA created the Health Improvement Center to track and trend performance in terms of quality, access, safety, and Veteran experience across multiple indicators and to identify medical facilities with unfavorable data trends or those not meeting goals and targets. In response to data trends, VHA contacts sites of concern or those not meeting targets and mobilizes a team of experts as needed to provide collaborative on-site consultation and follow-up to ensure progress is made and to support ongoing process improvement.

Scheduling and Training

Since 2014, when reports indicated that VHA needed improvement in scheduling processes and scheduler training, OVAC took the lead to modernize VA's approach to scheduling appointments and consults. These efforts have resulted in standardized national processes, national audits, and standardized scheduler trainings. More than 58,000 VHA employees, including Medical Support Assistants (MSA), clinicians, nurses, and health care technicians have completed this training, which includes technical and customer service skills, as well as in-depth training on standard processes and procedures per VHA's scheduling directive. Overall, this has improved access to high-quality care for our Nation's Veterans.

Continuing to Improve

We continue to look at ways to improve how we deliver care, utilizing a team-based approach. Recently, OVAC began implementing a three-phased initiative named Improving Capacity, Efficiency, and Productivity (ICEP) to help facilities, working through Veterans Integrated Service Network (VISN) teams, administrative and clinical staff, along with Group Practice Managers (GPM), to meet the access standards established by VA pursuant to the VA MISSION Act of 2018. As a result, more than 98.5 percent of VA sites have wait times under 20 days for new patients who want a mental health care appointment. This compares favorably to wait times in the private sector.

More than 60 percent of VA sites currently meet the 20-day threshold for new patient wait times in primary care, with the average primary care wait time in 2018 for new patients down to 21.2 days and moving closer to VA's access standards. VA

continues working strategically to help each facility improve in key areas through the ICEP initiative.

In 2016, VHA began offering Veterans the ability to directly schedule appointments in audiology and optometry without a consult from their primary care provider. The following year, VHA expanded direct scheduling to include podiatry, nutrition, prosthetics, oncology, screening mammography, amputee clinic, and wheelchair clinic. Using the Veterans Appointment Online Scheduling application, patients can make and cancel appointments via a smartphone, tablet, or computer. This application has improved customer satisfaction, increased data reliability, and reduced scheduling errors by putting Veterans at the center of their own care. Using this application, Veterans can also request a call from VA to help with scheduling primary care and mental health appointments.

VHA enhanced the VistA Scheduling software to automate the entry of the correct date, which is the agreed upon appointment date between the provider and the patients, directly into VistA Scheduling, eliminating the opportunity for human error in the process. Additionally, in association with the Veterans, Access, Choice, and Accountability Act of 2014, all VAMCs have at least one GPM. GPMs, who are a critical field position supporting Veteran access and every facility, coordinate with OVAC and their local team to implement best practices to improve scheduling processes and increase efficiencies to reduce wait times. OVAC often works with sites, through GPMs, to help them improve access to care.

Putting Technology to Work

Today's VA is using technology to create opportunities for better access to care, better care overall, and more convenience for our Veterans. For example, in 2018, VHA launched a new software named VEText that enabled us to send more than 98 million text message appointment reminders to more than 6.2 million Veterans. This resulted in significant improvements in no-show rates, decreasing from 13.7 percent to 11.7 percent, creating the opportunity for about 1 million new appointments for Veterans who needed to be seen. In 2019, VHA began offering earlier appointment times for Veterans when slots become available through the VEText software, resulting in over 3,800 rescheduled appointments to date because of this technology.

VA has invested in telehealth, providing Veterans the option of virtual visits using a smartphone, tablet, or laptop, resulting in more than 1 million video telehealth visits in Fiscal Year 2018, a 19 percent increase in video telehealth visits over the prior fiscal year. Networks are creating virtual care hubs for primary care and mental health coverage. The hubs are established in more than half of the country and will be nationwide in 2020.

Better Integrated Care - The VA MISSION Act of 2018

The VA MISSION Act of 2018 strengthens VA's health care system by improving both aspects of care-delivery - internal and community care - and by empowering Veterans to find the balance in the system that is appropriate for them. We believe VA's new Veterans Community Care Program is already working better for Veterans, their families, and providers.

More Veterans are now eligible for community care, allowing them to choose care in their community if that is their preference. Scheduling appointments is easier, and care-coordination between VA and community providers will be better. With implementation of the VA MISSION Act of 2018, Veterans have more ways to access world-class care through VA than ever before, and the data show that Veterans are choosing VA health care in record numbers. Veterans continue to tell us they trust us with their health care. VHA is completing more medical appointments than ever before, even as the total population of Veterans is shrinking.

Conclusion

Veterans' care is our mission. We are committed to building the trust of Veterans and will continue to improve Veterans' access to timely, high-quality care from VA facilities, while providing Veterans with more choice to receive community care where and when they want it. Your continued support is essential to providing this care for Veterans and their families. Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.

Prepared Statement of Kenneth W. Kizer, MD, MPH

Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for the opportunity to appear before you today to comment about assessing and tracking wait times and timely access to care and the evolving nature of what access to care means in a world that is increasingly connected by advanced communications and information technology. Thank you also for asking me to offer some thoughts about steps that the Department of Veterans Affairs (VA) might take to improve the transparency and availability of its wait time data to assist veterans make informed choices about where to receive care.

My comments to you today are informed by my prior experience in multiple different professional capacities in which assessing access to care was an important part of my duties. Among others, these roles have included serving as:

- A physician in military, private practice and academic health care settings;
- California's top health official where my responsibilities included managing the nation's largest Medicaid program (Medi-Cal), as well as numerous public health programs serving disadvantaged populations;
- VA's Under Secretary for Health for five years in the late 1990s, where I oversaw an internationally acclaimed transformation of VA health care, which included materially improving access to care and decreasing wait times;
- Founding President and CEO of the National Quality Forum, a public- private partnership organization which endorses performance measures that are widely used today by health plans and insurers, health systems and individual health care providers throughout the nation;
- Chief Medical Officer for the California Department of Managed Health Care, where my duties included assessing health plan network adequacy to ensure time////ly access to care;
- Director of the Institute for Population Health Improvement at the University of California, Davis, where, among other things, I oversaw programs and research studies aimed at improving access to care; and
- A health care consultant to various private and publicly funded health systems seeking to improve access to care, including the Los Angeles County Department of Health Services which manages the second largest publicly funded metropolitan health system in the nation.

BACKGROUND AND CONTEXT

Assuring timely access to care is widely recognized as an important dimension of high-quality health care and has been a priority throughout American health care for many years. However, consistently achieving timely access to care continues to be a challenge for most health plans, health care providers, patients and families throughout the U.S., as it is in other countries. Wait times for health care vary greatly across the nation, ranging from same day service to waits of many months, depending on the health care provider, the type of service sought, and individual patient factors such as type of health insurance and place of residence.

Except for certain well-defined emergent situations in which time to treatment is definitively linked to care outcomes there are no industrywide standards for timely access to care. Situations in which widely accepted timeliness of care standards exist include time between onset of symptoms and administration of thrombolytic medication in cases myocardial infarction (heart attack) or stroke, the time to surgical treatment in cases of severe trauma, and the time to administration of systemic antibiotics in cases of sepsis. In contrast to these emergency care situations, however, many different sets of timeliness standards are variously used by health plans and health care providers when assessing timeliness of care for primary, specialty, hospital or post-acute care. As a result, numerous different methods are used to assess wait times and access to care, making it difficult to understand and compare the timeliness of care across health systems and among individual providers. Further compounding this, information about wait times for private health care providers are not routinely made publicly available.

A good review of the many different methods used for measuring and tracking the timeliness of care is provided in the Institute of Medicine's 2015 report on patient scheduling and access.[1] Of note, this study was commissioned by the VA.

The problems related to long wait times (e.g., poorer health outcomes; patient inconvenience, frustration and dissatisfaction; and increased utilization and costs due to delayed care, among other things) are well known. As Drs. Jaewon Ryu and

[1] Institute of Medicine. Transforming Health Care Scheduling and Access: Getting to Now. Washington, DC. National Academies Press. 2015.

Thomas Lee succinctly summarized this in an article in the New England Journal of Medicine in 2017 when they said, "When patients wait weeks or months for physician's appointments, bad things happen."[2] Clearly, the goal of all health plans and health systems should be to ensure the timely delivery of care for each patient every time in every setting.

In 2001, in its landmark report Crossing the Quality Chasm,[3] the Institute of Medicine identified six defining properties of high-quality health care - that it be safe, effective, patient-centered, efficient, equitable, and timely. Given all that we know about the adverse consequences of untimely or delayed care, it is ironic that of the defining attributes of high-quality health care, timeliness of care is the least-well studied and least-well tracked as a health care performance metric. Forums such as today's hearing are important in focusing greater attention on better understanding and assuring the timeliness of care.

There are multiple reasons for the widespread problems in timely access to care in this country, and much has been written on this subject. Delving into these reasons is beyond the scope of this statement. Suffice it to say that among the patient-related reasons for delayed care, lack of health insurance or the type of a one's health insurance (e.g., Medicaid) continue to be the most common reasons for lack of timely access to care.

From a health system perspective, however, problems in timely access to care are primarily the result of the extreme complexity of American health care and the generally non-systematic approach to the design, implementation and assessment of patient scheduling protocols and scheduling systems and the absence of national performance standards for timeliness of care. The lack of reliable performance standards that can be used to assess and improve health care scheduling is due in significant part to the technical difficulties in reliably capturing all the data variables that go into accurately measuring wait times and the resultant paucity of good data on which to provide care setting-specific guidance on reasonable timeliness for care.

Measuring wait times seems on one level like it should be very straightforward, if not simple; however, in practice it turns out to be extremely complicated. For example, it is very difficult for scheduling systems to capture all the variables that go into patient preference and how one's preference for when he or she would like to be seen may change quickly and repeatedly due to real life circumstances. Likewise, it is very difficult for scheduling systems to capture clinical issues related to the appropriate urgency of being seen by a clinician. The same presenting complaint or reason for seeking care in different people with different histories and circumstances may translate into very different timeliness of care needs.

Notwithstanding what is said above, and despite the many technical challenges, health systems are developing systems-based approaches to improving access, and there are emerging best practices for scheduling and for improving timely access to care. A number of these approaches are highlighted in the previously referenced 2015 report from the IOM. I am hopeful that additional research and validation of some of these promising practices will soon provide the foundation for consensus standards for timely access to care.

Especially important to note in this regard are patient-reported measures of the timeliness of the care. Increasingly, health systems are finding that among the most useful ways to assess whether they are providing timely care is to ask patients to rate their ability to get the appointment they wanted or to report back on how satisfied they were with the length of time it took to schedule an appointment and whether the person scheduling the appointment seemed to care about them as a person and making sure they were seen as quickly as possible. While not as quantitative as wait time measures, patient-reported qualitative measures are very revealing as to how well a health system works.

Given the inherent difficulties is accurately measuring wait times, many health systems are increasingly relying upon patient reported measures for accountability purposes. They are not abandoning measuring wait times but are using wait times data more for quality improvement purposes. That is, they use wait time targets more for quality improvement than accountability.

I think what is clear from the evidence available today is that to measure and track timeliness of care we need to rely on multiple methods of assessment using a balanced mix of quantitative (e.g., wait times) and qualitative (e.g., patient-reported satisfaction) measures and that more attention needs to be focused on specifying setting-specific timeliness of care performance standards.

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[2] Ryu J, Lee TH. The Waiting game - Why Providers May Fail to reduce Wait Times. N Engl J Med 2017; 376 (24):2309–2311.

[3] Institute of Medicine. Crossing the Quality Chasm. Washington, DC. National Academies Press. 2001.

THE NEED TO REFRAME OR REDEFINE WHAT ACCESS TO CARE MEANS

In considering the timeliness of care and how accessibility should be measured today, we need to ask a basic question about what access to care means in an era of enhanced connectivity through information and communication technologies. In a time when a large proportion of the population accomplishes many critically important activities (e.g., banking) via the internet, why do we continue to view access to health care only or primarily through a lens of in-person face-to-face visits.

Measuring access to care by only counting face-to-face encounters between the patient and caregiver is anachronistic and does not promote patient-centered care.

Indeed, a variety of public opinion surveys indicate that 70 to 80 percent of respondents would welcome the opportunity to accomplish their health care needs through technology-assisted means such as telehealth.

Increasingly, health systems are finding that a large proportion, if not the majority, of patient-caregiver interactions can be accomplished through technology- assisted methods such as telehealth or secure e-mail. For example, Kaiser Permanente reports that more than half of its more than100 million annual outpatient encounters are now completed through various types of telehealth communications. In the same vein, the Los Angeles County Department of Health Services has dramatically reduced wait times for specialty care through implementation of an e-consult program.

The VA is widely acknowledged as a leader in telehealth and virtual care, but I believe it has only scratched the surface of what could be done to enhance access to care through technology-assisted methods. The VA was the first health system in the country to hire a chief telehealth officer when it did so in 1999, and it has made commendable progress in telehealth in the intervening 20 years. However, VA has not fully capitalized on its potential to enhance access to care by combining technology- assisted care with more traditional face-to-face. This remains an unfulfilled opportunity.

A PRESCRIPTION FOR ENHANCED VA ACCESS TO CARE

Mr. Chairman let me close these comments by responding to your request that I offer some thoughts about what VA could do to improve the transparency and availability of wait time data to assist veterans make informed choices about where to receive care. I would preface my suggestions by first noting that I believe the VA health care system has an unparalleled opportunity to become the nation's leader in assuring timely access to care. I believe the VA has the potential to define the future of what timely access to care could and should be.

With the right leadership and technical assistance, I believe the VA could quickly become the nation's gold standard for timely access to care for several reasons. These reasons include the VA being the nation's only truly national health care system, having health care facilities and other care delivery assets in every state - indeed in essentially every major metropolitan area of the country; because it is a federal system that is not encumbered by state practitioner licensure laws, among other things; and because it uses a global method of allocating resources (i.e., payment) and functions as both an insurer and provider so the distinction between cost and lost revenue to providers is much less important than in the private sector. Further, the VA has extensive research and training capabilities that could be applied to evaluating and implementing new methods of access to care.

I believe there are several things that the VA could do to facilitate the transparency and availability of data while making sure that veterans have access to care whenever and wherever they need it. Toward that end, let me note six things here.

One, the VA should set a goal of becoming the nation's leader in assuring timely access to care through a coordinated combination of virtual and in-person care utilizing technology-assisted encounters, face-to-face visits, in-home and group visits, mobile delivery assets, and expanded use of non-physician caregivers, among other means.

Two, the VA should engage the National Academies of Sciences, Engineering and Medicine to help it define what 21st century access to care means and to delineate the key operating characteristics and functionalities required to operationalize the definition.

Three, the VA should enlist the help of the National Quality Forum in identifying and endorsing performance measures to monitor and track access to care in ways that are transparent, reliable and understandable.

Four, the VA should take immediate and aggressive steps to increase access to care through virtual means such as tele-health and M-health. A systemwide initiative should be launched commensurate with implementation of the Mission Act that

would increase the number of encounters by virtual means by an order of magnitude within two years. I suggest that an initial high priority target for such an initiative would be virtual or telehealth urgent care visits.

Five, while the above efforts are in progress, the VA should increase the use of veteran-satisfaction measures of access to care, being informed in this regard by its work with the National Quality Forum. In doing this, VA should use this information, along with the wait times data, within the construct of a health care learning system that uses continuous quality improvement methods to feed information back to the system that leads to continuous improvement.

Six, the VA should call upon its Health Services Research & Development Service to evaluate the most effective strategies and methods to ensure timely access to care that meet the diverse needs of veterans in the many varied communities and settings where veterans live.

Thank you, Mr. Chairman and members of the Committee for the opportunity to appear before you today. That concludes my comments, and I would be pleased to respond to your questions.