IMPROVING ACCESS TO EXTERNAL VA CARE THROUGH ENHANCED SCHEDULING TECHNOLOGY

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

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C O N T E N T S

MONDAY, MAY 5, 2025

IMPROVING ACCESS TO EXTERNAL VA CARE THROUGH ENHANCED SCHEDULING TECHNOLOGY

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

The subcommittee met, pursuant to notice, at 3:01 p.m., in room 360, Cannon House Office Building, Hon. Tom Barrett (chairman of the subcommittee) presiding.

Present: Representatives Barrett, Luttrell, and Budzinski.

OPENING STATEMENT OF TOM BARRETT, CHAIRMAN

Mr. BARRETT. Good afternoon. The Subcommittee on Technology Modernization will come to order. Appreciate everybody who is here today. Appreciate our witnesses for being here and to the members that are here today for this subcommittee hearing.

The purpose of today's hearing is about scheduling and what goes on at the U.S. Department of Veterans Affairs (VA) for Community Care and access to that for our veterans, which is certainly a growing need that is taking place out there to make things more convenient and more conducive to veterans where they are and where they live.

When veterans are referred to Community Care, the scheduling process should be simple, fast, and focused on their healthcare and getting them through in a timely and efficient manner, but for too long that has not been the case. It has been something that has been fraught with inefficiencies, challenges, and a back-and-forth between veterans, the VA, and ultimately the Community Care partner where they are receiving their care.

To schedule an appointment, VA staff must pick up the phone again and again often calling the veteran and the provider multiple times to schedule an appointment. It is a tedious, manual, multi-step process that can stretch over hours into weeks, delaying care for the men and women who earned it. It is inefficient and unsustainable.

Community Care is VA care and will remain a critical component of effectively delivering veteran healthcare.

Approximately 2.8 million veterans used Community Care in 2023 alone, and the outdated telephone model for scheduling these appointments is being crushed by the volume of requests from veterans for healthcare in their communities.

VA's External Provider Scheduling, or EPS, is supposed to fix that and in many ways it is fixing it. EPS eliminates a large portion of the time and labor intensive aspects of Community Care scheduling by giving VA schedulers direct access to a provider's appointment availability, allowing them to directly interface with them to schedule their appointments.

Through EPS, providers agree to share their scheduling grids with VA and allow schedulers to search and sort appointments by distance, drive time, availability, and more. With available Community Care appointments on one screen, a VA scheduler can book the appointment directly with a Community Care provider with just one call to the veteran.

The average schedule for an appointment using EPS is 7 minutes. Without having to rely on making multiple phone calls, some schedulers have been able to book up to four times as many appointments per day. Spending less time scheduling each appointment means VA schedulers can be more efficient, and veterans can get their appointments faster.

Here is the problem: EPS is only active at about 20 percent of VA medical hospitals. Some facilities have only had EPS for a few months. While the program is adding new providers almost every day, there are roughly 6,000 provider services currently active in EPS, and that number will need to keep growing if the program is going to reach its potential.

Provider participation is absolutely critical. EPS is only a few years old, and I understand that it takes time to adopt new technology, and certainly we have had issues of healthcare delivery since the pandemic that have complicated rollouts in technology modernization and all kinds of things.

With strong leadership and a commitment from the VA, I fear that this will be yet another Information Technology (IT) project that withers on the vine with unrealized potential to improve veterans' lives. Without strong leadership, that could be the outcome.

Despite EPS' promising results, the Biden administration repeatedly placed roadblocks in front of the program. In 2024, VA paused recruitment of community providers into EPS, deactivated sites where EPS was already up and running, and canceled plans to expand nationwide, all while blaming fake budget shortfalls.

Turning off EPS at active sites does not just hurt veterans. It burns bridges with the community providers who may not trust VA to follow through again later.

The technology works, and this subcommittee is not going to allow the VA bureaucracy to stand in the way of its own success.

As the demand for Community Care continues to grow, VA cannot afford to continue scheduling millions of appointments over the phone.

EPS is not just about scheduling faster. It is about reducing administrative burdens on VA staff.

We are fighting every day to keep pace with scheduling Community Care appointments on behalf of veterans that the VA serves.

It is about letting veterans make informed decisions by comparing VA and community provider availability.

It is about honoring the basic promise that when a veteran needs care the system does not stand in the way.

That is exactly what House Republicans are focused on and why this subcommittee hearing is so important to me.

With the Trump administration in place, I expect VA to tell us what their plans are to reverse the Biden administration's protocols and expand the program to the rest of the VA, in addition to what they are doing to bring more Community Care providers into EPS.

With strong leadership from the Trump administration, planning and oversight from this subcommittee, VA has a real opportunity to improve veterans' lives with this technology.

Thank you again for being here, and I look forward to your testimony.

Before I turn it over to the ranking member, I just want to say from a personal standpoint I had an issue with this not long ago where I was called by a provider vendor about scheduling an appointment and I gave them dates that I was not available because I was going to be here, not at home in Michigan, and they turned around and scheduled me an appointment on a date where I was not even going to be at home.

When I called to inquire about that, they said, "Well, our protocol is if we cannot get you scheduled on a date that you have requested, our procedure is to give you the next available appointment date."

Well, that did not help me, and I am questioning, all right, well, now I am calling into this call center, which is taking up some other person's time on the other end of the phone to try and schedule this, and it does not ultimately yield the outcome, what the purpose of this is, which is supposed to schedule the veteran for the care that they have been scheduled or referred for. They said it was about meeting their required metrics with the VA.

This turned into a whole kind of chaotic thing. In fact, the culmination of this was they called me one morning when I was actually at a breakfast with members of this committee with Secretary Collins, and I was very tempted to just put this on speaker phone and see how it played out.

Anyway, there are certainly a lot of efficiencies to be had, a lot of lessons to be learned. I want to make sure that we are not looking at this through a clear, "if this, then that" metric-driven mindset and more of a how do we get this veteran the appointed time that can work for them, meet their schedule, and meet the outcome of actually getting them the care that they have been referred to.

With that, I will refer it over to the ranking member for your remarks.

Thank you again for being here.

OPENING STATEMENT OF NIKKI BUDZINSKI, RANKING MEMBER

Ms. BUDZINSKI. Thank you. Thank you, Chairman. Thank you for sharing that.

I want to also thank the witnesses for being here today. I, too, look forward to this afternoon's conversation about referral management and VA's modernization effort for Community Care scheduling with the External Provider Scheduling solution, or otherwise as we have been referring to it as EPS.

While I have grave concerns about the expansion of Community Care supplanting VA's ability to provide direct care, there is no denying that it is an important tool in ensuring veterans' access to healthcare, especially in rural America.

It is incumbent upon Congress and VA to ensure that both Community Care and VA direct care are properly resourced so that one does not diminish the other.

I am concerned that the technology that helps these programs run will be undermined by the Trump administration's proposed cuts of almost half a billion dollars to the VA's IT budget in Fiscal Year 2026.

That being said, VA's current practice for scheduling Community Care appointments is archaic and time consuming.

Referral management personnel call around looking for available appointments with Community Care, as the chairman talked about, and then coordinate with the veteran to find the right slot, added at the right time, in the right location, with the right doctor. Then they gather the appropriate medical record data and transmit it—frequently using a fax machine—to the Community Care provider.

I have heard this process averages around 20 days. That is an incredibly lengthy process given that it is in addition to the wait times many providers already have.

We can and must do better for our veterans.

WellHive boasts that through their system they connect Community Care provider calendars with VA referral management teams. The scheduling process can take as little as 6 minutes. That is great to hear. I hope the subcommittee can work with our Health Subcommittee colleagues to address the rest of the process.

To be clear, the technology is only one part of the solution. We should also be looking at the workflows leading up to the point of scheduling.

For instance, how can we help VA streamline tasks, like eligibility reviews, the development of the referral document, and the transmission of clinical documentation?

How can we improve the training and guidance provided to essential referral coordination teams to ensure they are able to do their jobs adequately?

How can we make appointment scheduling faster and easier for veterans?

How can we improve the workflows before and after the point of scheduling so that veterans are not sitting around just waiting for an appointment to be scheduled?

We owe it to our veterans to speed up this process so that they are receiving timely access to the care that they need and they deserve, whether that is at a VA facility or a community provider.

WellHive is only as effective as the network of providers connected to the tool, which has been inconsistent across the 34 sites currently using the solution. I have heard that some sites have hundreds of providers signed up while last fall at least one site only had two.

I hope to better understand the gaps in this network and what VA and WellHive plan to do to address it.

I look forward to hearing from our departmental employees here today, vendor partners like WellHive, and those organizations that bring community providers into the fold, like Mr. Hansen, on how we can further engage providers on the WellHive system.

Additionally, Congress has been calling for the VA to be able to provide an apples-to-apples comparison of wait times in VA direct care versus Community Care.

WellHive has that capability, so I would urge VA to utilize it. For example, with this tool, veterans could know that VA's first available appointment is in 22 days, making them eligible for Community Care. EPS' fully integrated scheduling solution might also tell them that the first available appointment in the community is in 35 days.

VA should give veterans that fuller picture of their options. This would let the veterans themselves make the informed choices among available Community Care appointments and VA direct care appointments.

Community Care is a critical tool for ensuring veterans' access to care, but for large swaths of our country community access is not any better than the VA access. VA has always struggled to communicate that to veterans because it did not have the tools to back it up.

As we work to modernize the Department of Veterans Affairs, veterans should be able to make decisions about their healthcare with the full breadth of information available.

Providing that access means ensuring veterans are educated on their options, the VA is adequately staffed and funded, modern systems are in place, and VA's employees know how to use them.

I thank the witnesses for being here, and I look forward to our conversation today.

Thank you, Mr. Chairman. I yield back.

Mr. BARRETT. Thank you, Ranking Member Budzinski. I think we both gave our remarks in just slightly more time than it takes them to schedule an appointment with their system. Look forward to hearing more about that.

I will now introduce our witnesses.

From the Department of Veterans Affairs, we have Dr. Lisa Arfons—did I say that correct, Doctor? Very good—Acting Deputy Assistant Under Secretary for Integrated Veteran Care.

That is a great title. Look forward to hearing from you.

Also joining us today is Mr. Chris Faraji, President of WellHive.

Is that right? Did I say your name correctly? Very good.

Finally, we have Mr. Jed Hansen—I did not have to ask on that one—Executive Director of the Nebraska Rural Health Association.

I will ask all the witnesses to please stand and raise your right hands.

[Witnesses sworn.]

Mr. BARRETT. Thank you.

Let the record reflect that all witnesses have answered in the affirmative.

Dr. Arfons, you are now recognized for 5 minutes for your opening statement on behalf of VA. Thank you again for being here.

STATEMENT OF LISA ARFONS

Dr. ARFONS. Thank you.

Good afternoon, Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee. Thank you for the opportunity to testify on VA's work to enhance veterans' experiences through modern and efficient scheduling technologies.

My name is Dr. Lisa Arfons, and I am the acting deputy assistant under secretary for health for integrated veteran care. My testimony today will focus on the External Provider Scheduling program, its successes, its opportunities for improvements, and VA's plans for expansion.

Since the enactment of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, VA has significantly expanded veteran access to healthcare. As of this past March, we have provided over 39.6 million Community Care referrals to more than 5.4 million veterans.

To improve service delivery, VA is focusing on innovations that put veterans first. EPS is an initiative aimed at improving veterans' experience and access to care through enhanced scheduling technology.

Recognizing the urgent need to prioritize veterans, this administration, under the leadership of Secretary Collins, reinforced the need for quick EPS implementation. In just the first 100 days, we expanded EPS from 16 sites last fall to 36 sites today, rapidly improving access and bringing more facilities and providers online.

VA recognizes the need to provide veterans with clear, concise, comparable information about their healthcare options, whether within VA or in the community. To support this goal, VA's exploring EPS capabilities for both VA direct and Community Care scheduling, furthering the Secretary's commitment as promised under the VA MISSION Act.

EPS allows VA staff to schedule veterans directly into available Community Care provider appointment slots through a single user interface, seamlessly connecting veterans to Community Care providers.

This single user interface displays provider availability and reduces back-and-forth communication delays. By providing detailed information on who, where, how, and when care is available, EPS helps veterans make timely and informed decisions about their healthcare.

Early examples demonstrate key benefits of EPS, including an enhanced veteran experience, streamlined coordination, and strengthened partnerships.

As of May 1, EPS has been successfully implemented in 36 VA medical centers with 18 medical centers scheduled to go live by the end of this fiscal year. Over 6,000 provider services are active in EPS across 62 specialties.

To realize the full capability of EPS, we do recognize the need for better change management and training. VA developed an online training program enabling VA staff to take the training as needed. The EPS team also provides office hours and immediate live support for those users requiring assistance.

Implementing EPS has presented many opportunities, particularly in onboarding Community Care providers. Many providers are understandably concerned about new systems integrating within their existing workflows and whether additional training or resources will be required.

We have addressed these concerns by demonstrating that EPS eliminates the need for phone calls, minimizes burdens on administrative staff, and streamlines the Community Care authorization process.

Providers retain control over their scheduling system visibility and they are able to display as many appointments as they wish.

This approach benefits providers and puts veterans first by mitigating barriers to accessing the healthcare choices they have earned.

In conclusion, the EPS program is no longer an experiment. It is a proven tool of fundamentally transforming how veterans access care.

Thanks to renewed focus and leadership, EPS is now reaching more veterans, at more sites, faster than ever before.

We are committed to building on this momentum, expanding EPS nationally, and continuing to refine the system based on real world feedback from veterans, VA staff, and community providers.

By removing barriers, minimizing delays, and placing veterans at the center of the scheduling process, EPS helps deliver the timely high quality care veterans deserve.

We look forward to working with the subcommittee to ensure continued improvements in the scheduling process and overall care for veterans.

Thank you for the opportunity to testify today. I am prepared to answer any questions you may have.

[THE PREPARED STATEMENT OF LISA ARFONS APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Doc. I appreciate that.

The written statement of Dr. Arfons will be entered into the hearing record.

Mr. Faraji, you are now recognized for 5 minutes to deliver your opening statement on behalf of WellHive. Thank you again for being here.

STATEMENT OF CHRIS FARAJI

Mr. FARAJI. Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee, thank you for the opportunity to testify today.

WellHive is a healthcare software technology company and we are proud to support the Department of Veterans Affairs through our role in the External Provider Scheduling program. Our fundamental goal is to partner with VA to modernize scheduling, improve care navigation, and ensure veterans receive timely, high quality healthcare.

Our platform seamlessly integrates across health systems, providing real-time visibility and access to provider schedules into a single intuitive interface, much like how platforms such as Expedia simplify finding and booking travel.

The journey to modernize scheduling for Veterans Health Administration (VHA) began with a pilot program launched in 2020. This pilot, starting in Orlando, Florida, and expanding to Columbia, South Carolina, sought to answer critical questions. Can this technology work reliable with VHA? Is it scalable? Most importantly, does it enable faster access to care for veterans?

A structured evaluation process, including input from integrated project teams and industry Request for Information (RFIs), confirmed the potential and led to a competitive award of the External Provider Scheduling contract to WellHive in September 2023.

In my February testimony, I emphasized the importance of aligning people, process, and technology. Today, under Secretary Collins' leadership and with bipartisan support of Congress and these committees, we are finally seeing that alignment deliver real progress for veterans through the External Provider Scheduling.

This program is fundamentally transforming how the VA connects veterans with Community Care. By offering real-time scheduling visibility across their vast, diverse provider network, including major health systems, academic affiliates, and individual practices, it empowers VA scheduling teams to act faster with greater insights. This significantly reduces veteran wait times and delivers a more veteran-centric experience.

Yes, like many ambitious initiatives, the External Provider Scheduling program has faced challenges since its award, including shifting priorities and coordination issues. Despite these hurdles, the underlying technology has consistently delivered on the original commitment to reduce wait times and enhance the scheduling process for veterans, VA staff, and Community Care providers.

Now, with renewed commitment and strong leadership, we are seeing significant momentum. This program is currently live in 36 VA medical centers across the Community Care Network regions and is on track to expand to the additional 18 VA medical centers with the potential for nationwide implementation by the end of fiscal 2025.

These results are clear and measurable, demonstrating tangible benefits. The average time to schedule an appointment using EPS is 7 minutes. We are seeing up to a four-times increase in productivity for VA staff using the program even without critical integration in the VA systems.

Since January, active provider services participating in digital scheduling through EPA have increased at a rate of 21 percent month over month.

Most importantly, appointments scheduled through EPS have increased by 121 percent in the first 4 months of this year. This means veterans are receiving care faster.

Community providers are also finding the model transformative and are actively participating. As one partner shared, "Partnering with WellHive has improved our scheduling process and has increased timely access to care for our veteran population."

This program has a strong backing from key stakeholders, including leading veteran service organizations and state directors who recognize its critical role in reducing delays and enhancing care navigation.

EPS is also paving the way for future advancements, such as integrating VA and Community Care scheduling into a single view, offering that apples-to-apples comparison which ultimately gives the veterans choice.

Achieving widespread veteran self-scheduling is enabled by a nationwide rollout of this program. Think of it as laying the digital tracks. The more tracks you lay across the country, the more veterans can ride the self-scheduling train.

This year, in collaboration with the VA.gov team, the program is helping VA make significant advancements in fulfilling the Cleland-Dole Act by introducing self-scheduling pilots in July 2025.

Before concluding, I would briefly like to address some of the comments that were made by the chairman and the ranking.

Mr. Chairman, you mentioned that your preference is that you had to provide to that call center agent or that Medical Support Assistant (MSA) was cumbersome, right, and having EPS on that phone call would have prohibited the back-and-forth, because you would have been able to make informed decisions, and that is what a lot of veterans are experiencing today with EPS.

Ranking Member, you mentioned about key integration with things like the referral management system. We also truly believe that that integration will help also streamline the process.

The External Provider Scheduling program is no longer just a promise. It is a proven, scalable solution addressing one of the VA's most persistent challenges.

Under Secretary Collins' strong leadership and with the enduring bipartisan commitment from Congress, we can and will fulfill the promise that this program holds, delivering timely, effective care for every veteran across the Nation.

Thank you again, and I look forward to your questions.

[THE PREPARED STATEMENT OF CHRIS FARAJI APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you.

The written statement of Mr. Faraji will be entered into the record.

To your point, I think I would have been better off if they had just told me here are three providers you can go through, call them and see if you can schedule an appointment, instead of going through the endless loop. I have some strong opinions about it, as you can probably tell. Thank you again.

Mr. Hansen, you are now recognized for 5 minutes to deliver your opening statement on behalf of the Nebraska Rural Health Association.

STATEMENT OF JED HANSEN

Mr. HANSEN. Thank you, Chairman Barrett.

Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee, thanks for the opportunity to speak with you today.

I am Jed Hansen. I am executive director of Nebraska's Rural Health Association where I work closely with our rural hospitals, clinics, and providers across our State.

I have spent over a decade clinically in emergency care nursing and as a nurse practitioner and more recently as an advocate for improving rural health systems.

I am here today to talk about the External Provider Scheduling program, or EPS as we are calling it, and why it is working for Nebraska's veterans and how it can be scaled nationally.

I first learned about EPS in 2023 during its pilot phases in South Carolina and Florida. I was impressed by the program's approach to streamline scheduling for veterans needing Community Care, and recognizing some of the unique challenges that we face in Nebraska and rural Nebraska, I pushed for a rural pilot.

Thanks to appropriations and policy support from one of our Senators, Senator Fischer, along with Senator Moran out of Kansas, the EPS program transitioned to a national rollout.

In 2024, the Nebraska Rural Health Association, along with our hospital association, launched a statewide effort to raise awareness and support for EPS adoption. We used our association's reach to accelerate implementation with newsletters, regional meetings, webinars, and even a technical session with members of the WellHive team at our annual conference.

Simply, the model is delivering results. Nebraska's two largest academic medical centers, Catholic Health Initiatives (CHI) Health Creighton and the University of Nebraska Medical Center, are actively implementing EPS.

We have 50 independent provider groups that are live today, including those in mental health, optometry, physical therapy, and chiropractic services. We also have 35 critical access hospitals engaged, with eight now in active onboarding.

We have also been fortunate to partner with national organizations like the National Rural Health Association and the National Organization of State Offices of Rural Health, which have both helped amplify EPS awareness regionally and nationally.

Just as importantly, we have maintained strong relationships with our local VA medical center leadership teams in Omaha, our State VA director, and the VA Office of Rural Health, all of whom have been critical partners in ensuring alignment and success.

I would like to share briefly why this matters.

I recently spoke with Mr. Gregory Hake, a Navy SEAL and Nebraska native, and he shared his story with me. He recalled long drives just to receive some basic care in rural Nebraska, something that he said was manageable when he was younger and healthier but now he sees those as potentially devastating barriers for older veterans, particularly those who rely on sometimes inconsistent transportation for services.

Now living in San Diego, Mr. Hake waited 9 months for an Magnetic Resonance Imaging (MRI) through the VA. He describes a system where treatment was only offered on an episodic basis and where specialty care was sometimes inconsistent.

As he put it, many veterans, especially those living in rural areas, are stuck navigating a fragmented, slow-moving healthcare experience when they are already vulnerable.

Unfortunately, I do have other stories to share.

He was, however, very quick to point out when we were talking that this was despite the kind and dedicated providers and staff of the VA.

Based on our experience, I would like to respectfully offer the following recommendations.

One, support our rural providers with Federal appropriations to help offset some of the IT staffing shortages and burdensome interfaces that they face.

Two, look to incentivize academic and tertiary providers with a time-limited enhanced payment model that could possibly speed adoption.

Three, looking to ensure Electronic Health Record (EHR) vendor alignment, especially with those large organizations, such as Epic and Oracle Cerner, to make sure that EPS integration is more accessible and affordable across all care spectrums.

Four, looking to leverage state-level organizations.

Rural health associations such as mine, hospital associations, and State offices of rural health are well-positioned to serve as liaisons for local implementation.

In States like Michigan, your State office is extremely active. In States like Illinois, you have organizations like Illinois Critical Access Hospital Network (ICAHN) that could easily fulfill this work in a similar fashion that we are doing in Nebraska.

Finally, we need to continue to engage our national partners, including the National Rural Health Association, American Hospital Association, and others, and very importantly, to continue to work with local VA teams and the VA Office of Rural Health to make sure that we are providing broad reach and awareness of the program and to ensure that EPS remains connected to the communities it is meant to serve, which are our veterans.

In closing, Nebraska's success shows that national innovation, when paired with local engagement, along with trusted partners, can produce some meaningful results for our veterans.

Thank you for the opportunity to testify, and I am truly honored to be a part of the conversation today.

[THE PREPARED STATEMENT OF JED HANSEN APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you. Thank you for your recommendations as well.

The written statement of Mr. Hansen will also be entered into the hearing record.

We are now going to proceed with questioning, and I will recognize myself for 5 minutes.

I really appreciate, again, the testimony of those of you that are here today.

Starting out, I had a question about the implementation of how WellHive organizes all this.

You sign up basically Community Care partners that will interface with your system, that then a scheduler can look at and see the availability that is out there for a particular veteran for the service that they are referred for.

Is that kind of a starting point of how it operates?

Mr. FARAJI. That is correct. We meet the providers where they are at. They continue to use their EHR systems and we have direct integrations into those systems.

Mr. BARRETT. Is every EHR, the scheduling component of that, is that a portion within the EHR or is that a stand-alone add-on that is usually available?

Mr. FARAJI. It is different from every EHR system and different manufacturers.

Mr. BARRETT. Okay. There is not like one scheduling system that every provider uses. They are all going to be a little bit different.

Is a portion, I guess, or the barrier to entry to get more providers signed up, is it the portal that needs to exist to get your ability to see their availability, is that something you have to code specifically for each individual provider that signs up?

Mr. FARAJI. Really, it becomes more of an awareness issue and understanding the benefits of the EPS platform.

Once providers understand that, it becomes—the technical part is very straightforward. We are merely putting connections in and establishing that so that we are able to see those clinical grids.

Mr. BARRETT. Okay. Then does the provider pay for that technical upgrade, if you will, to be able to interface, or is that done by WellHive?

Mr. FARAJI. There is no charge.

Mr. BARRETT. Okay. WellHive does that.

Mr. FARAJI. That is right.

Mr. BARRETT. You have just got enough people, and you built it for enough systems that you have probably got most of them interoperability-wise figured out at this point?

Mr. FARAJI. Correct. We have a formula of things where we are doing direct. We use partners, et cetera, to be able to make those connections happen.

Mr. BARRETT. Okay. Okay.

For Mr. Hansen, is the reimbursement rate that the VA pays pretty lucrative for rural hospitals? Like, if you have a procedure that is being referred out, obviously you would not want to be signed up in a part of this if it was not something that you felt was at least fair and equitable for the services you are providing.

Mr. HANSEN. Yes. I do not know that there is really much of anything that we would say is lucrative in rural healthcare.

[Laughter.]

Mr. BARRETT. Yes. If I ask any hospital that, they will say no.

Mr. HANSEN. There are certainly drivers, and volume is vitality when we are talking rural healthcare. Really what I found when I am working with our critical access hospital leaders is that is not the driver.

We have a number of our leadership teams where they are veterans or maybe their parent was a veteran or grandparent. Really in any rural community you do not have to go too far until you have that veteran connection. Really, the driver has been that they are wanting to improve access for their neighbors.

Mr. BARRETT. Sure. I know that, especially in rural communities, you might be separated a significant distance from the nearest VA larger facility that would afford you that opportunity then to go more locally and receive that service that already might be pre-

dominantly done through the rural hospital network, but for this one service-connected condition you might be getting treated for at the VA, for example, or something. I know that has happened multiple times in my own district where people have that.

Mr. HANSEN. Yes, that is correct, Chairman.

I can speak to Nebraska. I do not have some of the national data behind me. In Nebraska the average drive time for a veteran to a VA facility is about 39 minutes one way. On average, every rural veteran in Nebraska is going to be eligible under the MISSION Act for care in the community.

Mr. BARRETT. Sure. Okay. Thank you.

Dr. Arfons, roughly how many Community Care referrals were created in Fiscal Year 2024? I assume that is our last year of data that we have available.

Dr. ARFONS. I have Fiscal Year 2024 through Fiscal Year 2025 to date pulled up as of this morning. Fourteen million, just over 14 million.

Mr. BARRETT. Okay. Fourteen million. Has that volume trended up or down in recent years?

Dr. ARFONS. Increased.

Mr. BARRETT. Okay. Do you attribute that more to expanded programs, Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, other things of that nature, veterans coming home and conditions from war on terror service connection, things like that, or do you attribute it more to awareness, more availability of Community Care? Where do you kind of land that mostly? Or all of the above?

Dr. ARFONS. All of the above.

Mr. BARRETT. Okay. Yes. All right. Thank you.

I am running short on time, but I will come back with a few more questions, I am sure.

I want to yield to Ranking Member Budzinski for 5 minutes for her questions.

Ms. BUDZINSKI. Great. Thank you, Mr. Chairman.

Thank you again to the witnesses for your testimony.

As we have been talking about VA modernization, it is really come down to three different topics. It is either people, process, or technology.

I do want to spend a little bit of time in my opening questions on the people part, and so my questions are for Dr. Arfons.

I do remain very concerned about the Trump administration's actions over these last 3 months, and I fear that the VA is now being asked to do even more with less.

In particular, serving on this committee, and the importance of really these technology efforts and the amount of staff and the specialty of the staff, the technology staff, the IT staff that we need to successfully get these off the ground. Very concerned about those.

I was just curious if you could answer: Were any of the individuals with these referral coordination teams impacted by the probationary terminations that happened back in February?

Dr. ARFONS. The referral coordination team members are facility staff, so I cannot speak to that. I can take for the record.

Ms. BUDZINSKI. Okay. Would you know if any of those staff were rehired at all if they were probationary and terminated?

Dr. ARFONS. I would not know that either because they are facility staff.

Ms. BUDZINSKI. Okay. Have any of the individuals with the teams been targeted under the Secretary's reduction in force that you know of to plan to cut the VA's workforce by the additional 15 percent?

Dr. ARFONS. No, not that I am aware of.

Ms. BUDZINSKI. Okay. How many people in these teams have opted into the Deferred Resignation Program that you might know of?

Dr. ARFONS. I have no numbers related to that either. It is all facility led.

Ms. BUDZINSKI. Okay. Have referral coordination team positions been exempt from the hiring freeze?

Dr. ARFONS. I am not aware of that. In general, our frontline staff are exempt.

Ms. BUDZINSKI. Okay. Then a couple other questions.

What kind of assessments has the VA done to ensure that VA medical facilities have the necessary staff to support the rollout of the EPS system beyond the pilot sites?

Dr. ARFONS. We work closely with sites when we are looking to see their readiness. It is really two sides of one coin.

The first is assuring that sites themselves are ready. We look at their referral patterns, where they need assistance in terms of their workflows, referring veterans out, and what sort of leadership support that we have.

The other side of the coin then, of course, is matching it then with the provider network and assuring that we are able then with WellHive support to have at least enough providers on the network to start so we can begin to see with new go-live how we are able to use the system and then integrate it more fully.

This is a continuous process. We do not go live and leave. We continue to follow metrics. We look at veteran and staff feedback to ensure that we are rolling out correctly and then adjust if needed.

Ms. BUDZINSKI. Okay. As a part of that assessment that you make, do you take into account then my concerns around the Deferred Resignation Program, any impact that that might have on the assessments that you are making before a site goes live?

Dr. ARFONS. We have not incorporated that.

Ms. BUDZINSKI. Okay. Okay.

Then I have another question for you. This is more on the data side of things.

Dr. Arfons, prior to the WellHive pilot, how many days did it take from order placement to appointment scheduling for a Community Care referral?

Dr. ARFONS. If I can answer that a little bit differently. What we see at the sites that have gone live for those referrals that are being scheduled, using traditional means, it is taking on average about 33 days.

For those staff members, the veterans then who are scheduling referrals using EPS, it has cut that down by about a week to 25 days.

Ms. BUDZINSKI. Okay. Okay.

Then my next question is for Dr. Faraji.

As you connect Community Care providers to veterans, what kind of information do you share with the veterans as it relates to that provider?

Mr. FARAJI. Thank you for the question.

Right now the MSAs facilitate that conversation with the veteran, and they are using EPS to populate the information of the providers, their availability and what works best for them, where it calculates the drive time and distance.

Ms. BUDZINSKI. Okay. Does it share—do they share any information as far as, like, how much work that that provider has done with the veterans community, any of the specific training as it relates to military sexual trauma awareness, Post-Traumatic Stress Disorder (PTSD) awareness, things like that that that provider might have had experience with? Do you share that knowledge with the veteran when you are making the referral?

Mr. FARAJI. Thank you for that question.

The EPS program does not have those details inside the platform. It is primarily providing the information for availability——

Ms. BUDZINSKI. Scheduling. Yes, of scheduling.

Mr. FARAJI. That is right. The platform has an abundance of capabilities, but right now at that time is what it provides.

Ms. BUDZINSKI. Okay. Okay.

Oh, I am sorry. I am over time. I will come back.

I yield to the chairman. Sorry. Thank you.

Mr. BARRETT. Thank you, Ranking Member Budzinski. We will have more time for more questions as we go through.

I want to recognize Mr. Luttrell for 5 minutes.

Mr. LUTTRELL. Thank you, Mr. Chairman.

I am going to piggyback off your earlier statement.

Mr. Faraji, we have an institution in the State of Texas that we engage with about EPS, and their response was we have multiple scheduling platforms inside our organization and we are looking at EPS for the veteran space.

I do not understand the roadblock. Is that different institutions not wanting to onboard something because of complexity or is that just out of sheer laziness? I am going to say it that way.

Mr. FARAJI. Sir, thank you for the question.

Every health system, provider practice, they all work in different ways. Sometimes it is a very straightforward conversation. Sometimes it requires a multitude of people to be able to provide that integration and show the availability.

Mr. LUTTRELL. Dr. Arfons—actually, this is probably going to be for you, too, Mr. Faraji.

We have 36 sites that are going to be—we are going from 16 to 36, correct, 18 sites going live this year? Did you say that?

Dr. ARFONS. We are at 36 right now and going up to 54 by the end of the fiscal year.

Mr. LUTTRELL. Dr. Faraji, you said potentially all of our VA sites, correct, 170-plus? That is the idea, correct?

Mr. FARAJI. At this time it is the 36 and 18.

Mr. LUTTRELL. What is our projection to get every single site uploaded and on board?

Dr. ARFONS. VA is working through that right now.

Mr. LUTTRELL. You got to give me something better than that. How long have you been in this position, Dr. Arfons?

Dr. ARFONS. Acting, since February.

Mr. LUTTRELL. Okay. I am going to make the assumption or assume that the VA is completely on board with WellHive and the implementation of their software program inside the VA system is what we want?

Dr. ARFONS. We definitely recognize the benefits to veterans and connecting them to care sooner, yes, with EPS.

Mr. LUTTRELL. Can you clarify the answer? That sounds like a political statement. Can you clarify that answer for me a little bit more?

I think my concern is that how I understand it is this system works. If it is beneficial to the veterans, I do not understand why we are not moving forward. I am sure the Secretary will be 100 percent on board.

Now, do we have to talk to the individual VA facility to say, "Are you willing to onboard this?" Or is this command and control from the secretarial level, and says, "This is what we are doing"?

Dr. ARFONS. We are going to be continuing to roll out to the 18, so we have a total of 54. We will continue expanding throughout this Fiscal Year and then continuing to look at how those 54 sites have deployed to help guide us into the future.

Mr. LUTTRELL. Mr. Hansen, you kind of command and coordinate all the Community Care facilities inside Nebraska for WellHive, correct?

Mr. HANSEN. I work with our——

Mr. LUTTRELL. You bring all the Community Care facilities to WellHive or bring WellHive to those communities?

Mr. HANSEN. Correct. I provide the information on the EPS program out to our community hospitals.

Mr. LUTTRELL. It is very—is it well received?

Mr. HANSEN. It is. Kind of to maybe tip in a little bit on the conversation, I became aware of the EPS program before our Veterans Integrated Service Network (VISN) leadership team in Omaha did, and so I actually approached them to ask them what their thoughts were on the program.

I wanted to make sure that I was not missing something, because like yourself, it seems like this is just a good program for veterans.

Overall we had very good buy-in at Omaha. I cannot speak to other VAs. I think part of what we are doing——

Mr. LUTTRELL. You are sitting in front of me so just—has any of it blown up? I probably should not say it that way since we are in the House of Representatives. I mean, has any of it failed?

Mr. HANSEN. No. We have not had any points of failure right now. Really there is largely been goodwill with this program. It is just the right thing to do.

Mr. LUTTRELL. Do you have buddies that are just like you in the other 49 States across the country that you are talking to?

Mr. HANSEN. I have a lot of buddies in other States.

There is not really any secret sauce to what we are doing in Nebraska. In Texas you have Texas Organization of Rural and Community Hospitals (TORCH) as an example that would be an organization. I had mentioned the State office in Michigan. You have another private entity like ICAHN in Illinois. Every State has someone that is a good liaison.

Mr. LUTTRELL. You seem to be handling Nebraska, though.

Mr. Faraji, do you have to market this to all the community sites as well as the VA by, with, and through Mr. Hansen? I am sure that is pretty burdensome if you are the one—if you are the two doing it. It seems like something the VA should jump on board with. Is that happening?

Mr. FARAJI. As far as working—yes, we are individually going out and reaching out to providers and we have got a great recipe to that. We have seen a 21 percent increase month over month with the providers being onboarded.

Working with Mr. Hansen is one example. We have been able to replicate that with the Arkansas Hospital Association, which was able to produce similar results with these larger health systems.

It is definitely a team effort, but we are tackling this together.

Mr. LUTTRELL. Thank you. I yield.

Mr. BARRETT. Thank you.

I will recognize myself again. We will do more rounds for members who have further follow-up questions.

Dr. Arfons, I think it was you that said in answer to an earlier question that the average time had gone down from 33 days down to 25, I think.

Did you look anywhere at all about the distance traveled? Like, so going from 33 to 25 days, about a week give or take, depending on the thing you are referred for, that may or may not make a substantial difference to you.

Another aspect of that or another dimension of it that might be more important is the distance traveled or the time available for that veteran to get that appointment more close to home, especially in rural communities like Nebraska or parts of Michigan that I represent.

Dr. ARFONS. No, we have not. We can take that for the record.

Mr. BARRETT. Okay. I would be curious on that. I have only been to Nebraska once. I was in fifth grade. I did go to Creighton, and I saw Ozzie Canseco play a baseball game, minor league baseball game there, Jose Canseco's twin brother. It was definitely a Rural State. I can attest to that.

I am curious, in Nebraska, do you find that there is a suitable partnership between the VA and your efforts to take on some of that Community Care in Nebraska, there is not a hesitation to involve Community Care through the VA system or the VA network?

Mr. HANSEN. I would say largely no. There is always some concern on the speciality side within the VA. That is really not what we are looking to achieve in Nebraska with this, especially in our rural communities.

We want to make sure that things like primary care are covered, things like emergency care. Maybe after they have received special-

ized care at the VA that they can come back and receive their Physical Therapy (PT) in the community.

We are trying to close that gap. If we have an access into our community for that veteran to receive care and if that is where they would like to get care, that is what we are trying to achieve.

Mr. BARRETT. Okay. Thank you.

Dr. Arfons, is there any correlation at all or any thought process behind the kind of integrating this EPS model with the already existing rollout through EHR?

When a facility gets the new EHR rollout, they will also get EPS with it, so we are kind of doing this all at once when we are dealing with change management, or is there no rhyme or reason to how we are doing that?

Dr. ARFONS. As of this point, no. We certainly are open to that. We have gone live in Spokane, as I believe the committee is aware.

Mr. BARRETT. Oh, yes.

Dr. ARFONS. Definitely looking at opportunities for fuller integration with our technology systems, including EHR, so we can realize the benefits of EPS.

Mr. BARRETT. Okay.

Mr. Faraji, following up on my earlier point and Mr. Luttrell's point, let us say I am a large hospital network in Michigan and you approach me about being part of this EPS network and I give you the keys to integrate into my system.

You have got some adaptability that can probably do that. Whether I have EPIC, whether I have Oracle Cerner, whether I have one of the big ones, any large network is going to have one of only a few of these systems in all likelihood.

What if I am the small audiology clinic and I have got one or two practitioners there and we schedule through Microsoft Outlook, or something like that—I do not know if people even do that nowadays, but let us suppose they do—are you able to integrate down to that more small, granular Community Care provider that might not be a large hospital system somewhere?

Mr. FARAJI. Thank you for that question.

The answer, in short, is yes. We look at every site, every health system, every Practice Management System into the example that you provided, and we work closely with those providers and their team to understand what works best for them.

What we will do is we will come up with a plan that says, hey, we are going to do it this way or we are going to do option B, so that we are able to produce their grids, and so they are able to show up with the availability to the VA.

Mr. BARRETT. Okay. To Mr. Luttrell's earlier point about how a provider in his district says, yes, we are looking at adding this type of interfacing or a veterans scheduling, I would imagine, not being in that industry, that you would want one scheduling application for everything so you are not getting mixed up and turned around and double booking and all the other things.

Is it common to have multiple scheduling applications in one practice?

Mr. FARAJI. Again, it really depends case by case. Typically, it is streamlined. In some cases it is not. We do our best to make sure that that is all unified so there is no duplication.

Mr. BARRETT. Okay. All right. Thank you.

I will now turn to Ranking Member Budzinski for another 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman.

I just kind of wanted to pick up a little bit of where I left off. To Mr. Faraji, if WellHive had access to the data on cultural competency, wait times, et cetera, for Community Care providers, would you have the capacity to share that information with MSAs?

Mr. FARAJI. Yes. Thank you for the question.

We will take the direction of VA with what they would like to display and share with the medical support assistance. Our platform is very dynamic and agnostic, so whatever you would like to have us provide, we can do so.

Ms. BUDZINSKI. Okay.

My next question is for Dr. Arfons, then.

Does VA collect any quality of care metrics from the Community Care providers, like data on wait times, the return of clinical documents, and completion of VA's required trainings?

Dr. ARFONS. We do look at some required training completion. We do not collect national-level data on document return at this point. Then other quality data, we are building a more robust quality program.

Ms. BUDZINSKI. For the data that you might be collecting that might be a more fuller picture, would this be something that as the VA negotiates the new Third Party Administrators (TPA) contract, VA requiring the TPAs to collect and report this information to the VA, would that be possible?

Dr. ARFONS. I cannot speak to any acquisition-sensitive work right now, but we are definitely looking at what is most important to deliver quality care to veterans in direct and Community Care.

Ms. BUDZINSKI. Okay. Okay.

As I stated, I think it is really important for veterans to be able to make decisions about their healthcare with really the full breadth of information available.

This includes information about the timeliness and quality of the care they would be accessing. I appreciate I did not hear a no, so maybe there could be some room to work out more additional information collected.

Can I ask, Dr. Arfons, in 2021, the Government Accountability Office (GAO) released a report that identified approximately 1,600 Community Care providers who were not eligible to participate in the Community Care program, but were included on the provider list anyway.

Has the VA developed the necessary controls to identify such providers that should be removed from the VA's patient care environments?

Dr. ARFONS. Through EPS, we actually run the exclusions list daily.

Ms. BUDZINSKI. Okay. Dr.—I am sorry, Mr. Faraji—does WellHive perform any kind of regular assessment of the providers on its system to measure utilization or other metrics?

Mr. FARAJI. Thank you for the question.

Yes, we do measure utilization of the platform.

Ms. BUDZINSKI. Okay. Okay.

Dr. Arfons, on this point, GAO has also made a number of recommendations to VA that identify the need to establish timeliness standards for care received in the community, like timeframes for when appointments should occur. Many of GAO's recommendations remain open today.

Does VA intend to establish a standard for when veterans' appointments should occur?

Dr. ARFONS. We have that within the direct care system, namely how quickly we would like veterans to be scheduled and have their Community Care referrals processed within our system.

Currently, our network adequacy is not measured by individual Community Care providers, it is done through the TPAs, who then have different standards not related to MISSION Act standards that do outline those requirements.

Ms. BUDZINSKI. Okay. Well, given that, how does the department measure access for Community Care if they do not collect data on when or if appointment occurs?

Dr. ARFONS. We do collect that data. At this point we use it in two ways.

First of all, we have network adequacy standards. We work with our TPAs to understand their performance.

We also use it operationally at medical centers to understand how we can assist sites to improve their data and use their data to guide us to where we can improve people and processes.

Ms. BUDZINSKI. Okay. I understand the VA cannot fully control when appointments occur, but as we send more and more veterans into the community for care, we should have an idea of the quality of care that they are receiving and when they are receiving it.

Establishing guidelines and metrics would help make sure the veterans receive quality care. I really do urge the VA to implement such standards to ensure that veterans can make informed decisions about their own healthcare.

With that, I will pause and yield back, Mr. Chairman.

Mr. BARRETT. Thank you, Ranking Member Budzinski.

Mr. Luttrell, you are recognized for 5 minutes.

Mr. LUTTRELL. Thank you, Mr. Chairman.

Dr. Arfons, I am reading here that in order to schedule a Community Care appointment it takes nine different steps. Is that correct?

Dr. ARFONS. Yes.

Mr. LUTTRELL. With the implementation of WellHive, that is substantially reduced.

Dr. ARFONS. Yes, that is correct.

Mr. LUTTRELL. To how many?

Dr. ARFONS. Steps, I cannot say.

Mr. LUTTRELL. Plus or minus. Nine to three? Nine to two?

Dr. ARFONS. What it cuts out is the back-and-forth.

Mr. LUTTRELL. Well, I think—okay. I am going to speak as a veteran real quick.

There is expectations that I have. I can say we have, because the chairman is a veteran as well. We live and breathe off of that good order and discipline and that proper chain of command and kind of a good infrastructure surrounding us to get us what we want

and what we need. I think we deserve that right serving our military.

I get it, the VA is this big machine. It is. What we are trying to do is drop drill this thing into a point where it is successful.

My question to you is, what does VA consider success since we have nine—and I can promise you, if you are walking around with me in my district talking to all my veterans, one of the things they complain about is this.

I think we are sitting here with the opportunity to course correct this ship right now, and I do not want to kick that proverbial can down the road.

My question is, what does success look like in the VA?

Now, this looks—the conversations that we are having, this seems like this has got 70 percent, hey, if it looks good, we are rolling, that is mission success.

Can you walk me through this?

Dr. ARFONS. Success is always going to be delivering veterans the care that they want when they want it.

Mr. LUTTRELL. You should write that down and put it on a T-shirt, young lady. I got it. That is not what we are doing right now.

Dr. ARFONS. Yes. We are working toward success and this program is moving us toward that.

Mr. LUTTRELL. Now, I am never going to kind of force an answer out of anybody. What my ask is, I think we are kind of positioned to do something great here, and I do not want you to walk out of the room and go back to the VA and this thing die on the vine.

I can assure you, the 40,000 veterans in my community right now are watching this video and they demand the same thing that I would demand as a veteran, and I want to know if this seems solid. Why is not this implementation going to happen the way that it should?

Dr. ARFONS. We have made marked transit improvement since we last presented to this committee in September—more providers, more appointments scheduled, shorter timeliness to schedule—and every month and week we see increase over the prior.

Since September, we have onboarded more than 4,000 providers than we were here in September reporting. Just as of this month, we have made more than 3,000 appointments in EPS, which is more than any month prior.

We will continue to work to not only roll out the additional 18 sites, but also maximize and optimize the integration of EPS at existing sites.

Mr. LUTTRELL. Is this your sole responsibility in the VA? Are you the one in charge of this?

Dr. ARFONS. I am the executive sponsor. I have a team. That is their responsibility.

Mr. LUTTRELL. If I am going to somebody, you are who I am going to be speaking with?

Dr. ARFONS. Absolutely.

Mr. LUTTRELL. I look forward to—I do not even know what month it is now. Let us just say at the end of the year when these 36 sites go up and running and we are in a good place, I look forward to hearing where we have gone and where we intend to go.

Thank you very much.

Mr. Chairman, I yield back.

Mr. BARRETT. Thank you.

I will recognize myself again for 5 minutes.

Dr. Arfons, kind of piggybacking on that, why have not we already gone to every VA facility?

Like, if we know this works, if it is seemingly fairly plug-and-play, I do not want to oversimplify, Mr. Faraji, how the system works, but it sounds like it is not overly complicated to get someone signed up.

What is holding us back from just doing this everywhere tomorrow?

Dr. ARFONS. The redesign of the deployment efforts——

Mr. BARRETT. The what? Can you say that again?

Dr. ARFONS. The redesign, so our plan for deployment efforts in Fiscal Year 2025 that we started in September of this year really focused on fewer number of VISNs; we were able to be more regional and focus then on hopefully making it more attractive to larger providers in the community, provider networks, who then could serve more medical centers within a VISN or even potentially more VISNs given their geographic adjacencies.

This focus on having 6 VISNs rolled out by the end of Fiscal Year 2025, and the sites rolled out there, has proven to be successful given the trends that we are seeing. Then this, then, I think will allow us to plan in the future for further deployment from here.

Mr. BARRETT. Okay. I got some of that. I guess I am confused on a little bit of it. A lot of areas where perhaps you might find a more correlation of need for Community Care are going to be areas that are probably going to have smaller, not larger, providers already embedded in those communities, given the more disparate rural nature that they have. If we can make some assumptions there, why are we focusing so much on bigger providers? That is going to attract a certain segment of the healthcare industry, but what about, like I said, the small provider in my community that I live in, or the one in the town adjacent to mine or the one, two counties over that I also represent that is particularly rural.

Dr. ARFONS. It is still a both/and, we are working with those individual, our smaller providers, through sites, but then looking more regionally to understand if we can then get some of those larger providers because we are covering more sites within a VISN.

Mr. BARRETT. So, if, though, if we know we want to get there, we want to get every VA site loaded into this, and we want to get everybody through, and I guess you could even foresee scenarios where people, probably not as common in

Mr. Luttrell's district, but where I live, and maybe where you do, people spend a considerable amount of time out of State, like people in Michigan travel to Florida. A lot of veterans do that. What if they are in one VISN that has this service and the other one does not? It just—it could get into a weird scenario for people.

To me, it does not seem—like we have the ability, through the work you do, through Mr. Faraji, through the work here on this committee, to just kind of speed this up and get this done. Part of me feels like there may have been an element—I do not want to call it sabotage because that is a pretty strong word—but an element of artificially slowing this down in the last administration

from being rolled out. I want to make sure that we are not encountering that potential slow down or resistance currently. I tend to believe that that is not the case, but then I would like to see us accelerate some of the adoption of this.

Dr. ARFONS. From September, we have not slowed. We have sped up. Definitely. With the sites that we have with the 36 sites, we have continued to learn and optimize our own deployment with every site.

Mr. BARRETT. Could not we roll it out and then add the providers over time instead of saying we want a bunch of providers before we roll it out? It seems like a chicken and the egg thing. Like we roll it out; we get it in place; and then, over time, we add and collectively build more providers that are participating as more veterans become aware of it, as more providers become aware of it, and the thing naturally takes more shape.

Dr. ARFONS. That is what we are doing. With initial deployment, what we have learned, going back to the two sides of the coin, that the timing of having VA staff readiness to work in the system and then having a provider network that then has expectations for us to use the system is key. Focusing on that timing for better integration to go live is very important. I think what we have learned as a lessons learned is misalignment, going out too soon with having a site go live without the provider network, or having too many providers waiting for us to go live on the VA side only hurts further acceptance.

Mr. BARRETT. I have only got 15 more seconds. I want to ask quickly. What is the training, like the amount of time it takes to learn this system? I saw an example of it. It looked pretty intuitive to me, but probably there is some training that goes into that.

For Dr. Arfons, Mr. Faraji, maybe either one of you could explain, from the scheduler vantage point, what is that—what does that look like, and how long does it take because that to me does not seem like it would be a large barrier to getting this done?

Dr. ARFONS. From the VA side, we have an initial 30-minute training. That is all it takes to receive your keys to use EPS. We also, then, it is interactive training that will be about an hour so we can work virtually with teams, so——

Mr. BARRETT. Less than an afternoon still.

Dr. ARFONS. Yes. Yes.

Mr. BARRETT. Okay.

Dr. ARFONS. Yes. Then other opportunities to, after they are logged in and using the system, to improve their abilities.

Mr. BARRETT. Okay. Doctor Mr. Faraji, from the provider's standpoint, it is visible to them; they just see that an appointment got loaded into their system on the back end by somebody else, correct?

Mr. FARAJI. That is correct.

Mr. BARRETT. Okay. All right. Thank you. Ranking Member Budzinski.

Ms. BUDZINSKI. Thank you, Mr. Chairman. Mr. Hansen, I wanted to say thank you for being here. I really appreciated your testimony highlighting some of the unique challenges that it sounds like all of us face representing rural communities and access to rural healthcare. Obviously also highlighting, I think, some of the con-

cerns around potential cuts to Medicare, Medicaid, and other community services.

I just was wondering if you could give the VA and maybe us as Members of Congress advice on just how we can help streamline implementation of programs like EPS, especially when we know that, oftentimes, Community Care providers can be somewhat limited in their resources? Any advice you might have for us.

Mr. HANSEN. Yes. I really appreciate the question, Congresswoman. As we have been going back and forth with questioning, Chairman Barrett actually brought up a really good point about Cerner—Oracle, Cerner, and Epic, and whether you are talking a tertiary center or you are talking a critical access hospital, the services that WellHive are providing are included with the appropriation and the work they are doing. However, there still are interface fees that can be challenging for the smallest to small providers, including some of our critical access hospitals.

Potentially partnering or working with some of our other vendors so that, when they do have an update that is rolling out, so that interface could be more in line or more friendly to connecting with WellHive would be significant or providing some sort of an appropriation to our critical access hospital partners so that they can—so that they do not have to, they are not burdened with, with some of that extra cost.

Then some of it is just good old-fashioned awareness and getting out. We spend an awful lot of time—I live on the eastern side of the State. We will make this 7, 8-hour trek into our northwest panhandle often to work with teams, and some of it is just that, that level of elbow grease that needs to go in to making sure that programs that really matter get out to our communities.

Ms. BUDZINSKI. Okay. Okay. That is helpful.

Mr. HANSEN. I also wanted to—I really loved your idea on the quality initiatives, and that is something that we are starting to look at in Nebraska to make sure that we are doing that apples-to-apples, and we are working to align the VA ambulatory quality measures with some of those that are seen—that we are used to on the critical access hospital side. I am learning a lot, actually, through the questions that you are providing, which I appreciate.

Ms. BUDZINSKI. Thank you very much. Thank you. Can I go back to the VA and Dr. Arfons. Yes. In 2023, I wanted to highlight, committee staff was able to visit WellHive's pilot sites in Orlando and Columbia and saw two different pictures. Looking at data provided to this committee last fall, it seems that the success and use of this tool still varies from facility to facility. How do you account for that variation?

Dr. ARFONS. With any diffusion of innovation, you are going to see a different range of adopters. This is not a surprise. We see this with any initiative that we have.

In terms of Columbia, they were, I think, a little bit quicker out of the gate. Orlando has been more slow and steady and continues to evolve and improve.

As Mr. Faraji mentioned, they both answered in the affirmative the intent of our pilot questions and have been helpful.

They also then have very different veteran populations, community network needs that they are working toward, and so it does

not surprise us. We obviously work toward standardization as much as we can but then have to adapt to the unique facility needs with their unique veteran populations.

Ms. BUDZINSKI. Just following up—you are leading into my next question—one of the things, I think, was observed is that the success—or increased success—was really seen when VA leadership and its employees are adequately engaged in the efforts to recruit Community Care practitioners onto the tool.

As the VA plans to roll out this tool across more VISNs, how do you hope to standardize? You mentioned standardization. How do you hope to standardize these approaches and support the recruitment of Community Care providers?

Dr. ARFONS. One lesson that has been important over the past several months, I think, is the importance of having medical center directors engaged. It is important because, not only are medical center directors leaders within VA, but they also are healthcare leaders within their communities. Many of them have trusted relationships already with community providers. When we approach them—to answer Congressman Luttrell's question, VA does feel it is our responsibility to enroll providers—it helps that they have a trusted voice encouraging them to explore the opportunities for EPS.

Also, medical center directors are setting the culture and the strategy and the tone for their medical centers, and their staff very much look to them to set that direction. Moving forward, I think this will be, continues to be a key piece of the success of EPS moving forward.

Ms. BUDZINSKI. Thank you. I yield back.

Mr. BARRETT. Thank you.

Mr. LUTTRELL.

Mr. LUTTRELL. Mr. Faraji, how many VA facilities do you have on your list to incorporate your software with? You could say all of them, but I was curious if you have a number because we are putting those numbers together right now, and I think it is 1,380 VA facilities across the country.

Mr. FARAJI. Actual VA facilities?

Mr. LUTTRELL. Yes, sir. We are in the VA——

Mr. FARAJI. I am sorry. I do not understand. Could you clarify?

Mr. LUTTRELL. Well, I mean, you are implementing yourself in the VA hospitals, Community-Based Outpatient Clinics (CBOCs) and everything; correct? It is not just the main hospitals. It is all in the rural little CBOCs and satellite campuses?

Mr. FARAJI. From my awareness, it is specific to the actual VA medical centers.

Mr. LUTTRELL. Just the big ones?

Mr. FARAJI. The Community Care, right, which encompasses all——

Mr. LUTTRELL. That is just 172.

Mr. FARAJI. That is correct.

Mr. LUTTRELL. Just 172. My question is, if I was to give you—how do you—I need to bring that back. Off the record. I misspoke. I do not know how to do that officially. Okay. If you had the opportunity to jump in front of—or jump inside of 172 facilities and I said "go," could you do that right now?

Mr. FARAJI. Thank you for your question. What we found, and Dr. Arfons touched on this, is that every site we are learning every time.

Mr. LUTTRELL. I know. I got it. Every one of them is different.

Mr. FARAJI. No, but it is a lessons learned because those lessons learned compound, and we are able to take that to the next site, into the next site. What you are seeing is much more speed behind these rollouts because of everything that we have been able to do, and the preparation.

For us, as far as the technology and making sure that we have everything, the answer is yes. There is other things that have to move behind the scenes, and that is what Dr. Arfons is alluding to with the different people and the training and the providers.

Mr. LUTTRELL. What is the—give me a—can I get a left and right flank on, hey, like if I was to say, "You are coming down into Houston into DeBakey, ready, go," how long would it take to implement your system inside the DeBakey Medical Center?

Mr. FARAJI. We would need to look at the site. We would have conversations. Let me back up a second. When we go to these sites, we are having conversations with the chiefs of Community Care and the staff to understand the data: What are the referrals? Who are the providers that they refer out to——

Mr. LUTTRELL. This is specifically on scheduling alone, right?

Mr. FARAJI. That is right. Yes. We need this information because it is important because what we do is we then take that information and go back to see what we already have in network, and then who do we need to bring on board? Right. To then go reach out to medical centers and——

Mr. LUTTRELL. Bring on board, you mean the Community Care providers?

Mr. FARAJI. That is right. Correct. The Community Care providers.

Mr. LUTTRELL. Would not it be better if you found a facility that did not have that many Community Care providers and implemented your system because then the spiderweb is not that big, instead of going into a facility that has got thousands of them?

Mr. FARAJI. Again, it varies per site.

Mr. LUTTRELL. Quit saying that. Okay. I got it. All right. It varies. I got it a hundred percent. Go ahead.

Mr. FARAJI. Once we—once we have that information at our fingertips, then we are then off to the races, then, at that point. The VA is doing their thing for training, getting the site up to speed, and we are bringing on providers daily.

Some of them are large health systems. Some of them are the small mom and pops that we are bringing online, and those grids start digitally connecting.

In between that, because we have an integration into the provider profile management system, which is the main system that provides the credentialing of all of the Community Care providers, we are able to see all 1.4 million providers inside of——

Mr. LUTTRELL. You have to—Doctor, you said it takes, let us just say an afternoon to train whomever on the system, and then you have to train all the Community Care providers on the system as well?

Mr. FARAJI. No. No. No. There is no training on the Community Care providers. They are going to keep using the EHR that they have always been using.

Mr. LUTTRELL. Okay. I really have no idea why we are not in every single facility right now. This is me looking back at you waiting for somebody to say something.

Mr. HANSEN. Congressman, I can maybe provide a little bit of insight on this. We have two academic medical centers in Nebraska, both are in the onboarding process. One of the facilities——

Mr. LUTTRELL. What day did that start?

Mr. HANSEN. What day did that start? Started last October.

Mr. LUTTRELL. To onboard this?

Mr. HANSEN. It is. With these academic medical centers, the complexity is that they have specialists, subspecialists. They have—they have layers of bureaucracy on their end as well, and it can even vary from medical center.

We have one medical center that has taken the approach to go a full onboard. They are just bringing in—they are doing what you are wanting to do. They are applying the gas pedal, and they are going to move forward with it.

Our other academic medical center feels they have some unique scheduling protocols in place, and so they are going to start with a smaller subset of specialties, like dermatology, ophthalmology, physical therapy, where there is high volume and less complexity to the schedule, and then scale it up.

They are trying to use kind of your spiderweb, where they are starting with some of those high-volume, high-impact areas to relieve backlog in the VA, and then expand out from there.

For critical access hospitals, it is maybe a—it is a slightly simpler process than what we are going to see tertiary, where you have got some of your primary care; you might have some colonoscopies; you might have some PT; and then you have some—maybe you have got a local PT or just medical clinic, and they do not have any of the prior authorizations, prerequisites to get into that specialty.

It can vary, and it is somewhat dependent on the partner, the community partner that you are working with.

Mr. LUTTRELL. Thank you.

I apologize for going over, Mr. Chairman.

Mr. BARRETT. Thank you. I appreciate that.

I am confused a little bit. Dr. Arfons said it takes, let us call it an afternoon, to train a person at the VA to integrate—or interface with this system. You are saying it will take more than 7 months to onboard. You can birth a human in 9 months. I do not know why it takes so long to do that, but it slows down the rollout for this if things are taking 9 months to do it—or 8 months or 7 or however long we are up to from last October. That is hardly giving me confidence that we are going to be able to expedite this or roll it out in a way that will be a meaningful improvement soon.

Mr. HANSEN. Some of those—those were first conversations that were taking place. These are when our academic—like in the case of our academic medical centers, the first time that they are hearing about EPS was last October. Some of those challenges were we did not know which—if Nebraska or VISN 23, which encompasses

Omaha, if that was going to be included in the initial rollout. We thought we were. Then we heard that there were going to be some budget drawbacks, and then going——

Mr. BARRETT. Yes. That is some of the frustration I felt is that there were mixed signals sent about this that I think gave Community Care providers the belief that maybe this is not going to happen; why go through the process of figuring it out if it is not actually going to roll out or get used?

I am hoping, through Dr. Arfons' testimony today, that is hopefully put to rest and that there is full confidence going forward that we are going to integrate these scheduling things in a really expedited fashion or as quickly as possible going forward to hopefully alleviate that.

I had a few more follow-up questions just quickly, too, and I do not want my time to expire. Mr. Faraji, does your software have the capability of exchange referrals and authorizations with Community Care providers?

Mr. FARAJI. Thank you for that question. Currently, right now, VA sends these referral authorizations through fax or secure email. We have to—WellHive's platform needs to move to the next security level, which is high. We just completed our Federal Risk and Authorization Management Program (FedRAMP) high authorization. We submitted our security assessment to VA. They are reviewing it, and that should be completed by fall of this year.

Once that is completed, we are going to take an integral part—key steps into going and working with the referrals, and so, at the point where the scheduled appointment is booked, we will also be including that referral package with the appointment.

Mr. BARRETT. Okay. The upgraded security, I assume that is an industry standard that is pretty clear.

Mr. FARAJI. That is correct. Like the—it is FedRAMP certification.

Mr. BARRETT. Okay.

Mr. FARAJI. Yes.

Mr. BARRETT. That is something that is pre-established. You are not reinventing the wheel doing that. You are just making sure that your protocols are appropriate.

Mr. FARAJI. Correct.

Mr. BARRETT. If that is the case, and maybe this is a question for Dr. Arfons—I do not even know if you have the answer to this—why does it take us through the fall if this is a standardized security measure to get that piece of it done?

Dr. ARFONS. I will just take that for the record back to IT.

Mr. BARRETT. Okay. Then would the—would, I guess for Mr. Hansen, assuming that you could—assuming your security protocol is going to pass, because I assume it is a "if this, then that" kind of thing, Mr. Hansen, would Community Care providers like those that you represent benefit from obviously upgrading these from a fax or a secured email that is basically a PDF of a fax to something that is more electronically delivered with the appointment?

Mr. HANSEN. They would. For a lot of our rural providers, it just comes down to human capital. Any time that you can streamline a process, that is going to help them out.

Mr. BARRETT. Sure. That was an easy one. Thank you. Dr. Arfons, does VA have any plans to utilize EPS software to send referrals and authorizations to Community Care providers, assuming we have the security that meets adequate protocols?

Dr. ARFONS. Yes. We are working with our Office of Information Technology (OIT) partners and looking at that capability.

Mr. BARRETT. Is that the same process that is used to determine the security nature, like where—I get the kink in the hose right now is getting the security authorization. Once that clears, is there another protocol that needs to be passed, or is that the last hurdle?

Dr. ARFONS. There will have to be software integration from there of our systems with WellHive.

Mr. BARRETT. Okay. How, assuming this security, like let us say we start moving that direction because we assume the security measures will be passed, are we going to start integrating then, or can we start building integration models now so that, when the security thing is done, we are already partway ready to go?

Dr. ARFONS. IT dictates that. We can take that back for the record.

Mr. BARRETT. Okay. I would appreciate a little bit of an understanding. I think we can walk and chew gum at the same time on that and maybe have a little bit of a jump start on that. Thank you. Very good.

I will recognize Ranking Member Budzinski for your closing remarks.

Ms. BUDZINSKI. Okay. Great. I have actually just one quick question, and then I am going to move to closing. A question just for Mr. Faraji and Dr. Arfons, do you know what percentage of Community Care Network providers have shared their schedules with WellHive and the VA? Let us start with Mr. Faraji.

Mr. FARAJI. I do not have that number off the top of my head, but we could get that for you.

Ms. BUDZINSKI. Great. Okay. Thank you.

I do want to say thank you to Chairman Barrett, again, and I really do appreciate the witnesses and their testimony today.

Last week marked the first 100 days of the Trump administration, and I do worry that the Department that is now less prepared than ever to modernize its service offerings.

As I had mentioned before, we have focused on all the pieces of the puzzle here, not just the technology. As members of this committee, we must use our role to ensure that veterans have top-of-the-line access wherever they decide to receive care.

We continue this oversight role, and I hope we continue to hear of an adequately staffed and funded VA, clarity in the referral work flows, relieving these teams and veterans of burdensome and prolonged processes, an increase of data being returned by community providers, improving the continuity of veterans care, and that facilities, both VA and those in community, have the resources they need to implement the technology at hand.

I look forward to performing this work with Chairman Barrett, our witnesses today, and, most importantly, hand-in-hand with our veterans.

Thank you so much, and I yield back.

Mr. BARRETT. Thank you, Ranking Member Budzinski.

Thank you to the members for your presence today. I appreciate that.

To our folks here testifying as well, thank you for your participation in answering so many questions.

I want to thank you all for appearing today to provide your expertise on the EPS program. What we heard today was clear, the technology to modernize VA scheduling exists, and it is a proven tool to fix one of the most frustrating barriers veterans face, getting timely access to care. I mentioned this even from a personal experience I had very recently.

This system is simpler It is easier, and it gets veterans scheduled with their doctors faster and with fewer obstacles, and it is making a real difference for veterans of VA staff where it is available. Despite the success in the data, only a fraction of veterans benefit from it, and it appears that there is not going to be a substantial adoption of this for quite some time. Only a fraction of VA medical centers are using it.

If VA is serious about improving access to care and fulfilling the MISSION Act, then it must make EPS a priority and expand it to the rest of the VA. I think that we can look at this as less of a competitive thing between VA and Community Care and more of a comprehensive and collaborative effort to provide care for veterans where they are that suits them best.

Every day VA continues to rely on its outdated scheduling process, thousands of veterans are stuck navigating a maze of phones calls and missed opportunities, and thousands of veterans are forced to wait too long for the care they have already earned and received and been referred for. VA simply cannot continue with the status quo when the technology solution exists that can make a meaningful lasting impact on veterans' healthcare.

Thank you again for your participation in today's hearing. I look forward to working with the Trump administration to make EPS a success for our veterans with each of the stakeholders that are here today as well.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

This hearing is adjourned.

[Whereupon, at 4:25 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Lisa Arfons

Good afternoon, Chairman Barrett, Ranking Member Budzinski, and distinguished Members of the Subcommittee, thank you for the opportunity to testify on VA's work to enhance Veterans' experiences through modern and efficient scheduling technologies. My testimony today will focus on the External Provider Scheduling (EPS) Program, its status, challenges, and future plans for expansion and improvement.

Introduction

Since the enactment of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (P.L. 15–182), VA has significantly expanded Veteran access to health care. The Veterans Community Care Program, launched on June 6, 2019, has been a cornerstone of this effort. As of March 2025, we have provided over 39.6 million community care referrals to more than 5.4 million Veterans. To improve service delivery, VA is focusing on innovations that put Veterans first. EPS is an initiative aimed at improving the Veteran's experience and access to care through enhanced scheduling technology.

Last year, Veterans faced unnecessary delays in accessing community care due to the Biden Administration's decision to pause the implementation plan of the EPS program. This slowdown limited Veterans' ability to quickly and easily schedule appointments with community providers. Recognizing the urgent need to put Veterans first, this Administration, under the leadership of Secretary Collins, reenforced the need of EPS implementation quickly. In just the first 100 days, we have expanded EPS from 16 sites last fall to 34 sites as of today, increasing access, and we are rapidly bringing more facilities and providers online. This renewed commitment reflects VA's belief that Veterans deserve a streamlined, reliable experience when accessing community care. EPS represents a critical step toward ensuring timely access to high-quality health care choices that Veterans deserve.

In addition to expanding EPS in the community care setting, VA recognizes the critical need to provide Veterans with clear, complete, and comparable information about their care options, whether within VA or in the community. To support this goal, VA is exploring EPS capabilities for both VA direct care and Community Care scheduling. This furthers the Secretary's commitment to delivering on the health care choices and transparency promised to Veterans under the VA MISSION Act.

Overview of EPS

EPS allows VA staff to schedule Veterans directly into available community care provider appointment slots through a single user interface, thereby more seamlessly connecting Veterans to appointments with community care providers. This single user interface displays provider availability information in one place and reduces the back-and-forth communication that often contributes to delays in care. By providing detailed information about who, where, how, and when care is available, EPS plays a vital role in helping Veterans make timely and informed decisions about their health care. Early examples demonstrate key benefits of using EPS. Some of these benefits include the following:

- **Enhanced Veteran Experience:** EPS improves access to high-quality care, minimizing the challenges Veterans face when scheduling multiple appointments. It ensures that appointments are made efficiently, taking Veterans' preferences into account. VA Schedulers using the EPS system are booking appointments in less than 10 minutes, compared to up to an hour without EPS.
- **Streamlined Coordination:** Community Care providers and VA staff have real-time updates on rescheduled, canceled, or completed appointments thereby eliminating the need to call and verify status with the providers or Veteran.
- **Strengthened Partnerships:** The EPS system improves coordination between VA and Community Care providers.

Implementation Status

As of April 18, 2025, EPS has been successfully implemented in 34 VA medical centers (VAMC) with 20 additional VAMCs scheduled to go-live by the end of Fiscal Year 2025. Since October 2024, EPS has onboarded over 3,300 provider services. This is more than 60 percent of total provider services since the pilot began in December 2021.

Over 5,200 provider services are active in EPS across over 60 specialties, including primary care, mental/behavioral health, dermatology, optometry, chiropractic care, dental, and orthopedics. EPS continues to onboard new provider services at a rate of over 100 per week, prioritizing based on initial site feedback and referral data.

Training

To realize the full capability of EPS, we have recognized the need for better change management and training. VA developed an online training process enabling VA staff to take the training, as needed. The EPS team provides office hours and immediate live support for users who require assistance.

Enhancing Provider Collaboration

Implementing EPS has not been without its challenges, particularly in onboarding Community Care providers. Many providers are understandably concerned about how new systems will integrate with their existing workflows and whether additional training or resources will be required. We have addressed these concerns through targeted solutions such as:

- **Efficiency at no cost to providers:** EPS eliminates the need for phone calls and waiting for authorization numbers.
- **Control and compatibility:** Providers retain control over their scheduling system visibility to VA, ensuring no electronic health record information is shared except for appointment availability. This integration is designed to be hassle-free, requiring no additional staff training.
- **Immediate authorization:** Referral authorization numbers are provided at the time of appointment scheduling, simplifying administrative tasks and reducing the workload for provider staff.

These features save providers significant time and allow them to maintain their existing systems without incurring any upfront or ongoing fees, making it both an attractive and practical solution. This approach not only benefits the providers but also puts Veterans first by reducing wait times and eliminating barriers to accessing the health care choices they have earned.

Conclusion

In conclusion, the EPS Program is no longer an experiment – it is a proven tool that is fundamentally transforming the way Veterans access care. Thanks to the renewed focus and leadership of the Trump Administration, EPS is now reaching more Veterans, at more sites, faster than ever before. We are committed to building on this momentum, expanding EPS nationally, and continuing to refine the system based on real-world feedback from Veterans, VA staff, and community providers.

By removing barriers, minimizing delays, and putting Veterans at the center of the scheduling process, EPS helps deliver the timely, high-quality care Veterans deserve. We look forward to working with the Subcommittee to ensure continued improvements in the scheduling process and overall care for Veterans. Thank you for the opportunity to testify today. We are prepared to answer any questions you may have.

Prepared Statement of Chris Faraji

Written Testimony of Chris Faraji
President, WellHive
Before the **House Veterans Affairs Committee, Subcommittee on Technology and Modernization** Hearing: *Improving Access to External VA Care through Enhanced Scheduling Technology*
May 5, 2025

Introduction

Chairman Barrett, Ranking Member Budzinski, and distinguished members of the Subcommittee, thank you for the opportunity to testify today. My name is Chris Faraji, and I serve as the President of WellHive, a proven healthcare software technology company supporting the Department of Veterans Affairs (VA) through our role in the External Provider Scheduling (EPS) program. WellHive is committed to working with VA to modernize scheduling, improve care coordination, and ensure Veterans receive timely, high-quality healthcare. Our platform seamlessly integrates across health systems, electronic health records (EHRs), and practice management systems, to deliver real-time visibility and access to provider schedules into a single, intuitive interface. Our approach to modernizing and simplifying healthcare scheduling is similar to what platforms like Expedia have done for travel.

In February, during my testimony before the House Veterans Affairs Committee's Subcommittee on Health, I emphasized the importance of aligning people, processes, and technology so that Veterans receive the timely care they deserve. Now, under the leadership of Secretary Collins and bipartisan support of this new Congress and its Committees, we are beginning to see real progress. Decisive actions are being taken, and the integration of these three pillars is beginning to deliver timely and meaningful care to our Veterans.

Today, I will highlight how the EPS program is transforming care coordination between VA and their Community Care Network (CCN), the measurable impact on Veterans, and opportunities for broadscale optimization.

Background and Historical Development of External Provider Scheduling (EPS)

In 2020, the Veterans Health Administration (VHA) launched a three-year pilot program at the Orlando VA Medical Center, later expanding it to the Columbia, South Carolina VA Medical Center, to test the feasibility and scalability of what is now known as the External Provider Scheduling (EPS) program. This pilot aimed to answer three critical questions:

- Can this technology concept demonstrate utility and reliability within VHA?
- Is it scalable across different VA markets and facilities?
- Does it enable faster access to care for Veterans?

To ensure a thorough understanding of both the challenges and potential solutions, VA implemented a structured and competitive evaluation process. As part of this approach, they

conducted an in-depth analysis of the pilot programs and, at different stages, formed two Integrated Project Teams (IPTs). These teams, composed of experts from VHA, OI&T, and VACO, defined the necessary requirements for modernizing Community Care access.

Following the IPTs' findings, the VHA issued two separate Requests for Information (RFIs) to collect industry input on Community Care Scheduling solutions. This process was designed to ensure that any future system would align with both Veteran needs and VA operational requirements. Input from these RFIs directly informed the development of the External Provider Scheduling solicitation, which was openly competed and awarded to WellHive in September of 2023.

The EPS Program: Modernizing VA Healthcare Scheduling

VA is leading a mission-critical modernization of its healthcare scheduling through the EPS program, with WellHive's Software as a Service (SaaS) platform serving as the foundation of this effort. Now in the second year of a five-year contract, EPS is not merely a technology implementation; it is a critical enabler of VA's core mission to deliver the right care, at the right time, in the right place, with the right provider for every Veteran.

EPS has fundamentally enhanced how VA connects Veterans with Community Care by offering real-time scheduling visibility and access across their vast and diverse provider network. This capability has empowered VA scheduling teams to act faster with greater insights, significantly reducing Veteran wait times and delivering a more Veteran-centric experience. EPS streamlines provider access, strengthens VA's control, and dramatically improves healthcare delivery for Veterans. EPS' expansive provider network includes national groups, major health systems, and individual practices, ensuring Veterans have access to care options regardless of their location or healthcare needs. EPS also offers scheduling for telehealth providers, a benefit that resonates strongly with Veterans in rural communities where in-person care options can be limited. The ancillary impacts are numerous, including the potential to reduce reliance on emergency care, a growing trend when timely access to care is a challenge.

Overcoming Obstacles to Success

As previously mentioned, successful enterprise-wide digital transformation relies on three pillars: people, process, and technology. When technology is proven and effectively addresses its intended challenges, the focus must shift to leadership to provide strategic direction. Strong leadership ensures alignment, execution, oversight, and accountability, while well-defined and repeatable business processes designed to maximize the technology's impact ensure the greatest return on investment and adoption at scale.

Since its award in September 2023, the External Provider Scheduling (EPS) program has faced avoidable challenges, including shifting priorities, lack of coordination, and limited resources. Every time the program gained momentum, unexpected obstacles forced reassessment and adaptation. Without clear leadership and strategic direction, VA Program Management and

front-line staff tried their best to engage in a system they found user-friendly and effective but lacked integration resulting in inefficiencies and unaccountability.

Despite these obstacles, the technology has consistently delivered on its original commitment, to reduce wait times and enhance the scheduling process for Veterans, VA staff and Community Care providers.

Moving Forward

Despite significant roadblocks, the small but dedicated VA team assigned to the EPS program has remained focused on its success. Their commitment to the mission and the impact it has on Veterans is commendable and deserves recognition. However, as noted, for EPS to reach its full potential, systemic changes in leadership and processes are still essential.

Encouragingly, we are seeing a renewed commitment across the agency on improving care for Veterans and strengthening accountability within the Department of Veterans Affairs.

Recent successes within the EPS program reflect this shift. Strong support from the administration, extending from VA Central Office to field leadership and frontline care teams, has driven measurable progress in advancing the delivery of more efficient, timely, and high-quality care to Veterans.

Program Expansion and Training

The program's reach and impact continue to grow with every new site that implements it. EPS is currently live in 36 VA Medical Centers with presence across all CCN regions and is on track to expand to an additional 18 VAMCs with the potential to go nationwide by the end of Fiscal Year 2025. Central to the rollout is dedicated change management and training efforts for Medical Support Assistants (MSAs), field leaders, and VHA staff. Equipping these frontline teams to effectively utilize the EPS platform is essential to maximizing its impact. By prioritizing user adoption and promoting a shared vision, the program advances its goals of increasing scheduling productivity and reducing wait times for Veterans.

Provider Network

A critical component to the success of the EPS program is the engagement and participation of the CCN. As of today, EPS has over 6,000 provider services active in the platform with hundreds of providers joining each week. EPS currently has participation commitments from 54 major health systems, including many VA academic affiliates as well as large and mid-sized practice groups who collectively service tens of thousands of VA referrals annually. For each new implementation, the EPS contract team collaborates closely with site leadership to identify the providers and specialties whose participation will have the greatest impact, using this input to guide provider outreach and engagement efforts. This new model of care coordination has not only been transformative for VA staff and Veterans, but also for the Community Providers who are committed to providing Veterans timely and meaningful care. Below are a few quotes from CCN providers currently participating or actively onboarding to the Program.

"Partnering with Wellhive has improved our scheduling processes, overall care coordination and has increased timely access to care for our Veteran patient population. Their platform is intuitive, reliable, and easy for both our staff and the VA staff to use... We're excited to continue building on this successful partnership and see the enhancements that come down the pipeline to continue making improvements for our staff and our patients".- Ali Worthy, Director of Operations (Veterans and Corrections Health ICCE), Medical University of South Carolina

"I received my first digital referral yesterday as well as 2 others shortly after. I received the faxed referral packets within 15 minutes of the newly booked appointments... I have already contacted the Veterans and can easily take it from here with them. Always happy to welcome new patients, and working with Veterans continues to be one of the most rewarding parts of what I do." -Dr. Nadia Ayadi, DTCM LAc, Owner of East lake Acupuncture in Orlando, FL.

Stakeholder Support for EPS

The EPS program has also received widespread support from key stakeholders who have long advocated for improved healthcare access for Veterans. Over the past decade the oversight committee has taken a bipartisan approach to improving Veteran's access, especially when it comes to scheduling. Its legislative initiatives and strong leadership have been instrumental in propelling the agency forward. Leading Veterans Service Organizations (VSOs)—including the Veterans of Foreign Wars, Disabled American Veterans, and the American Legion—have been strong EPS supporters, recognizing its critical role in reducing delays and enhancing care coordination for Veterans. Additionally, the National Association of State Directors of Veterans Affairs (NASDVA), representing state-level Veterans' agencies, has expressed strong backing for the program, advocating for EPS to be made available for Veterans in their States and Territories. The overwhelming and bi-partisan endorsement across these major service organizations and stakeholders highlights the importance of EPS as a vital component of VA's continued modernization efforts and reinforces the urgency of implementing External Provider Scheduling at a broader scale.

Integrated Scheduling

While currently focused on improving scheduling for community care, VA is actively preparing to extend the platform's capabilities to include VHA direct care appointments. This expanded functionality is driven by bi-partisan Congressional intent and shaped by VA, the priorities of VSOs and Veterans themselves to ensure VA can offer Veterans the most comprehensive and transparent view of their available care options. Through a pilot in January 2023 WellHive successfully integrated over 15 VistA instances across VISNs 7 and 8 into a single application, a capability that provided significant scheduling efficiencies for Clinical Contact Center staff. Building upon the success of this pilot and the EPS program, a new pilot at the Charleston, South Carolina VA Medical Center is currently being considered. In the potential upcoming Charleston pilot, referral teams would have a single, unified view of both VA and community care appointment options and the ability to take immediate action on available appointments and schedule care. This capability would represent a transformative step forward for VA— real-time, apples-to-apples comparisons of care options across both networks. This level of

visibility and access has the potential to dramatically reduce the referral-to-appointment time from days or even weeks to mere minutes, and most importantly, it ensures that Veterans have real, informed choice in their healthcare journey.

Veteran Self-Scheduling

One of the primary objectives of this administration is providing Veterans greater and more convenient options for scheduling their healthcare needs. While some Veterans prefer to book their own appointments directly, others value the familiarity of having VA handle scheduling on their behalf. A critical enabler of self-scheduling across the healthcare industry is a robust provider network willing to make their availability accessible for digital booking. Through the EPS program and the expansion of its digital provider network, VA is establishing the necessary foundation to offer patient self-scheduling in parallel. This year, in collaboration with the VA.gov team and Integrated Veterans Care program office, EPS is helping VA make a significant advancement in fulfilling the Cleland-Dole Act by introducing self-scheduling for community care. Two pilot sites are preparing to go live with this offering in July 2025, representing a critical step toward giving Veterans greater control, speed, and transparency when scheduling care. Veterans will continue to use the familiar VA.gov interface, but behind the scenes, WellHive Application Program Interfaces (APIs) will provide the technology that enables seamless appointment scheduling. Through self-scheduling, Veterans will be able to directly book appointments with participating community care providers, dramatically reducing administrative hurdles and improving access.

Fully Integrated Care Coordination

A unified and fully integrated technology environment is essential to deliver timely and accurate care coordination at scale. EPS' recent integration with VA's Provider Profile Management System (PPMS) now seamlessly incorporates over 1.4 million provider profiles within the platform. This integration has significantly streamlined the scheduling process for staff by providing access to comprehensive provider information and scheduling capabilities in a single application. Without the unification of this data, the VA would face significant fragmentation from various health systems, EHRs, and TPAs, leading to conflict data and confusion for staff, community providers, and Veterans. Unlocking the full potential of EPS requires additional integrations with current VA systems that also play a central role in Veteran care coordination, including HealthShare Referral Manager (HSRM), Consult Toolbox (CTB), and Enterprise Appointment Scheduling (EAS). These integrations are not merely beneficial to the EPS Program; they create a more integrated and streamlined approach to scheduling and navigating care at all stages of the referral and appointment lifecycle. VA staff will be able to access must-needed scheduling information in one system rather than opening up multiple systems and screens that reduce the ability to schedule in a timely manner. They also directly support future capabilities like Veteran self-scheduling and integrated scheduling across both VA and community providers. A key next phase for the EPS Program in helping VA achieve end-to-end care coordination is the automated exchange of health records, a capability that will also be supported through integration with these systems. While full integration is still in progress, it remains a top priority for both the Office of Information and Technology (OI&T) and VHA.

Outcomes and Future Outlook

EPS is about more than just improving scheduling; it's about delivering better outcomes for Veterans. Early results already demonstrate tangible benefits that when scaled across the enterprise will have a significant impact on Veteran care. We anticipate even greater improvements and efficiencies upon full integration with VA's other care management systems, as mentioned above.

- The average time to schedule in EPS is 7 minutes.
- A 4x increase in productivity among MSAs and referral teams.
- Since January, the number of active provider services participating in digital scheduling through EPS has steadily increased at a rate of 21% month over month.
- EPS appointments have surged by 121% in the first four months of this year, more than doubling since January.
- The potential for decrease in emergency room visits by ensuring timely specialty care access.
- Enhanced Veteran experience and autonomy through faster, more transparent scheduling processes.
- Greater visibility into the status of Veteran care when received in the community.

EPS has not followed a straight path. Like many ambitious initiatives, it has faced challenges, setbacks, and moments of uncertainty. However, for the first time, we are seeing External Provider Scheduling treated as a true priority. Our team stands ready to support the continued expansion of the EPS program to ensure every Veteran across the country has access to timely and equitable care.

Under Secretary Collins and his leadership team backed by bipartisan support of this new Congress, there is revitalized interest in EPS which is breathing new life into the program that has simply needed the right support to succeed. With strong leadership in place and a clear vision, External Provider Scheduling is no longer just a promise, it is a proven, scalable solution to one of VA's most persistent and pervasive challenges. And with continued focus, it will fulfill its ultimate mission: delivering timely, effective, and life-changing care for every Veteran across the nation.

I appreciate the opportunity to speak before you today and look forward to your questions.

Chris Faraji
President
WellHive

Prepared Statement of Jed Hansen

NEBRASKA RURAL HEALTH ASSOCIATION

WRITTEN TESTIMONY

Jed Hansen
Executive Director, Nebraska Rural Health Association
Hearing before the U.S. House Committee on Veterans' Affairs, Subcommittee on Technology Modernization
"Improving Access to External VA Care through Enhanced Scheduling Technology"
May 5, 2025

Chairman Barrett, Ranking Member Budzinski, and distinguished members of the Subcommittee - thank you for the opportunity to testify today. I appreciate your leadership in examining ways to improve veterans' access to care through enhanced scheduling technologies. It is an honor to share my experiences supporting the External Provider Scheduling (EPS) program and its critical role in connecting veterans to timely care.

I serve as the Executive Director of the Nebraska Rural Health Association and work closely with rural hospitals, clinics, and providers across our state. My background includes over a decade of clinical practice - most recently as a nurse practitioner, extensive healthcare policy work, and rural health system advocacy. My testimony today reflects my commitment to ensuring that rural veterans receive timely, seamless access to care — when and where they decide to receive care.

I became aware of the VA EPS program in 2023, during its early pilot phase in South Carolina and Florida. I was impressed with its innovative, veteran-centered approach to streamlining exogenous scheduling demands. Recognizing the unique challenges rural veterans face, I advocated for a rural pilot expansion in Nebraska. With appropriation and policy support championed by Senator Deb Fischer and Senator Jerry Moran, the program pivoted toward a larger national rollout.

In 2024, the Nebraska Rural Health Association, in partnership with the Nebraska Hospital Association, launched a coordinated initiative to promote EPS adoption across our state's 72 rural hospitals and two academic medical centers. We deployed a multi-faceted strategy — including newsletter updates, regional meeting presentations, webinars, and hosting technical sessions with Well Hive at our annual Rural Health Conference. Our associations recognized that it would take years for a single vendor to individually connect with every hospital; by leveraging our trusted networks, we accelerated outreach and engagement exponentially.

This model is working. Nebraska's two largest academic medical centers are in active EPS implementation:

- **CHI Health/Creighton University Medical Center** is finalizing appointment mapping and will soon launch an enterprise-wide EPS go-live across Nebraska.
- **The University of Nebraska Medical Center** is completing its security assessments and selected ophthalmology and dermatology clinics for phased EPS rollouts.

Additionally:

- **50 independent provider groups** are live, including three mental health practices, Nebraska's largest private physical therapy group, and numerous optometry, nutrition, and chiropractic practices.
- **35 Critical Access Hospitals** are engaged, with eight in active onboarding processes.

National organizations such as the National Rural Health Association (NRHA) and the National Organization of State Offices of Rural Health (NOSORH) have also played important roles in promoting EPS. NOSORH, in particular, helped engage its state-based membership in 2024 and provided platforms for sharing EPS implementation strategies at regional conferences.

Equally vital is the engagement of local, state, and national VA partners. In Nebraska, we have benefited from active and productive relationships with our VA Medical Center team in Omaha and the State VA Director. Nationally, the VA Office of Rural Health is a critical partner that can help align initiatives like EPS with broader rural veteran care priorities. These relationships have helped us align efforts and build stronger bridges between rural providers and VA systems.

Why EPS Matters: A Veteran's Perspective

Gregory W. Hake, a Navy SEAL and Nebraska native, shared his personal reflections with me ahead of today's hearing. Growing up in rural Nebraska, he often had to drive long distances for even basic care. As a young, healthy individual, it was manageable. But today, he reflects on the burden faced by elderly rural veterans, particularly those with complex health needs and limited transportation. A caregiver in Lincoln shared with him how many rural veterans struggle with unreliable VA transportation services—a barrier that delays or even prevents access to care.

Now based in San Diego, Mr. Hake described long delays within the VA system: a nine-month wait for an MRI, sequential-only treatment plans, and inconsistent specialty care. Despite dedicated providers, he experienced a system that felt fragmented and unwelcoming at times. As he put it, "Many veterans, especially those in rural areas, are stuck navigating a fragmented, and slow healthcare experience when they're already vulnerable."

I believe the EPS program offers a meaningful solution to help close these gaps. By improving care coordination and making appointment scheduling more efficient, EPS can directly reduce wait times and improve access for veterans like Mr. Hake.

NEBRASKA RURAL HEALTH ASSOCIATION

Recommendations for the Committee:
Based on our experience in Nebraska, I respectfully offer the following recommendations to support broader and more equitable EPS adoption:

- **Support Rural Providers Through Appropriations:** Provide federal appropriations to help rural providers cover scarce IT staffing resources and burdensome interface fees associated with EPS implementation. These financial barriers are particularly challenging for small, under-resourced facilities despite their willingness to participate.
- **Incentivize academic and tertiary providers:** Provide pathways for enhanced payment models or temporary incentives to encourage rapid EPS adoption in tertiary care settings.
- **Enhance Collaboration with EHR Vendors:** Encourage Epic, Cerner, and other major EHRs to prioritize EPS integration and interface affordability, especially for rural providers.
- **Support State-Level Organizations:** Encourage state-level rural health and hospital associations and State Offices of Rural Health to serve as liaison partners for VA initiatives. These organizations are well-positioned to engage local providers, facilitate implementation, and strengthen trust between VA systems and rural communities.
- **Leverage National and Local Partnerships:** Engage national organizations such as NRHA, AHA, and NOSORH alongside local VA teams to support coordinated EPS rollout and adoption.

In closing, the EPS program holds great promise to bridge gaps in veterans' access to care. Nebraska's progress demonstrates that when national innovation meets local leadership and collaboration, real results follow. I look forward to continuing to work with VA, Congress, and our rural partners to ensure every veteran — regardless of where they live — receives timely, coordinated care.

Thank you for the opportunity to testify.

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I LOVE RURAL HEALTH