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House Veterans' Affairs Committee Holds Hearing on Veterans Health Administration Assessment

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WITNESSES:
SECRETARY OF VETERANS AFFAIRS ROBERT MCDONALD

RICHARD BYRNE, SENIOR VICE PRESIDENT, THE MITRE CORPORATION

BRETT GIROIR, SENIOR FELLOW, TEXAS MEDICAL CENTER HEALTH POLICY INSTITUTE

VA UNDERSECRETARY FOR HEALTH DAVID SHULKIN

MILLER:
The committee will come to order -- if we can get somebody to close the door. Thank you, Bob. Thanks, everybody for joining us for today's oversight hearing called a call for system-wide change, Evaluating the Independent Assessment of the Veterans Health Administration. This morning we're going to discuss the findings and recommendations of the independent assessment of V.A.'s healthcare delivery system and management processes.

The assessment was required last summer by the Veteran's Access Choice and Accountability Act, and was intended to develop a path forward for the V.A. healthcare system that was then and still does continue to have difficulties. The Secretary's prepared remarks for this morning's hearing called the assessment of valuable instrument for validating the areas that require attention, and a presentation two weeks ago before the commission on care. Dr. Shulkin, the Undersecretary for Health called the assessment an excellent tool.

But I see the assessment as much more than that. It is more than an instrument, it is more than a tool. The assessment encompassed review of virtually every aspect of V.A. healthcare, and over the course of more than 4,000 pages it described in painful detail the numerous, significant, and systemic flaws that challenged the healthcare system that is tasked with providing high-quality healthcare to our veterans. The assessment then thoughtfully lays out what steps need to be taken to transform the broken V.A. healthcare system into one that our nation's veterans can truly be proud of.

Perhaps most alarming, are the assessments finding regarding leadership. For example, the assessment found that V.A. healthcare facilities are plagued by an ever growing but ineffective bureaucracy that has ballooned by 160 percent over the last five years, without resulting in any discernible improvement in business or health outcomes. That could be because the assessment also found that V.A. suffers from an expanding scope of activities that has led to confusion about strategic direction and leadership priorities, and has an unnecessarily complex and fragmented organizational structure as characterized by a culture that is risk-averse and distrustful, and is run by a workforce that is steadily losing its motivation.

Consumed by addressing crisis after crisis and lacks a leadership pipeline is failing to attract and train the next generation of healthcare leaders. Sadly, these findings are not new to those of us who have been working on these issues. In fact, many of them are things that those around this dais had been discussing in his hearing room for many years. However, they are startling and they are deserving of both our immediate attention and our prolonged commitment to sustain change, a change that will come from nothing short of a top to bottom transformation and a willingness to have difficult conversations about V.A.'s true mission and should be in support of our nation's veterans.

Unfortunately, rather than detailing V.A.'s plans for systematically implementing in the recommendation of the assessment and deviating from the status quo that is harming our veterans, the testimony that we will be hearing today repeats a lot of the same talking points that we've heard in the past. For nine pages, V.A. provides little in any way of concrete details about what if any specific actions V.A. is taking as a result of the assessment, and how we has a committee can assist V.A. in its efforts.

But V.A. does take time in their testimony to repeat misleading talking point from May regarding house past fiscal year 2016 budget, equating it to a V.A. medical care budget cut, and claiming it would result in 70,000 fewer veterans receiving care. Both of those allegations are untrue, as the Washington Post fact checker pointed out earlier this year. In fact, the V.A. budget that the house is proposed represents an increase in V.A.'s discretionary budget and would continue the trend of budget increases that have led to more than 70 percent increase in the bottom line over the last six years.

I appreciate the Secretary being here today, taking time out of his schedule, but we both can agree that we each can do better and make more out of the assessment that is before me today. If we avoid retorting to disingenuous talking points and instead focus on the hard work that lies before both of us, our veterans cannot afford to let this assessment become just number 138 gathering dust on some shelf locked away where nobody else will see it again.

Before I yield to the Ranking Member, I'd like to take a moment to thank the MITRE Corporation, the RAND Corporation, the Institute of Medicine, McKinsey and Company, and Grant Thornton for their efforts in completing this assessment. I'm also grateful for the efforts of the members of the Blue Ribbon Panel who selflessly lent their expertise as well. Thank you all for your hard work. I guarantee that our hearing today is just the start of this committee's work regarding the many thoughtful findings and recommendations of that -- this group has laid out for us, and I recognize the Ranking Member, Ms. Brown for her opening statement.

BROWN:
Thank you, Mr. Chairman. Before I begin my statement, Mr. John E. Arnold is here, he is a Vietnam veteran and he came all the way from Jacksonville, I would just like for him to stand because this is what -- this is all about veterans. Sir, from Jacksonville would you just stand and thank you for your service. Thank you. Last year, in the Veteran's Access Choice and Accountability Act of 2014, we mandated that there be an independent assessment of veteran's healthcare.

This morning's hearing is on the results of that independent assessment. The assessment highlights many other things we hear from our veterans. We hear that the V.A. provide excellent healthcare, especially healthcare related to the special needs of the veterans. We also hear that in certain areas, V.A. is the forefront of healthcare in this country. We also hear from our veteran's that V.A. care is often fragmented and that it can be difficult to navigate and arrange non-V.A. care. We hear of long waiting times and limited access to.

For us on this committee, the result of this assessment is not new. Over the years, and for me it's 23 we've seen a system being mired in bureaucratic --and be required to do more with sometimes the resources to do more have not been made available. What the independent assessment provides us is a detailed, thorough, and fair look at where the veterans healthcare administration is and the steps that we must take together to get it back to the right track and focus on veterans. What is clear is that if we are to meet our promise to the veterans, we must begin to look at reform.

This reform must enable veterans to focus on healthcare and operations like the Secretary has previously stated, as a business, and the business of the veterans health administration must be clear and unwavering focus on the veteran's patient. The independent assessment points out that -- and legislation targeted at only one issue will not cut it. VHA needs a complete overhaul on the way its schedule and delivers care to patients, to the way it treats its employees, and I want to point out in the way we partner with community providers.

It's been more than two decades since VHA last underwent a major reform effort. We must now begin the work of ensuring that V.A. healthcare is poised to meet the challenge of healthcare today and the independent assessments will help us in this endeavor. I look forward to hear from the Secretary as to what steps to be taken to begin the reform process, and to hear from our other witnesses as to how we can work together to ensure that healthcare for our veterans receive the very best. Thank you, Mr. Chairman and I yield back the balance of my time.

Thank you very much, Ms. Brown. We're joined this morning by the Honorable Robert McDonald, Secretary of the Department of Veterans Affairs, better known to many people is Bob. Secretary McDonald is accompanied by the Honorable David Shulkin, he is the Undersecretary for Health. Dr. Shulkin, thank you for being here too. We're joined by Richard Byrne, Senior Vice President of the MITRE Corporation, the Independent Assessment Program Integrator, and by Dr. Giroir, who is Senior Fellow of the Texas Medical Center Health Policy Institute and the Chairperson of the Independent Assessment Blue Ribbon Panel.

Mr. Secretary, we appreciate you being here. Two things before we begin, thank you for allowing us to compress into a single panel instead of doing two panels today, and secondly your staff had asked for a 10 minute opening statement, but because of time and many of the questions that members have today, I've asked that you restrict your comments to five minutes so that we can ask the question. All members can avail themselves to the Secretary's written comments that are in the binder before you.

Mr. Secretary, you are recognized for five minutes.

MCDONALD:
Chairman Miller, Ranking Member Brown, members of the committee, I'm pleased to be here with Dr. David Shulkin, Undersecretary for Health to talk about the independent assessment and all of V.A. is doing to improve the veterans experience at V.A. I think this is the most important hearing that we've had since I've been Secretary, because the first hearing that we've had on the transformation of V.A. For the most part, the assessment which is you know started over a year ago, confirms our own analysis, and I'm pleased to say we've already started taking action.

The assessment had a great deal of information on known problems, but also had some new ideas that we are incorporating into the transformation we're doing. One aspect of the assessments findings recommendations deserves special emphasis, and that's the misalignment of requirements and resources. We know now that the axis crisis of 2014 was mostly a matter of growing demand for V.A. healthcare, overwhelming our capacity for supply. For example, we have a requirement that all disability claims should be adjudicated in under 125 days and we made outstanding progress in meeting that requirement.

We've cut the backlog of those claims from 611,000 in May 2013, to less than 75,000 today. But we've done that by having our workers -- our VBA workers work mandatory overtime for over four years. We incrementally put more people in the budget each year, there's been stripped out, we obviously need more people if we're going to be able to get those claims down to -- down to zero. So this is a classic case of where the 125 day requirement and the budget that we've given don't match, and we can't have people working overtime forever.

I take issue with one of the assessments recommendations, and that one is that Congress establishes a governance board to "Develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures." I believe this is a role of this committee, and the Senate Veterans Affairs Committee working collaboratively with the department and me. We've proven that V.A. can make changes needed to provide veterans with the care and benefits they deserve, all we need to do is have your support and work together to do so.

At the enterprise level, My V.A. transformation is well underway providing both short-term and long-term support for effective responses to many of the assessments recommendations. As you know, we have five strategies, first is improving the veteran experience, second is improving employee experience, third is achieving support service excellence, fourth is establishing a culture of continuous improvement, and fifth is enhancing strategic partnerships, and we would be happy to drill down on those during the question period.

We're also implementing VHA's Blueprint for Excellence, detailing how VHA will evolve as a model of healthcare provider. It's designed to improve access to healthcare, create a personalized experience for each veteran, and bring VHA's performance measurement and reporting requirements in line with those in use throughout the healthcare industry. In the past year, we've moved out aggressively in response to the axis crisis, meeting increasing demand and expanding capacity on forefronts. More staffing, more space, more productivity, and more V.A. care in the community.

During that period of time, we completed 7 million more appointments for veterans of completed care, 4.5 million in the community, and 2.5 million within V.A. We've added more space, we've added more providers, and we've added more extra hours, all in affect to get more veterans in. But because of that and because we've done a better job of caring for veterans, we have more veterans desiring care. So even those 97 percent of appointments are not completed within 30 days the needed or prefer date, the number not completed in 30 days has grown from 300,000 to nearly 500,000.

This brings us back to the fundamental problem, the imbalance of supply and demand and the need of congressional action. So let me get to what we need. The house's proposed $1.4 billion reduction of the V.A.'s budget request would mean 688 million less for veteran's medical care and a 50 percent cut in V.A.'s construction budget, a 50 percent cut in the construction budget at a time that our facilities -- 60 percent of our facilities are over 50 years old, doesn't make any sense.

Second, we need Congress to give us the flexibility to align resources with veterans demand for care, as the independent assessment suggested. Third, we need Congress to act on the proposal we submitted May 1st, and the uncertainty about aspects of purchase care that are outside the veteran's choice program and the complicated provider participation in V.A.'s other care and community programs. Finally, we need Congress to address the many statutory issues that burden V.A. with red tape and bureaucracy.

This is a problem almost everywhere in V.A. We simply can't make many necessary changes because of statutory limitations. We need to consolidate our various cares in the community programs. We need a free our hand to hire, assign, and reward the executives we test to act as change agents. We need a freer hand in disposing of outdated, unused, or little used facilities. We need a freer hand in the management of existing facilities, so facilities managers can adjust their use of resources to the changing needs of veterans.

Bottom line, we at the V.A. are working hard to do our part. We moved out smartly to aggressively tackle issues within our control, we've also demonstrated tremendous readiness and the ability to affect fundamental organizational change. My V.A. is already making a difference in the veteran's experience of V.A. Maybe someday we can hold a hearing on My V.A. transformation. I would welcome that. But we can't continue making progress without reconciling requirements and resources, and we can't reconcile requirements and resources on our own. We need your help to do that.

Veterans and the American people expect us to work together on their behalf, and we look forward to doing so.

MILLER:
Thank you very much, Mr. Secretary. We intend to work with you and we will look at some of those issues that you have just raised. I got a couple questions I'm going to ask you in just a few minutes as well in reference to legislative solutions and suggestions. Mr. Byrne, you're recognized for your testimony for five minutes.

BYRNE:
Chairman Miller, Ranking Member Brown, and distinguished members of the committee, thank you for the opportunity to appear before you today. My name is Rich Byrne and I represent the MITRE Corporation and our partners as the senior executive responsible for conducting the independent assessment as required by section 201 of Veterans Access Choice and Accountability Act of 2014. Before I get to the details, I'd like to acknowledge the many, many individuals, men and women throughout V.A. who are deeply committed to the welfare of our nation's veterans, and who unselfishly supported the assessment in every way they could.

We saw no hesitation for them help us in any way. It was a privilege for every one of the team members to work on the assessment of this historic organization and on the nation's most complex healthcare system. Our assessment was conducted in partnership with the Rand Corporation, McKinsey and Company, and Grant Thornton, it is supported by an independent Blue Ribbon Panel composed of 16 top healthcare experts who reviewed our work to ensure that incorporate the very best practices of the private sector.

The assessment team visited 87 facilities, analyzed over 19,000 documents and data sets, and reviewed 137 previous assessments, and conducted over 1000 V.A. interviews. We spoke with 10 veteran service organizations and 27 U.S. healthcare organizations. Our assessment presents a broad, independent, and evidence-based set of findings and recommendations, while overall, VHA quality care was comparable to private sector and had pockets of excellence. We found large variations in performance that resulted in too many unacceptable veteran experiences.

This lack of consistency we believe is due to four pervasive, systemic, issues, under governance, there was a disconnect in the alignment of demand, resources, and authorities. Under operations, there were uneven bureaucratic processes that would too often provider-centric and not patient centric, and under data and tools are too many variations of non-standardized data and non-interoperable tools. And finally, under leadership, leaders were not fully empowered due to lack of clear authority, confusing priorities, and a culture of distrust.

In reviewing the past 137 assessments of VHA, we found a number of fighting that persisted year after year despite heroic efforts to resolve them. We concluded that these individual findings addressed individually did not then it will not now result in sustainable or scalable solutions. It is our belief that the only way to successfully transform VHA in an enduring manner is to address all of these four systemic issues using an integrated systems approach. A systems approach would simultaneously build on improvements in all four of these four systemic areas in an integrated and consistent manner -- independent which findings we're going to address.

Each -- would then build upon the previous solutions to increasingly improve the underlying root causes of the system that allows these anomalies and variations that happen. This will result in a sustainable and scalable solution. So taking the whole system perspective also supports reframing problems within a larger context, which in turn can lead to radically different even transformational solutions with the potential to provide much greater value than simply improving the status quo.

For example, if a hospital's construction is overrunning, in addition to looking at funding increases, it is critical to assess the four system cornerstones. Let's take an example of that, on the data, using accurate data what is the veteran demographic demand for that hospital in that local area, applying the appropriate governance for purchase care options for the private sector. Do we have to build the entire hospital for that -- or are there excess capacity and private sector. To streamline operations, one of the national productivity standards that should be targeted, and from leadership how will healthcare be delivered in the future to incorporate translate telehealth.

Taken altogether, these four cornerstones make you look at the problem of funding a specific facility in a bigger light. What is the future hospital that the V.A. needs to build, not the one of the past? Together, these four system perspectives is what we believe is the secret to having enduring, scalable, sustainable solutions. Now as one private-sector doctor said, VHA is strong in anatomy but weak on physiology. What that means it is clear that VHA has all the parts necessary to be a world-class provider. However, for all these parts to work smoothly together it will take a significant transformation to build the collaboration inside and outside of VHA, to create patient- centered operations led by empowered leaders or informed by the right data and tools with the appropriate governance and resources to deliver our nation's promise to our veterans, thank you very much.

MILLER:
Thank you very much. Dr. Giroir?

GIROIR:
Chairman Miller, Ranking Member Brown, members of the committee thank you for the opportunity to be here today. My name is Dr. Brett Giroir and I am honored to serve as Chair of the Independent Blue Ribbon Panel created by MITRE to provide support, oversight, and guidance for this independent assessment. The Blue Ribbon Panel was composed of 16 distinguished and outspoken independent experts, whose names and biographies are listed in the integrated report.

But briefly, the panel included the former CEOs of Kaiser Permanente, Geisinger, Healthcare Partners in the California Healthcare Foundation, the former executive V.P. of United Health, the Physician in Chief of Mass General Hospital, the former Surgeon General of the Army and Vice Chief of the Army, the world's leading academic experts and organizational change in health innovation, the CEOs of the National Quality Forum in the Texas Medical Center, the Dean of the Jefferson College of Nursing, a board member of the National Patient Centered Outcomes Research Institute and a former director of Medicare and Medicaid services.

Each Blue Ribbon Panel more importantly shared a deep commitment to our veterans and nearly all had direct personal or family experiences with the VHA. Ultimately, the panel members unanimously endorsed the integrated report and its findings and recommendations. The report contains numerous near-term operational recommendations, few of which were unexpected by anyone in this room. For example, enhanced physician

productivity, a key element of enhancing access will require more exam rooms, increase clinical support staff, improved patient scheduling, and greater authority granted to clinic directors for overall sourcing.

But more importantly, the report also offers recommendations to solve deeper root cause issues that have persistently plagued the VHA and have prevented the successful implementation of reforms that were already suggested by the 137 previous VHA assessments. As Mr. Byrne has already testified, these root cause issues are the basis for four overarching recommendations in the area of governance, leadership, operations, and data and tools. Indeed, even the example I just gave of improving physician productivity appears straightforward, but would require reform of unnecessarily bureaucratic clinical staff hiring processes, which take three times as long as the private sector.

Empowerment of V.A. medical center leadership to flex resources to meet dynamic patient access needs, commitment to a modern electronic scheduling system that transparently indicates appointment availability to both schedulers and patients alike, and overhaul of the facilities construction leasing processes that now cost twice as much as the private sector but proceed at a pace that is two to three fold slower. I would also emphasize that one of the most urgent strategic priorities is to establish and clearly communicate the future mission of the VHA, and for Congress to align resources in authorities to achieve that specific mission.

As background in 2014, 9.1 million of 21.6 million U.S. veterans were enrolled in the VHA, of these 5.8 million were actual patients, and on average these patients relied on the VHA for much less than 50 percent of their healthcare services. These demographic data combined with axis challenges suggest reconsideration of whether the VHA should aim to be the comprehensive provider for all veterans health needs, or whether the VHA should evolve into more focused centers providing specialized care while utilizing non-VHA providers for the majority of veteran's healthcare needs.

Either paradigm could be highly beneficial to veterans, as long as the demand and resources are prospectively aligned or there is a consolidation of current programs to simplify access to non-VHA providers. I also want to emphasize that although the report clearly outlines significant and long-standing problems, there are shining examples of emerging best practices at the VHA regional level that have improved access and quality and begun to change the overall organizational culture.

Finally, on behalf of the panel, I would also like to express our appreciation to the hundreds of experts who contributed to this report, and to the literally thousands of contributing veterans and VHA employees who believe that this report would become a roadmap to achieve the highest quality of care for veterans. I would also like to express our gratitude to this congressional committee for your support of veterans and our panel, and for the opportunity to answer any questions related to our assessments and recommendations. Thank you.

MILLER:
Thank you very much, Dr. Giroir. I would like to begin questioning with you on the point that you just brought about -- both your written and your spoken testimony about the demographic data that the assessment collected, and I think that's a question that has been raised in this hearing room many times over the last year and a half. So I'll ask you given the choice of the two paradigms that you have discussed, one of which were V.A. aims to be a comprehensive provider of care for veterans service-connected and non-service-connected care needs for or -- one in which V.A. functions as a coordinator of care focused primarily on being a center of excellence for specialized care, which do you think that V.A. should pursue, and why do you think the way you do?

MCDONALD:
Ok, well, this certainly is one of the key questions. The Blue Ribbon Panel clearly made a recommendation that veteran's healthcare within each region needs to be evaluated by assessing both the VHA capabilities and the non-VHA capabilities, and that is clearly trending. The use of non-VHA providers both when care is unavailable, or when it is more readily available is something that is -- needs to continue and probably needs to expand. The Blue Ribbon Panel did not make an assessment of those all -- of those two alternatives in the

extreme, but clearly focuses on the ability to expand integration with the private sector because the VHA is no longer a siloed institution.

It is part of an integrated healthcare network, and the veterans are telling you that with their voting their feet, less than 50 percent of their healthcare even among VHA patients are received from the VHA, and as little as 15 percent of their outpatient appointments come from the VHA. So they are telling you that an integrated approach with the commercial sector is desirable and beneficial.

MILLER:
Dr. Shulkin, could you comment just a little bit. I know it's at odds with the V.A.'s approach, but do you differ from Dr. Giroir's assessment in regards to people voting with their feet.

SHULKIN:
Thank you, Mr. Chairman. I don't think that this differs from the V.A. approach. The V.A. approach is to find the very best care that serves the veterans, and I think that we've shown that in response to our access crisis that we have encouraged the use of community -- I think the difference here between -- maybe what I would expand on what Dr. Giroir said is that the care the V.A. provides is very, very different than the care that the private sector provides.

The V.A. provides a much more comprehensive approach than just dealing with physical illness issues, and provides psychological and social aspects of care that actually meet the needs of what veterans require. And that's why I think that we really do need to do what Dr. Giroir said, which is to see what VHA provides best for our veterans and what care can be provided by the private sector, and it is that hybrid type system that's going to meet our veteran's needs.

MILLER:
So Mr. Secretary, when you talk about the house passed budget being a cut, effectively taking away healthcare from 70 plus thousand veterans, is that not what we tried to solve back last year with the choice program, where we gave billions of dollars to provide -- if you could have provided inside the V.A., you can provide it outside, so it is -- something doesn't match with the continued statement that the house passed budget is a cut that will harm veterans healthcare.

MCDONALD:
Mr. Chairman, as Dr. Shulkin said we are in favor of a hybrid system that takes advantage of all of our partners, even before the Choice Act we had many veterans who were going our medical school affiliates, who were going to the Alaska Native Health System, who were going to the Indian Health System, who were going to joint DOD/V.A. facilities. We're totally in favor of that. Right now in Fort Benning for example, Columbus Georgia we've got veterans going to Martin Army Hospital for 18 specialties that the V.A. doesn't provide. We're totally in favor of that.

But here is the issue, as Dr. Giroir mentioned, veterans today we estimate use the V.A. for only 34 percent of their healthcare. Every percentage point that they decide to use the V.A. more, that means we need an increase in budget of $1.4 billion. The federal budgeting process is not dynamic enough to take advantage of that and what we've got is we got veterans coming to V.A. because the care is better, in fact, the recent VFW study showed that 82 percent of veterans preferred the V.A. and showed that 87 percent of veterans recommend the V.A.

So as that 34 percent gets higher, we have got to have the money to care for those veterans. When we put together the budget for 2016, we put together a budget that we thought would meet demand if we got the total budget amount and as you recall after we got budget flexibility to move money from one of the 70 line items to the other that we don't have that flexibility today. So this was not a question of trying to put money in coffers

or in a bank, this is the demand that we see, and if we don't get that money we won't be able to meet the demand at the requirements that we have.

Importantly in my statement, I said if we want to work together to change the requirements, for example 30 days appointments maybe -- maybe it doesn't need be within 30 days, that's fine but we got a match requirements and budget at the same time.

MILLER:
Well, I would remind you that the 14 day and the 30 day were dates that V.A. said, not us, so...

MCDONALD:
As you know, we've eliminated the 14 days.

MILLER:
I know, but if you need to change for budgetary reasons, I would understand that. You're also talking about increasing and requiring $1.45 billion. That number could also decrease as well, and I would tell the members here that the cut to the president's request "Is less than what we added to finish the Denver project," and with that, Ms. Brown...

MCDONALD:
Mr. Chairman, remember the cut also included a reduction in construction by 50 percent, at a time when 60 percent of our buildings are over 50 years old.

MILLER:
Ms. Brown.

BROWN:
Thank you. Mr. Chairman, I'm going to yield most of my time to the Secretary, but before -- I want to thank the panelists that did the assessment. But I want to mention that I think the elephant in the room is that there are people out there that would actually want to just completely close the V.A. and privatize the entire V.A. system, which is totally unacceptable and it is absolutely not what the veterans want. And as you begin, I want you to discuss flexibility, but I want you to let people know how many people we actually serve everyday throughout this country.

MCDONALD:
Thank you, Ranking Member Brown. As I was going through my confirmation process, I often got the question from senators why -- you know from some senators, small group, why don't we get rid of the V.A. and just give out vouchers. So I studied that, as a business person, I wanted to know, and what I discovered was V.A.'s not only essential for veterans, it's essential for American medicine, and it's essential for the American people. Three legged stool, research, we spent $1.8 billion a year on research, we invented the nicotine patch, we were the ones who discovered the aspirin was important for heart disease, take an aspirin every, day first liver transplant, first implantable pacemaker, last year two V.A. doctors invented the shingles vaccine.

I could go on. That research is important for the American people, and I didn't even mention posttraumatic stress and traumatic brain injury or prosthetics, things that we're known for. Second, training, we trained 70 percent of the doctors in this country, who's going to train those doctors without the V.A.? We have also the largest employer of nurses and the largest trainer of nurses, third leg is clinical work, our veterans get the best clinical care because our doctors are doctors that not only do the clinical care but also do research and teaching the best medical schools of our country.

So I think the American people benefit from the V.A. and it would be a big mistake to even think about privatizing it.

BROWN:
Would you expand on that flexibility as far as hiring, and the flexibility which is budget.

MCDONALD:
Well, we -- in the last fiscal year, flexibility for the budget is absolutely critical. We have 70 -- over 70 line items where we can't move money from one line item to the other, despite the fact that we've all agreed to give veterans choice. So the veterans have a choice, but we don't have the ability to move money where they decide to go to that choice. So as you know, last year we had to ask your permission to use care in the community money to pay for care in the community, because that care in the community money was in the Choice Act funds not in the regular appropriation.

So flexibility's absolutely critical because we give them veteran's choice. In terms of pay and performance, we've put together a -- some requests for legislative help, one example is the 80 hour week that required by federal law to use, which is prohibiting our ability to hire doctors in emergency rooms. There is no private sector medical system that has this requirement, as a result of that we even have the V.A. outsourcing some of our emergency rooms, and that's just wrong. So we need that legislation passed in order to free up our ability to hire the people we need.

BROWN:
Did you want to -- I have another minute there and 19 seconds, do you want to add to that?

MCDONALD:
Well, I passed along a letter to you and of the Chairman on September 8th detailing the legislative requests, including the 2016 budget. Obviously, operating under continuing resolution is going to be terrible for us, it means no new programs, it means no way of meeting this increasing demand that we're seeing. Budget flexibility for the future, we talked about that, thank you for your work on the Denver Hospital construction, provider agreement legislation. We have veterans homes right now deciding not to renew their contracts with us, because our provider agreement legislation is not clear.

So that's a problem. We need to streamline and consolidate our care in the community, which we're going to have a proposal to you before November 1st. I need help in West Los Angeles. Senator Feinstein has put together a marvelous bill, the Senate held a hearing this week to allow us to get into extended use agreements with providers to build housing on that campus that we can use as bridge housing or supportive housing for homeless veterans. We all want to end homelessness in Los Angeles.

There are several other pieces of legislation I requested, but I think every member has this letter, and we would appreciate your hard work on this.

BROWN:
Thank you.

MCDONALD:
And we will help.

BROWN:
I yield back.

MILLER:
Thank you very much, Mr. Secretary. I do look forward to working with you on the Los Angeles issue, and I hope you will be looking at the enhanced use leases that are on that property that probably shouldn't be on that property for whatever reason. And I know that there is a significant amount of turmoil going on right now. This should be about veterans that are what the property was donated for and I think that's what this committee and that's what the V.A. should expect.

MCDONALD:
Absolutely right, Mr. Chairman. We've already sent out letters of notice of eviction to many of those users.

MILLER:
Many or all?

MCDONALD:
Many because again it depends what value veterans are getting from the presence of that provider, that partner on the property. We can go through that in greater detail if you like.

MILLER:
Ok. And the other thing you talked about budget flexibility, I'm waiting for language from you in regards to budget. You've talked about it for a long time, but we haven't received anything from you. We asked for it probably 30 days ago, we still haven't gotten anything from you and would like to -- if you really want budget flexibility, send us some language that you want us to work on.

MCDONALD:
We'll do, Mr. Chairman.

MILLER:
Ok. Mr. Lamborn, you're recognized.

LAMBORN:
Thank you, Mr. Chairman. I want to thank all the people who put this assessment together. I want to thank the V.A. for cooperating and working so hard to help get the assessment done also. And Mr. Chairman, thank you for your work and bringing us to this point. Secretary McDonald, I have a really specific question I want to ask you, a local question and then broaden to a general and national question. But first of all, I see in your written statement that you referenced a potential lack of funding for four major construction projects, and six cemetery projects, since the cemetery project in my district is already well under design is it still on track for construction funding in 2017? And will a funding shortfall in any way impact the southern Colorado Cemetery construction?

MCDONALD:
Thank you for the question, Congressman Lamborn. Those six would be new cemeteries. The project in Colorado would be ok.

LAMBORN:
All right. Then let me broaden to a larger, more general question but very vital. I believe that access to care and streamlining community care are critical, and we talked a lot about that this morning already. Are you on track to deliver the New Veterans Choice Program by November 1st, 2015 as promised?

MCDONALD:
I would say we're making progress. In fact, the authorizations climbed by multiples every month, but I would say just like we talked about variability in the V.A. system, there will be variability. I was with Dave McIntyre last night of Tri-West for example, it is going to take us a while to build capability in some of the geographies where not surprisingly there is a shortage of primary care physicians or mental health physicians, but we're working as hard as we possibly can and I'm hopeful and I believe that the consolidation of all the programs will make choice even more effective, why, because we will go one program that our employees have to administer, and the veterans will only have one program for outside care.

So I think it will simplify things dramatically.

LAMBORN:
Ok, thank you. And Dr. Giroir, I hope I pronounced that correctly, one of the things that you referenced of the many that need reform or improvement is physician productivity. What are your specific recommendations in that very critical area, and we can talk about so many things, and I know we will during the rest of this hearing, but that's what I like to drill down on.

GIROIR:
Thank you for the question. If you take the top line that for example VHA primary care physicians have 14 percent fewer patients or that the specialist are much below the 50th percentile in productivity, the immediate potential response might be well get physicians to work harder. It is a much more complicated problem, as I outlined there needs to be improved clinic space, that improve clinic space implies though that the V.A. has the authorities to make leases in less than six to nine years to do that.

It means that hiring a nurse doesn't take six months or eight months or nine months, it takes two months like it does in the private sector because you lose those people on -- it also requires scheduling. Imagine if your calendar was on six different separate screens depending on whether the person was a constituent a non-constituent member, will that sort of the scheduling system that we found in many of the V.A.'s which makes it impossible to understand what the physicians real schedule is going to be.

So I think on the near-term, these are the kinds of issues that can promote productivity even within the system and enhance the job satisfaction among not only the physicians and the staff, but again as Mr. Byrne said, think of all those cornerstones, leadership, governance, operations, and data and tools and I think this is one example of them, and hopefully that answered your question is some degree, sir.

LAMBORN:
It really helps and, that's something I'll work with you. I know that all of us here have a -- Dr. Roe, and everyone here has a concern about that specific area -- Dr. from Ohio, and we all want to work with you on this. This is so critical. Thank you and I'll yield back the balance of my time.

MILLER:
Thank you. Mr. Takano, you're recognized.

TAKANO:
Thank you, Mr. Chairman. Mr. Secretary, do you agree with the systems overhauls -- the systems-based overhauls described in the report could take at least five to ten years to take hold?

MCDONALD:
First of all, it's already underway.

TAKANO:
Ok.

MCDONALD:
Second of all, you know while we -- while Congress demanded this assessment, and this assessment costs $68 million from our budget, $68 million, I had done my own assessment when I took over -- my own root cause analysis. I've done this before, and we're on track with many of the same things. I appreciate the depth of the analysis. I can't do that myself, but these things are already underway, and we're already seeing results. We wouldn't have had seven million more completed appointments if we didn't put in 1.8 million more square feet of space, if we didn't put in over 1400 new providers, if we didn't put in over 3000 new nurses, so progress is being made.

TAKANO:
My concern is that if it were true, I've seen the turnover in this committee and the turnover within the administration. We have one year left of this ministration, the change in administrations regardless of who the next -- which party will occupy the White House. That part of the problem is the institutional memory, and you mentioned you didn't agree with the idea of the commission that you think see this committee and the Senate committee as the -- and I agree with you, but I think both parties need to be committed to constituting this committees with people that are going to stay here and work with the department even as the top positions...

MCDONALD:
The Chairman and I have said publicly, please correct me if I'm misquoting you, we have unique moment in time right now where we have tremendous unanimity between the two parties, between the house and the Senate, and we have a new leadership team at the V.A., 13 of my top leaders are all new, 13. We got the transformation underway, the work that was done by the independent assessment is incredibly helpful because the depth of analysis. I think we just join arms we do it and we create irreversible momentum in this transformation.

TAKANO:
Mr. Secretary, I was disappointed to learn that the DOD let out the contract -- a several billion dollar contract for health I.T., and that there's still no commitment for it to sync up with...

MCDONALD:
Their contract has a provision that it has to be interoperable with V.A.

TAKANO:
So there is a provision.

MCDONALD:
There is a provision for that, and we're working very closely with them on that. We have so many joint DOD/V.A. facilities now. There's no turning back on this. We've got to have an...

TAKANO:
That's a relief to know. I've been fighting about the fact that contracts and the let out.

MCDONALD:
We would be happy to send a team of people to your office and have them show you the interoperable...

TAKANO:
I would be very pleased to learn more about what you're doing. The report also talks about the -- points out that many feel that in this area -- what was once V.A.'s crown jewel has been allowed to stagnate and now 85 percent V.A.'s I.T. budget is now going to the maintenance of the stuff. Past efforts to update -- particularly achieving interoperability with DOD have been mired with problems. What lessons can we learn from past efforts to ensure that we're on a successful a pathway to create a comprehensive system able to seamlessly operate with DOD -- and a third party provider that we want to do with the...

(CROSSTALK)

MCDONALD:
Well, that's absolutely critical. We've have got to have interoperability with DOD, but the interoperability with the private sector is absolutely critical, because we do agree that there will be times where veterans will go outside V.A. for care. So that interoperability becomes critical. It starts with getting the right leader in place. We now have the right leader in place, Laverne Counsel, who is been the head of I.T. at Johnson & Johnson, she knows how to do this. She's very good. She's all over it. Number two is we have got to take on the big systems. Our financial management system which ran into problems last fiscal year was written in COBOL.

COBOL is the language I wrote at West Point in 1971, 72, nobody -- you can't even find people writing COBOL. Now the Chairman will bring up -- I'm sure that we tried twice before to replace that system and failed. I'm telling you we can replace that system. We have the leadership to do it. The scheduling system, which was properly brought up in 1985, dates to 1985, we put in 11 patches but they're just patches. We need to overhaul the system. We need a new system.

As the doctor brought up, so we have a lot of systems work to do, we need the budget to do it, and I'll get to the right people to do it, and we will get it done.

TAKANO:
This is very heartening testimony, Mr. Secretary. Mr. Chairman, I look forward to hearing what he has to say about simplifying our ability to do community care with private providers.

MILLER:
Thank you very much, Mr. Takano. And I think that there are two words, interoperability and that sounds great and integration, the integration of the system is the thing that is so critical. And I understand maybe not integrating the private sector but for DOD to continually be the agency that is pushing back over billions of dollars that have been spent, it's not helping -- and even when Congress orders it to be done it doesn't get done. And we want to help the V.A. and we understand that you're not the one that's causing the problem.

MCDONALD:
I'm happy to put on a display, a demonstration for the committee so all of you can see what we've achieved. In the end it's all ones and zeros, and that's why the interoperability is relatively easy to do, but we're happy to demonstrate for you.

MILLER:
Thank you very much. Mr. Bilirakis.

BILIRAKIS:
Thank you, Mr. Chairman. I appreciate it. I think Mr. Lamborn mentioned about the physicians would have you -- and one of you testified with regard to medical scribes. Why don't we have medical scribes available to

all our V.A. physicians? And I hear from my veterans and they say the doctor really wants to treat them, and they still have to scribe and to take so much time away from the patient.

MCDONALD:
Congressman, I think as you're suggesting the issue of taking physician time away to spend on doing that entry into a medical record is a problem -- it's a problem in V.A., it's a problem throughout the healthcare industry. We are seeing practices particularly in the private sector of using scribes, something that I'm very familiar with, and we actually are beginning in different areas of the V.A. to begin to take a look at this as an option.

I think it is a viable option that we're exploring. It's obviously an expensive option, and given the size of V.A., we're taking a hard look at that because using resources appropriately is certainly very important to us. But it is an area that we are trying to lessen the time that physicians are spent entering information and record some more time with their patients and the scribe system certainly one of those avenues we're looking at.

(CROSSTALK)

MCDONALD:
We're piloting the scribe, the flip side of the argument just -- both sides is if we simplify the medical record enough so that the alerts that come up really help the doctor, and you know you want the doctor interfacing with that record to see those alerts rather than a scribe who may not be sufficiently medically trained to understand what those alerts do. So we have to work both sides of the equation.

BILIRAKIS:
Thank you. And your testimony, Mr. Secretary, you mentioned that this independent assessment reinforced the V.A.'s own analysis. Has there been a day -- have you done an independent -- has the V.A. done an independent assessment of their own?

MCDONALD:
We have. In fact, in my first few weeks in position I traveled to as many facilities as possible. I've now been over 220 facilities, and that has fed the information into our transformation plan. I shared it with the Chairman within my first couple weeks. You might recall the high-performance organization model. I shared it with the President of the United States, and that's what led to the 90 day plan called the Road to Veterans Day, and also to the My V.A. Transformation and the Five Strategies of My V.A.

BILIRAKIS:
Would you be willing to share that with us?

MCDONALD:
It's only two pages long. It's not the 4,000 pages and it didn't cost $68 million.

BILIRAKIS:
I appreciate us taking a look at it. We really would, I think we get a lot out of that. Was there anything that V.A.'s assessment discovered that was not included in the independent assessment?

MCDONALD:
I think -- what I would argue is my assessment was more about leadership and culture. It became very clear to me that I needed a new leadership team. Jim Collins who is a friend of mine likes to say you have got to get the right people on the bus and get them in the right seats on the bus. The assessment talked a lot about

leadership, but very specifically I need a new leadership team. Secondly, I spent a lot more time about the culture. What do I need to change the culture?

I called out two things, one called Design Thinking, Design Thinking is a technique that's used to design delightful consumer experiences. And I can go into more detail of the training that we did two weeks ago or week ago on that. Secondly, a lean Six Sigma -- lean Six Sigma. Think about Design Thinking as the way you design the experience for the consumer, think about lean Six Sigma as the way you improve productivity of what's backstage, what the consumer doesn't see.

BILIRAKIS:
Thank you. Last question, V.A.'s presentation to the commission on care two weeks ago stated that VHA has begun to work on many of the 188 recommendations that were included in the assessment, the independent assessment, which of the assessments -- many recommendations have you been working on and prioritized, if you can give some specific examples.

Congressman, be glad to do that. I think that in addition to what the Secretary said, VHA is also had its own strategic plan called Blueprint for Excellence. That was created after the Phoenix crisis, and Dr. Jonathan Perlin came in for a period of time to help with VHA to create its own strategic plan. So we have been hard at work in many of these areas that actually fit very nicely aligned with the recommendations that were identified in the independent assessment. They have to deal with these exact issues, how we prioritize our data, how we essentially address our leadership issues, how we engage our staff and improve morale and improve our hiring practices, how we ensure consistency and best practices across the system, something that both Mr. Byrne and Dr. Giroir identified today.

So these are all issues that VHA is hard at work, I didn't say that we've done all 188 but that we have begun work on the vast majority of these and we're going to use this independent assessment, and what comes out of commission on care to make sure the we're fining those appropriately.

BILIRAKIS:
Thank you. I yield back, Mr. Chairman.

MILLER:
Thank you very much. The Secretary keeps reminding us that we've invested $63 million or thereabouts for the...

MCDONALD:
Sixty eight million.

MILLER:
Ok. I like to remind the members that we just raised the cap on the Denver hospital $1.675 billion.

MCDONALD:
It's a complex of about 16 buildings.

MILLER:
It is a massive cost overrun and screw up, and we agree with that, thank you. Ms. Titus.

TITUS:
Thank you, Mr. Chairman. Maybe we should've used the 68 million to apply to that hospital.

MILLER:
They're probably going to need it before it's over with.

TITUS:
That's what worries me. Thank you, Mr. Secretary for being here. It is always a pleasure to see you. I just want to begin by taking exception to the doctors blanket statement that veterans are voting with their feet by going to the private sector. I think that's a spurious conclusion. I think some of those veterans are going to the private sector not because they want to but because they have to, because they can't get the services, get the appointment don't, live close enough to a facility, but they preferred the V.A.

And that kind of brings me to my general point. I made this on the floor last week that I'm worried about how the V.A. and how Congress is funding needed healthcare for our veterans. Last week as you heard, many times we voted to fund the construction of the Denver facility, and I know it is a good facility, I'm not questioning the importance of it. I'm not questioning the import of it, all veterans everywhere need care, but when we are talking about paying for it, we are just moving around the deck chairs. We're not saving the ship I'm afraid.

We're waiting for the specific recommendations of how the V.A.'s gonna move that money around, but what we have seen so far is pretty troubling. We are robbing Peter to pay Paul, and two of the points have come up this morning. You mentioned the COBOL antiquated language of computers and I.T. problems but one of the recommendations for paying for Denver is taking about $50 million out of that I.T. budget. You also mentioned that you're going to propose cutting funding for retention and recruitment programs, and yet one of the recommendations in one of the problems that seen is that we cannot hire enough doctors -- even enough much less the best and brightest, and that our hiring process is much longer than you find in the private sector.

I talked to the head of the medical facility in Las Vegas, and he said they had run out of this money. They need more money, not less as an incentive to get the professionals there. Now I'm not just blaming the V.A., I think Congress is at fault too. You mentioned that these short-term C.R.'s are not helpful, certainly I think they're irresponsible, and also we had these arbitrary caps that don't make any sense, and they don't allow us to accommodate future needs. You know maybe we should just put the V.A. in the -- account that seems to be where everybody wants to put the money.

But I'd like to ask you how important is it to get a real appropriations bill, I mean -- and also do you think you'll be coming back to us with another crisis situation. We're going to have to close down hospitals if we can't move this money around or we can't get some more money. Give us kind of a projection for that.

MCDONALD:
Well, I hate to predict a crisis, but remember the rate at which we're -- with these new hepatitis C drugs which are curing hepatitis C for the first time without the side effects that occurred previously. Remember veterans have a higher incidence of hepatitis C than non-veterans. We are trying to cure all of those veterans of hepatitis C. That's what helped create the budget crisis of the last fiscal year. That demand for the hepatitis C drug is not going to abate, because suddenly it's October 1st. So the continuing resolution is obviously not sufficient to be able to continue on the path we were on in order to treat the hepatitis C.

That's just one example. The other example of course is that you said I said earlier, on average 34 veterans using the V.A. for 334 percent of their care, 78 percent of veterans have a choice. TRICARE, Private Health Insurance, Medicare, V.A., they choose V.A. because of the care, that's what the VFW study said, 82 percent choose V.A., 87 percent recommend V.A. If that 34 percent number continues to rise, which it appears to be doing as more people are coming in the system as the care improves, then we have a real budget problem. And the dynamic -- the budgeting the way we do it isn't going to work.

It's not the way a business would do it. I mean we started the budget for 2016 two years ago, the drug was invented and you know between the time we started the budget and the time the budgets actuated, so that becomes a problem. We need a more dynamic's system. We also need to do a better job forecasting, and that's

on us. And then the inflexibility causes us to end the year with pockets of under-spending, where if we could aggregate all of those funds together we could make sure that they were all spent on behalf of veterans.

But because this particular fund isn't -- may be needed and we don't want to go over, we always under-spend. In business, you tend to aggregate funds so that you spend all the money that you've appropriated.

TITUS:
And I worry about the personnel for the appeal system. You're talking about the need for personnel, for the original backlog, but you got over 300,000 appeals in the system right now, and that number is going to grow too.

MCDONALD:
It is. We're working right now to reengineer that process. We will need some new legislation, we've been working with the veteran service organizations on something called the Fully Developed Appeal that will accelerate the process. But we need more people, and those people were in the budget proposal.

TITUS:
Thank you, Mr. Chairman.

MILLER:
Dr. Roe.

ROE:
Thank you, Mr. Chairman. I also thank the committee for all the work you all have done. I'm going to pass along the wisdom I got from an old G.P. when I started my practice many decades ago. He said you need to follow the three A's in the practice of medicine, one is availability, which the V.A. is flawed. Two is affability, do they like you once they get in, and third is your ability. And I think one of the things we ought to talk about, and I'm going to bring up some issues that came up with my veteran's person at home and walk you all -- to ground level not at the 30,000 foot level where we've been.

On productivity, I had a colonoscopy a couple weeks ago, the two docs I went to see in the private sector -- V.A. do 30 to 40 per day. You would overwhelm a V.A. anywhere if they felt they had 30, and this is just a routine day for guys in the private practice. You talk about scribes, my goodness, hiring a six figure doctor to make them 15 or 20 percent more productive with a 12 or $13 an hour makes perfectly good sense. Almost every private doctor you see now our shifting to that, and that's an added cost to them. It allows the most skilled person the healthcare system to stay productive.

And let that data entry go to somebody who's of a lower skill, and I think you're going to have to switch to that to make up the difference -- just not enough doctors in America with the current system. It slowed me down by about 25 or 30 percent. The electronic health record -- I tried to speed up -- use everything I could I just couldn't do it. And on facilities, I think you need to be innovative. We had a facility in our area where a local hospital had been vacated and they leased at the V.A. for dollar a year.

We need to be looking at innovative ways like that, and one of the things it said in the report -- and by the way this was a fantastic job that was done -- was at the capital requirements over the next decade the funding levels are two to three more than the funding levels are, and then it goes down two bullet points later and says V.A. construction costs are similar to other public agencies but double the private industry best practices in V.A.'s time to complete exceeds both the public and private -- other private sectors.

So you may have enough money to just get it done on time, and use those other things. I would point that out -- which is not mound veteran's officer at home personally does my work at home, and basically what she sings how you get an appointment to the veteran's choice program. She said she had been trying to put together a

summary, and what's happening is there are two ways you get in there -- eligible by 30 day wait list for more than 40 miles, and most of problem she saw was the 30 day list. This is what happens. Below is information been given to me about the rollout the program and my experience your piece to be a breakdown somewhere in this process, but it been unable to get clear answers on how to fix it.

The V.A. blames Tri-West, Tri-West blames the V.A. Eligibility is determined by the V.A. primary care Doctor if the appointment is passed 30 days. The non-V.A. care staff then uploads this list of eligible veterans to the V.A. central office here in Washington, and the veterans told wait five to seven days and then call Tri-West. The central office then sends information to Tri-West can take three to seven days -- if the consults don't get added, medical documentation didn't get uploaded, authorizations gets canceled, and the veterans on a merry-go-round.

I came to my office to get an appointment, I said you need an appointment with Dr. Smith. They went out front and made the appointment. That's what should happen. It isn't that complicated. And all this in between -- and I go on -- Tri-West has a different view of it. I'm going to submit this to the record because it really gets to the bottom of...

(CROSSTALK)

ROE:
Thank you, Mr. Chairman. The non-V.A. care staff was given no training on this and they basically left just to wing it how to make these appointments. It was one of the things was brought up and report. Our local V.A. care -- non-V.A. care staff increase from 5 to 15 but still a struggle and make all these appointments, and there's talk of calling each patient for every appointment to make sure they keep it. If the patient says I don't want to go, they still are told to call two times a month to past employment time. That's a complete waste of time. And the outpatient clinics also ought to be able to add patients to the electronic waitlist and instead of sending -- because appointment may come up, veterans get left out like that.

And the Tri-West portal is not very friendly. Private doctors did not like jumping through all the hoops of the choice programmers think they must give a percent of their fee to Tri-West in order for Tri-West to file the claim. So we have a clinic its close them at our office in our V.A. on chiropractic and -- with the way the system is. It is so bureaucratic. So anyway, I can go on and on -- this is a very extensive -- this is on the ground stuff that's going on today at our medical center, and I bet you it's going on around the country. These are things I will submit to you so you can get to work on this, and again appreciate the effort that you put into -- Mr. Chairman, some valuable information here for the V.A. to use.

MILLER:
Thank you. Ms. Brown, you had a question.

BROWN:
I do because I want the Secretary to answer that, because I think -- I'm neither with Tri-West today, but the important thing is you can't send a veteran to an agency or anywhere until they get approved from the V.A. because the most important thing is that that doctor -- reimbursement. So can you clear this up? No person in my office can send someone to a doctor, it must go through the system so that you get approval, and once that's done how long -- why does it take so long for that physician to get reimbursed, and can he answer that question.

MCDONALD:
We have flowcharted that process, and let me let David talk about the improvements that we made to that process. He'll answer questions one and three, and I'll take two on the facilities.

SHULKIN:

OK. Dr. Roe, I think your old adage on the three A's is exactly right. And you have to remember we brought this choice system up in 90 days. This is a national, very complex system, and what we've heard after bringing it up in 90 days is exactly the type of feedback that you've been hearing from your constituents. The Secretary and I are both out in the field, we understand that these problems are happening, and so what we've begun to do is to redesign the system and the process map it out.

Both the Secretary and I spoke to the CEO of Tri-West last evening, and we are beginning now to make outbound calls to the veterans before they had to call in. We are beginning to actually embed Tri-West staff in the V.A. so that they're working in teams, and we're beginning to start eliminating some of those steps. It is going to take a while. It is painful to watch this when you hear stories like what you're hearing, but we understand the problems there, we are working very hard, we think Tri-West and Health Net are working to help us make the system better and we're committed to doing this with urgency.

MCDONALD:
Relative to facilities, we agree with your comment. In fact, one of the things we talked with Rich about is figuring out how we can come up with a total system map that includes all the DOD facilities, all the V.A. facilities, Indian Health Service, medical school affiliates, so we can better understand where do we need to invest, where are the gaps where we need to invest were facilities don't exist. With the drawdown in the wars in the Middle East, what we're finding is DOD has a lot of capacity that we can use.

Martin Army Hospital is an example I used earlier, but there are many examples of where we're working together with DOD so that we can use the same facilities. If you look at the space that we've been doing over the past year or so, we've been leasing more space than we've been building, almost to a factor two to one. So I mean that's going to continue to be the case, because we got to be more flexible to meet the demand where the demand goes.

MILLER:
Thank you. Mr. O'Rourke.

O'ROURKE:
Thank you, Mr. Chairman and Ranking Member for organizing today's hearing, and to the panelists for joining us. I want to get back to a question that was raised earlier about the role of the V.A. system going forward, and the question raised by Dr. Giroir -- the letter that you signed to the Secretary in September 1st, suggesting that it is worth looking into whether or not the V.A. should focus on specific areas of service-related conditions, and some of things that we've heard from the Secretary about the 34 percent utilization rate today, and that for each additional percent of utilization it costs the V.A. I think $1.4 billion was a number that we got from you.

And that's -- 34 percent is just of -- those veterans who are currently eligible -- enrolled, doesn't include all eligible which I believes is 9 million or all veterans in the country over 20 million. So from a fiscal perspective, it's hard to make the case that the V.A. should provide all care to all veterans all the time, and just don't know how we could do it fiscally. I think there are some very serious operational concerns that are self-evident to everyone here. And then on the moral dimension, we really have a crisis in mental health care, when officially we know that 22 veterans a day are taking their own lives, and most veterans organizations that I spoke to think the real numbers is certainly much higher than that.

And we know that care delayed becomes care denied, turns into tragic outcomes for veterans and their families. I want to ask you and Mr. Byrne and the secretaries about the -- this question of prioritization. Should we be prioritizing the 41,000 funded but un- hired positions within VHA mental health providers, should the V.A. become a center of excellence as I think you suggested in the matter -- one of the issues we should look at so that perhaps 100 percent of eligible veterans who have post traumatic stress disorder or suffering from the consequences of traumatic brain injury have military sexual trauma, have traumatic amputations or other significant combat service-related conditions.

They go to the V.A. because it's a center of excellence, there are no access issues, and we prioritize hiring and resources there. And when we refer people out into the community, we refer them out for conditions that are comparable to what the general population has, whether that is diabetes or the flu or someone looking at ideology or your feet or any number of other conditions that are comparable. Tell me -- and I'll start with you, Dr. Giroir, what's wrong with that conclusion, and why the commission has not reached that already.

GIROIR:
Thank you for the question, and there were so many statements that we do support very strongly, what you said. Among the first -- that the first point I think it's -- it goes back to aligning resources with demand, and the V.A. in some aspect is an impossible situation, because the demand could literally double overnight depending on how the services are provided in the demand for the veterans. And that's an impossible situation to plan for, X two X, or three X, and you know the numbers as we outline them.

So to specifically define what the V.A. is going to do to fund it specifically for that and to provide other sources of care for the remaining is the main point. We have to align demand with resources however that's defined, it can be done two or three different ways. They can all work...

O'ROURKE:
Is some demand more important other demands? So if a veteran is coming back from Afghanistan with post traumatic stress disorder and cannot get into see a mental health care provider, isn't that more important?

GIROIR:
I'm not going to say more important, but what I will say which is the essence of your question, sir, the Blue Ribbon Panel does feel and I think it is true that there is care for these kinds of specific issues, post traumatic stress disorder, traumatic brain injury, traumatic amputation, severe burns and injuries, that nobody on the planet does it as good as the V.A. and it needs to be comprehensive care, not just in the operating room but all the social services, the mental services, the comprehensive provider care that needs to be done, and certainly at the essence that is something the V.A. among all things needs to be preserved for, whether the V.A. should take care of every patient with hypertension or diabetes or other issues is a question that needs to be resolved by the governance.

But clearly, those core issues are something that our veterans rely on, will rely on, and the future injuries of war that we cannot predict, the V.A. must always be there for that in our opinion.

O'ROURKE:
I'm out of time so I have to follow-up with the other panelists at a future date, but I would certainly love to sit down and talk with each of you to get your responses to...

MCDONALD:
We look forward to that opportunity. We have eight classifications today that help sort through some of that and we love so sit down and go through it with you.

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

MILLER:
Dr. Abraham, you're now recognized for five minutes.

ABRAHAM:

You said on multiple occasions that you want the V.A. to be run as a business, you -- business background with Procter & Gamble knows that certainly the V.A. could be a more efficient entity if it were run a business model. I want to reference -- you said that you were somewhat opposed to the governance board evidence of oversight of the V.A., why would you be opposed to that, sir.

MCDONALD:
I'm not opposed to a board as such, in fact. I even set up an external advisory board which is loaded just like the Blue Ribbon Panel with experts to help advice me. The reason I did that was I was disappointed that I've attended lots of committee hearings but nobody wanted to talk about the transformation of V.A. We are talking about problems that occurred in the past. So I do see the role of the board, but my thought is that if U.S. Congress really decide you need this board, isn't that an abrogation of your responsibilities? Can't we -- I think with the Chairman that we have, with the committees that we have, with the unanimity of purpose that we have, we can do these ourselves without needing a separate board.

ABRAHAM:
And we want you to do-it-yourself.

(CROSSTALK)

ABRAHAM:
We understand, but again, we don't want to abrogate our authority or our responsibility.

MCDONALD:
Absolutely.

ABRAHAM:
But we want you to do what you're paid to do and herd your people into the right direction, and make this V.A. system a better system -- Dr. Roe we -- back in the district so almost a weekly basis -- our veterans really aren't feeling the love so to speak. We are still having some massive issues, and you go across anyone's United States and the same issues come up and up. Dr. Shulkin, I'll also reference Dr. Roe on his scribes. I've used scribes for years, and I understand the alert deal, but the let me tell you, they work very well. And you as a physician can increase productivity at least by 30 to 40 percent if you have a scribe that is knowledgeable just in the system.

His other point -- availability, another novel idea and I'm sure you guys have thought about it, if you would expand hours of your V.A. clinics, I assure you as being a director of a multi-doctorate practice there will be nurses and doctors that stand in line that will take that 5:00 p.m. to 11:00 p.m. shift if they have children, if they have a spouse that works. And again, you're using just the same facility and just getting more efficiency out of that. So again these are ideas that don't...

MCDONALD:
Our RVU productivity is up eight percent and a budget increase of about 2.8 percent -- and extended hours is one of the reasons.

ABRAHAM:
And I know Dr. Wenstrup on my right here, he has referenced this RVU situation before, now we're to the point now where you can give us an RVU number?

MCDONALD:

Yes.

ABRAHAM:
Ok, excellent.

MCDONALD:
And David can talk more detail about our RVU.

SHULKIN:
I mean I think all your points are excellent, Congressman. We are actually doing many of the things that you've talked about, as the Secretary mentioned we've extended hours, we've improved productivity the RVU basis approximately eight percent, but many of our specialties well above that as well. And we are looking at issues like the scribe, but what we want to do is to take the independent assessments recommendation and look at these as system issues rather than pushing on...

ABRAHAM:
And I understand that. Mr. Byrne gave the four cornerstones of what assessments said, and if you look at a map and that's just basic business 101. It doesn't take a rocket scientist to figure this stuff out. What we're asking you guys to do is take it to heart and actually do it -- a few seconds left, Secretary, do you now have the power has -- have we as Congress empowered you now to be -- you talk about change in culture -- do you have that power now to do that?

MCDONALD:
Yes. We've -- 2100 people since I became Secretary.

ABRAHAM:
That is actually five. That is not retiring.

(CROSSTALK)

MCDONALD:
It includes some people who are in probationary status where we didn't hire them afterwards, but I think you know if you want to look for points of accountability, let's talk about a gentleman named Cathedral Henderson in Augusta, Georgia who now has 50 counts of falsifying consult records, each one carrying a potential fine of $250,000, and in total potentially looking at five years in jail. He's going to trial, so while I would like to do it faster we are holding people accountable. We're using all the forces of our ability whether to the office of special counsel, I.G., or in this case the FBI.

ABRAHAM:
Thank you, Mr. Chairman.

MILLER:
Mr. Walz, you're recognized.

WALZ:
Thank you, Mr. Chairman and Ranking Member for all of this -- thank each of you for your citizenship, for being involved in this. This is not going to be fixed by Congress, it's not going to fixed just by the

administration, and it is going to be fixed by citizens demanding and using our best and brightest to figure out a way to do this. So I for one am grateful, and Mr. Secretary, thank you. And I'm glad to hear you say, while not totally accurate, some of us have been asking to have this conversation a long-term systemic change.

I brought up many times the idea we had a Quadrennial Defense Review that drove policy, strategy, and budgeting from that. We never had such a thing on the V.A., and so I think it's really heartening. I appreciate all the work that went into this. I think hearing from Dr. Roe, sounds like he did just what we talked about, Mr. Secretary, we did a postmortem on someone's experience and those folks out there. So I here Tri-West alike keep Health Net in mind to on this, and I know you do, and I'm grateful for that.

I want to come back where Dr. Abraham was, this was an interesting point, Mr. Secretary, of all the recommendations and in full disclosure I always say this because it certainly influences my decision. I represent Mayo Clinic area so I look at how Mayo Clinic model is on outcomes, and this idea of a recommendation of a nongovernmental entity -- I looked at that and try to understand but I kind of think that I agree with where Ms. -- Dr. Abrams talk about you have a job to do we urge you to do it.

The public hired us to do a job too. I'm a little bit uncomfortable too putting someone between us and them, I'm just not sure we have the resources or if we've done it well enough. So I kind of like it each of your -- because I know this board concept is -- it is with mail -- Kaiser and all that I know that work came from.

MCDONALD:
I have over 25 special advisory committees today, 25. I like the statement Jack Welch used when he talked about G.E. We're trying to reduce levels and layers. We're working very hard at that, that's why we not filled a lot of positions, that's why we're reducing the number of -- from 21 to 18, that's why each state now will generally have one. Jack Welch used to say that adding levels, layers, and boards is like putting on more sweaters. You don't know its cold out because you got all these layers on. I like to have my pulse on what's going on in the business, that's why I travel so much. I don't think that creating a separate board is going to stop this committee from doing what this committee does, and I would just like to transform what we do and to be working on the transformation in the future rather than what we've been doing which is...

WALZ:
You think it's possible for us to assume that role too, because I would like to be that. I would like to be part of this transformation project, not just coming in here screaming when there's a fire to put out.

MCDONALD:
Yes, I do and you're right. You did bring this up in the past. We are all for it.

BYRNE:
So the recommendation that came from our assessment -- actually originated from best practices in private sector as you mentioned, I think the transformation requires a strong partnership and level of trust with the board wherever they may be and represent that. In a situation that looks complex as a veteran healthcare system, which is very complex and very distributed is not something you can pick up in just a couple hours. You saw when we did an in- depth study the amount of effort it took, for people to have enough familiarity to help make strategic decisions and guide levels of expected performance, you have to spend time.

There is just no way around that. I think it be great if this body did that, but some organizations say if I can endorse a proxy to help advice me and spend that time -- to build those levels of trust, and then -- you then use that as a faster way to do it. To be quite honest, there are 25 advisory boards, but none of them really have governance properties. And that is why we thought it would help actually build the partnership, but if it doesn't build the partnership, then we wouldn't do it. That is the purpose of the governance board, is to build that trust by having people spend more time and also to avail yourselves of the best experts in the private sector, because this is not just putting time with people who have done this job from all different states.

WALZ:
I'd like to spend more time on that. I think we as a body need to explore this whatever because I'm always fearful of giving away our power, because -- maybe and we talked about on -- I think I have a record streak going here saying Denver, so I'm gonna say it today again -- Denver, that I said maybe we should be involved in change orders if that's what it takes to get our hands in this and take responsibility. So I'll leave you with this, and Mr. Secretary, all the things you got on your plate you got a lot, but I think people here need to recognize, last week this Congress allowed the Agent Orange Act to expire, and I think it's altogether possible that the study that we asked for extensions so we can see if it's going to come out in March is going to add hypertension and stroke to that.

And you're going to have literally hundreds of thousands of people who by the scientific data are going to show experience these catastrophic health consequences because their exposure to Agent Orange, and the pressure is going to be on. If we don't have the courage to do it, they're going to ask you and much like the -- claims it's going to add to your work. And I just lay that out there for our folks to start thinking ahead.

MCDONALD:
It's a very good point. We've been working very hard to clean up some of the things that have been hanging around. C123 Agent Orange for example, we now cleared out.

WALZ:
Which I very much appreciate.

MCDONALD:
This is the right thing to do. Brown water navy, blue water navy, we're going through all of these things detail by detail. The point is that -- I get lots of letters from members of Congress wanting to add more and more benefits for veterans and I support that. But we also need the funding and the personnel to be able to do it. If we added for example -- and this is --this is not in the decision but if we added another precondition and we don't get the people to do it, 80 per plus percent progress we've made on the backlog of claims will go away.

WALZ:
Your decision is going to be to deal with that or to die the claims, and I think all of us here need to recognize that we are part of this.

MCDONALD:
We prefer to do what's right for the veteran and have you help us get the people we need to get it done.

WALZ:
Thank you for the time, Mr. Chairman.

MILLER:
And I think part of the problem is -- and we're looking backwards but this -- we were never asked for additional resources in order to deal with the presumptive claims that were added in the past. And so we're more than willing to help. We weren't asked and all of a sudden there was a backlog in and folks were using that as an excuse for the backlog, and we just -- we need to work our way through it. So I agree with Mr. Walz and with the Secretary assessment well. Mr. Huelskamp?

HUELSKAMP:

Thank you, Mr. Chairman. This is an excellent topic for us to discuss. It is something obviously we want to have happened last summer and had a chance to actually get down into it, so Mr. Byrne, I appreciate that. I am struck by some of the words that are used inherent -- and Mr. Secretary, I appreciate you being here. But looking at this independent assessment and I know it's a lot of pages -- Mr. Secretary, if I missed that -- how much have you read of this assessment.

MCDONALD:
I've read all 4000 plus pages, how much have you read?

HUELSKAMP:
Excuse me?

MCDONALD:
How much have you read, sir?

HUELSKAMP:
Well, good that your job. Your job is to take a culture of non-accountability on. There is a culture of silence, do you disagree with that assessment that folks are reluctant to speak up because of your lack of leadership?

MCDONALD:
Last September, there were people who were unwilling to speak up, that's the reason I've been to over 200 facilities, done town hall meetings in all of them, and I was...

HUELSKAMP:
Does this still occur, that's the question, could you answer the question please?

MCDONALD:
What was the question again?

HUELSKAMP:
Is there a culture -- do you disagree with the assessment that there's a culture of silence that your employees are afraid to speak up?

MCDONALD:
I disagree with that. In the town hall meetings I have...

(CROSSTALK)

HUELSKAMP:
You're in the midst of a leadership crisis.

MCDONALD:
I am in the midst of a leadership crisis. That's the reason I brought on 13 of 18 new leaders, and that's also why I'm asking you to step up and provide the support we need for the demand that we're facing.

HUELSKAMP:

You need more staff in your headquarters program office? Is a 160 percent increase in five years, is that not enough to take?

MCDONALD:
I saw that in the study as well, and I refer back to a letter I wrote the Chairman September 14th of 2014, that talked about the fact that the way V.A. -- September 16th of 2014, that talks about the Way V.A. codes these positions, many of those people who show up in the headquarters staff are not in the headquarters staff. They don't live in Washington, D.C. They're outside Washington, D.C. The letter is right here. We can look at it.

HUELSKAMP:
So it wasn't 160 percent increase in your staff?

MCDONALD:
No.

HUELSKAMP:
How much of an increase did you have?

MCDONALD:
The V.A. workforce grew 36 percent, between the end of fiscal year 2007 through August 2014. The largest growth was in position to interact daily with our veteran population, medically focused positions such as nurses, physicians, medical assistants, and claims.

(CROSSTALK)

MCDONALD:
About -- the largest increases, Congressman, were essentially where field positions were aggregated and then moved into the central office that was 420 positions between workforce management, between logistics and procurement, and emergency preparedness. So while there was an increase between 2009, 2014, it was not nearly as large as 160 percent because it was an aggregation of field positions to the central office.

HUELSKAMP:
The assessment also compares the VHA to other nationwide or regional providers and the compression that caught my interest in the Secretary was a provider that cares for almost 3.3 million more patients but does it with 114,000 less employees in 1800 less physicians. Can you explain why you need 114,000 more employees to take care of 3.3 million fewer patients?

MCDONALD:
As you know, our patients typically have very complex situations. Many of them have been created by the battlefields that they serve on, so it's very difficult. And I think most of the studies have been done including the Congressional Budget Office study find it very difficult to compare what goes on the private sector, and what goes on in V.A. Maybe Dr. Shulkin would like to add because he's been in both.

SHULKIN:
First of all, part of our job is to figure out how we can always do things better and more efficient. So I don't want to say that we're not always looking at that. But coming from the private sector, we're doing things in V.A. that are not done in the private sector. We are addressing many, many more behavioral, health,

psychological issues, we're dressing caregivers, we're addressing homelessness, and we are addressing services in our vet centers that just don't exist out in the private sector. So the comparisons are hard to make.

(CROSSTALK)

HUELSKAMP:
Does that comparison make sense or (OFF-MIKE).

SHULKIN:
Probably with Kaiser, I have to go back and look at the data, but there are several different aspects to make the comparison. One of them is that there is a risk -- adjusted risk with the different patient populations and the veterans are different and sicker and older than the other populations. That is one factor, and we did not do that risk adjustment to see it. And secondly, to be quite honest the number of missions in the VHA is much more complex than the private sector. We mentioned about the R&D, that's a massive 1 to $2 billion research a year they do.

You're talking about the training of 120,000 people, they are doing in the -- example of Kaiser they are laser focused on just healthcare, and that makes their ability to have efficiencies and focus much, much easier. Now if they took on those other things, I don't know if they'd be more efficient, but that's why it's very hard. And remember also Kaiser is probably at the top whether one of the high-performing healthcare systems, and the reason we went to those it because...

HUELSKAMP:
And I'm out of time. Why did you use that comparison if you have no basis to make comparison? I didn't read the 4000 pages -- could you explain it?

SHULKIN:
When we compared VHA with the private sector, they're about average, but we saw this large variation that was unacceptable. So we said the only way to make that variation go way is to get the best performing practices and that's why we shifted midway, and said let's start looking at the highest performing and make that the bar for VHA because that's the only way we felt you get the variations out. If they're already about average, those variations are going to be maintained if that's their bar.

HUELSKAMP:
So you can't compare them, is that your assessment?

SHULKIN:
I can't do a comparison.

HUELSKAMP:
Thank you, Mr. Chairman.

MILLER:
Thank you. Mr. McNerney?

MCNERNEY:
Thank you, Mr. Chairman. I want to thank you, Mr. Secretary, and I applaud your efforts for taking a sort of a systemic look at this. Maybe 50,000 foot view, because I started with this committee in 2007, we've seen the

budget increase greatly at that time, and we've seen some improvement. For example, the disability claims have improved, there still needs improvement but then also this crisis in healthcare pops up. It seems like it's a whack a mole, you hit one thing really hard, and some other problem pops up. So a systematic look at this is really needed, and I appreciate that.

Do you agree that the systems approach is the right approach moving forward?

MCDONALD:
Yes, sir, I do. I think one of the best business books ever written was the Fifth Discipline by Peter Sankey. He devotes a lot of time in that book to systems thinking, I'm an engineer, I'm a systems thinker, and I like the systems approach that the independent assessment took. The only thing I would have liked more is if that independent assessment included in the system Congress.

MCNERNEY:
Is there any way to get them to add that assessment?

MCDONALD:
I've made some suggestions. Their proposal was an independent board. I think -- what I believe is that this unique moment in time we got two great committees with two great Chairman, we got unanimity in the country, let's work together. I think we can get it done without the board, and by the time we get it done before the board gets set up.

MCNERNEY:
One of the problems in that interaction between Congress and the V.A. is in my opinion anyway, we have hearings and it is not clear that we're being told the whole story. We can ask a specific question, we will get a specific answer, but they'll avoid the greater problem that may be something that we can help with. So we need a better level of communication between the two bodies.

MCDONALD:
Sir, we want you to know all the problems. And even though we've made some progress, we have a lot more to do.

MCNERNEY:
The independent assessment looked at the demographics of veteran populations and stated that only half of the populations use the V.A. healthcare. What tools do you have available to help capture more of the veterans that could use healthcare?

MCDONALD:
We have developed an advertising campaign with the Ad Council, I don't know how familiar you are with the Ad Council but the Ad Council does pro bono work where companies put money in. We had done an independent campaign to encourage more veterans to sign up. We've not aired that campaign completely yet, because we need to build the capability to make sure we can take in those more...

MCNERNEY:
So have you had an independent assessment of the return on investment you've made in that?

MCDONALD:

We have not yet. We've done testing. The Ad Council did testing at their cost to show that the ads were effective, but we've not done any piloting of it to see how many people would come into the system. As I said earlier, and Dr. Giroir supported this, veterans only using the system for about 34 percent of their care, in every percentage point are $1.4 billion, so we have to be careful as we bring more people into the system that we can take care of them.

MCNERNEY:
All right. Mr. Chairman, I'll yield back.

MILLER:
Thank you. Mr. Secretary, is it your job to make sure that veterans receive healthcare or that veterans -- more veterans come into the V.A. system?

MCDONALD:
I think it's to take care of a veteran, that's what I'm here to do.

MILLER:
So if they're getting their healthcare somewhere else, they're getting their health...

MCDONALD:
If a veteran wants to get his healthcare somewhere else that's fine with us, we're here for them, and as the VFW showed, you know 82 percent choose the V.A., 87 percent recommend the V.A. So you know we're here for them and we want to build the capability for the number that comes.

MILLER:
And so my question is, is the ad focused on getting people to come back into the system, or is it to get people who are not getting healthcare at all...

MCDONALD:
It's to teach them how to sign up on E-benefits.

MILLER:
Ok. So they're not even...

MCDONALD:
They're not even in the system.

MILLER:
It's a conversation that we need to continue...

MCDONALD:
We do, because we need to -- as we've talked, we really need to talk about demand or requirements versus support.

MILLER:

And you talk about people coming to the to the V.A. because they like the V.A., delivers the best in the most quality healthcare and you hear anecdotal evidence out there too, that many veterans are going to the V.A. because you have no co-pays.

MCDONALD:
That's also true.

MILLER:
So that needs to be part of the discussion as well. Dr. Wenstrup.

WENSTRUP:
Thank you, Mr. Chairman. I thank you all for the hard work that you've put in here today. One thing I'd like to address, Ms. Brown, I think in this committee there's no elephant in the room. I think that everyone wants to keep the V.A. up and running, but we can have a conversation about centers of excellence, and I do think that there are things specific to military duties that create the need for these centers of excellence, but we also talk about how veterans have so many co-morbidities. We have to be able to address those as well, which is unique compared to a private practice.

And I also feel that we can have what we call VHA providers -- V.A. providers outside the walls of the V.A. and sort of breakdown that stigmas as a you're not a V.A. doctor, but you can be outside the walls. I think we will all benefit from that, especially like the analogy today about anatomy and physiology that we may have too much anatomy and not enough physiology you know. We can have a lot of -- we can have a lot of anatomy but if the heart rates 30 it doesn't really help much, right?

So I look in that direction, but really Dr. Giroir, I appreciate what you have come here and talked about today because it's something I've been talking about for three years, really taking a look at how we do our business. And it's nice today for example some of the things are going to DOD, but as someone who's been in V.A. and DOD, they have some the same issues as far as productivity, because I know as a practitioner and reservist I'll see 50 patients in my practice but 15 in the DOD, and it's not because of co-morbidities and sicker patients necessarily.

So there are some areas where that apply and others where it doesn't, and so when we talk about increasing our numbers and we got more appointments, we have to take a look at what we're really going, are we just extending hours or adding more providers, or we actually increasing the productivity for the providers. And I think that that's a key component, and it sounds like we're talking about it. And in the V.A. it is different too, because most V.A.'s are involved with education and training, that slows you down there's no doubt about it. We all know that in our practices, but that -- but still if we're talking about increasing to match the private sector to some degree, you know eight percent that sounds nice, but when we're talking 200, 300 percent higher in the private sector obviously there's a lot more we can do.

So I do applaud the decrease in wait times, the efforts being made, and actually finally having a frank conversation that I've been wanting to have for three years and how we actually improve the capabilities of our providers all across the board. One of the things that Dr. Abraham referred to, and I've -- you've heard me refer to it, Mr. Secretary is about the RVU's, you inherited a system that really couldn't tell you what we're spending for RVU, and we need to do that if we're really going to compare the cost of outside the walls of the V.A. and inside the walls of the V.A.

And until we can do that, we really can't make good assessments of what makes sense. We need to be able to assess our physical plans, I'm encouraged to hear you say things like -- if you're a doctor with one treatment room, you cannot be productive. It just doesn't work. So we also need a total cost per RVU, then we can start looking at facility cost for RVU, whether it's a CBAC, or whether it's a hospital setting, and specific clinics per RVU.

Then we can make some smart decisions. So I guess the only question I really have, are we getting closer to being able to do that?

MCDONALD:
Congressman, we do have RVU data. We have work RVU data. And our RVU data is directly comparable because it is the time and effort a physician puts in before, during, and after the visit. And so that's where we can show you the comparisons. It's not 2 or 300 percent difference, but you are correct, the private sector has higher RVU's than the V.A. Several reasons for that, our staffing ratios are far lower than they are in the private sector. We can begin to start getting at the cost issue, but this is where gets to -- is the work they we're doing in V.A. comparable to the work that's happening outside the private sector, dealing with the pure physical components of care.

But we are working towards that. Our commitment is to get the best value for the taxpayer and do the right thing for the veterans, so we are focused on efficiency and productivity as well as quality of care.

WENSTRUP:
When I talk about cost, you understand I'm talking about the physical plant, the administrative cost, all those things because when you refer outside of the V.A., you're not paying their malpractice and their physical plant, you're giving that fee for what they did similar to what Medicare does to a provider. And that's what we have to take into consideration, and I know that's a behemoth, but we really have to be able to look at those types of numbers to make logical decisions as we move forward.

And I'm talking about over the next decade.

MCDONALD:
Yes, I agree with you. We are looking at those things. Medicare does reimburse them more than the work RVU, they reimburse on the total cost RVU because there are three components to RVU's that are calculated when you're paid. And V.A. has different infrastructural requirements than the private sector, but I do believe that you're pushing us in the right direction to take a look at these issues and we're committed to doing that.

WENSTRUP:
Thank you very much. I yield back.

MILLER:
Thank you. Ms. Brownley, you're recognized.

BROWNLEY:
Thank you, Mr. Chairman. Mr. Secretary, good to see you again. Thank you to all of you for the hard work that you've done to bring us this report. And I apologize for being late, I was in another important hearing that I had to attend. But I wanted to ask Dr. Giroir a question, the assessment refers to a long-standing truth in the veteran community, if you've seen one V.A. hospital you've seen one V.A. hospital. And of course, we want to be as veteran-centric as possible, and certainly our veterans expect some level of standardization when it comes to not only intake, but obviously their healthcare.

So what are the most important recommendations do you think your report makes to ensure that veterans have a consistent experience within the V.A. system?

GIROIR:
Thank you again for the question. I think it's a very important one. In addition to the four cornerstones, I think a main principle here is an -- and again, no veteran cares about what the average is, the veteran patient cares

about the experience of that patient. But on average, the V.A. does pretty well compared to the private sector, but the variability is tremendously wide. So there are fantastic, wonderful, national-leading practices, but there are also V.A. medical centers that lag far behind the leading practices within the V.A.

And one of the recommendations that I think is obvious or should be obvious and probably is obvious to the leadership panel, is there needs to be transparent open process to share best practices, to encourage innovation that are in the visions. And if we focus on bringing the underperforming centers up to the level of the higher performing centers, you're going to have a system that is nationally -- could be nationally leading and certainly comparable to the best ones.

So one of the most important things is yes, if you've seen one V.A., you've seen one V.A., and that has to change because a culture of best practices needs to be developed and shared. And that's one of the primary recommendations of the panel. I see everyone shaking their head.

MCDONALD:
Well, this was the number one requirement when David and I -- when I was recruiting David for this position is we simply have to do this. We have pockets of excellence, but we have got to get everybody up to that standard. The thing we have to do is we have to do a better job with the employee experience. I want to share this with you. Last week, we took our top 300 leaders of V.A. off-site for training for three days. It's the first time they've ever been together for training, even though this is what you do in the private sector all the time.

This is a map of the veteran experience for the C&P exam, compensation and pension exam. So there's technology that exists where you actually map the experience, you map the backstage which is what's in the veterans mind, you map the onstage which is what happens when you -- when you work with them, and you map the backstage which is what you do in the backstage to make sure they have a great experience.

And then you design your facilities consistent with this, so we have people off-site -- remember the first strategy of My V.A. is to improve the veteran experience. We're mapping these experiences and improving them using lean Six Sigma in the backstage, using Design Thinking on the front stage, this is what the very best companies in the world do, and this is why we have to train people.

BROWNLEY:
So will that be a benchmark if you will in terms of identifying the lower performing facilities?

MCDONALD:
Yes, this is a technology we were going to use to redesign our experiences in every facility and across V.A., and then we will take the current best approach and we will make sure everybody does that current best approach. The reason we started with the C&P exam is that's typically the worst experience a veteran and a V.A. employee can have, and it's also often times the first time V.A. touches a veteran.

BROWNLEY:
And so do you have identification now of the lowest performing -- the best performing.

MCDONALD:
Yes, David can talk about...

SHULKIN:
I just want to reinforce what Dr. Giroir has said. V.A. overall has lower mortality rates than the private sector hospitals do. V.A. overall has better patient safety rates than overall sectors do, but the variation is certainly there. And I think as Dr. Giroir suggested, if we could bring everybody up a level and we saw 44 percent of

our medical centers actually improve their quality metrics last year, we could have an extraordinary healthcare system and that's that we're designing to do.

So our metrics now identify high performers, low performers, we know that. We're working with low performers to get their performance up, it is exactly where our focus is -- one of my top priorities to identify best practices.

BROWNLEY:
Thank you, and my time is out. I'll yield back, Mr. Chairman.

MILLER:
Thank you. Dr. Benishek.

BENISHEK:
Thank you...

MILLER:
I'm sorry. Mr. Coffman.

COFFMAN:
Thank you, Mr. Chairman. Secretary McDonald, the President recently signed a law a piece of bipartisan legislation that essentially transferred the V.A.'s construction program for projects costing more than $100 million to other agencies such as the Army Corps of Engineers. As you know, there have been billions of dollars of waste in the V.A.'s construction management program that could've been diverted towards veteran healthcare and other benefits. Are there other areas that you can look at in the V.A. that is really not your core mission like construction management that could go to a private entity, such as claims processing for purchase care -- Medicare have been successful with?

MCDONALD:
Thank you for the question, Congressman Coffman. We're looking at that as part of our My V.A. transformation to see what it is we should do in our core business, what it is perhaps we shouldn't do. But you know the building thing is even more than that, I think you know if I look at the problems with the building, I include the Aurora facility. Each one was designed as a one off. If Walmart builds a new store in Japan, that Walmart store in Japan looks very much like the Walmart store in the United States.

As a result, if you transfer somebody from Walmart U.S. to Walmart Japan, they know how to operate in that store. So not only your construction cost less because you keep building it, but your operating costs are less because people know how to operate in it. So one of the things we're doing with our construction -- and I know we're -- we got to work with -- will -- we will work with the Corps of Engineers over hundred million, is even what's under hundred Maine is how can we go to a modular design so that every facility is built the same, and we can transfer people from one to the other and they can operate.

And importantly, our patients will know where to go, I mean consumers love shopping in stores where they know how to navigate the stores. So I think there's a much bigger idea in construction than just giving the Corps of Engineers -- I think we have more work to do.

COFFMAN:
Some of the requirements that you have in terms of protection and renewable energy requirements that are nice to have, but are over-the-top relative to what's done in the private sector. And I think -- and clearly are driving costs as well.

MCDONALD:
As you know, those are federal laws, federal requirements and we will work with you on those.

COFFMAN:
Ok. Mr. Giroir, I think -- would like to comment as well on the -- what could be outsourced from the V.A. that might be more effectively done?

GIROIR:
Again, thank you for the question. And the report was fairly comprehensive, and particularly in the business systems that need to be fixed one way or the other. For example, claims processing probably left almost $600 million in reimbursement on the table from 2014, the lack of automation in reviewing bills from the private sector. If you want networks to common private physicians to see V.A. patients, they expect at least at some point in time to get reimbursed for their services.

So these are all aspects that we would hope there would be a critical analysis of either doing it in-house or certainly there are precedents for outsourcing these kinds of business functions to get the efficiencies and ultimately divert that money back into patient care.

COFFMAN:
Ok. The integrated report notes that VHA is in the midst of a leadership crisis, and according to this report it said, "At almost every facility visited, at least one leader interview mentioned that risk aversion and reluctance to speak up for a significant issue." This retaliatory culture permeates across all levels of V.A., and this committee has seen countless examples of retaliation against agency whistleblowers. Mr. Secretary, how are you dealing with the leadership crisis and the problems within the culture of the V.A.?

MCDONALD:
This is a big issue. Number one, we have got to get the leaders in place. Right now, 90 percent of our medical centers have had a change in leadership, but we're committed to that. David can talk about that in a minute. Number two, is we have got to make it perfectly clear what kind of culture we want, where we identify people retaliating against whistleblowers we're disciplining them. Number three, we've been working with a special counsel to make sure that the 45 or so whistleblowers get restitution in a positive way within our organization. And I met with the special counsel just this week, and we discussed how we can do a better job of this.

Number four, we've been certified by the office of special counsel for doing the training that we need to do to improve on this. Number five, town hall meetings, we have got to have townhall meetings, we've have got to get the light shined on these kinds of things, we got to listen to employees, and then importantly, I also meet privately with the whistleblowers and the union leaders when I go to every site.

SHULKIN:
Congressman, I'll just add to what the Secretary said. We do have a crisis in leadership. We have too many open-vacant positions, we have too many people in acting positions and interim positions. You can't expect that you're going to have a transformation in a health system unless you have stable leadership in place. We need your help on this. We need your help to help create the V.A. to be an environment people want to come and serve and be excited about, and we are asking for your help in title 38 for the -- hybrid title 38 to be able to help get the right type of compensation for leadership positions in V.A., that will help us a lot.

COFFMAN:
One issue -- and I'll yield back there, we are divided on as a Congress and I think your role divided on as well and that is the need for personnel reform, the need to be able to -- within the entire organization to fire those

who are -- to expeditiously get rid of those who are incompetent, those who are not performing, those who have committed fraud, to be able to get rid of them it is simply too difficult. There is a -- I think the principal problem in the culture of the organization is that it is too difficult simply to get rid of those who are not performing.

Mr. Secretary, when you're in Procter & Gamble clearly you do not have -- I think you had a more balanced approach in that -- in that environment than exists here and it needs some change. Mr. Chairman, I yield back.

MILLER:
Thank you. Dr. Benishek.

BENISHEK:
Thanks. I just want to touch on a few specifics that came to my attention from the report. It's something that you brought up too, Mr. Secretary, you mentioned using more leases to use the space -- just reminded me of the CBAC that we're trying to expand in my district in Traverse City -- the leasing process is like five years long. And you know if there is a way that we can help you speed that up, because that's as long as a construction process. I know a lot of bureaucratic reasons for that, but I think that's an issue that practically would help.

MCDONALD:
We agree -- we're now going through a lean process -- a lean study on that process. We will be back to you with the help we need.

BENISHEK:
Another issue, that is the -- nursing practice guidelines within the V.A., a lot of concern -- you know as a surgeon from the anesthesia department, independent practice of nurse anesthesia, doesn't seem to be any additional information about nurse anesthesia safety, versus the family practice type nurse practitioner, can you tell me what the situation -- I just want to make sure that out veterans are safe.

MCDONALD:
We put together a new nursing handbook which is now online for comment. I did get quite a few letters from members of Congress, particularly doctors who thought that nurse practitioner -- theology was going too far, we've noted that on the website. On the other hand, I've also gotten letters from nurse practitioners who say we should take full advantage. There are some studies available out there, one of which I think is a DOD study that says the safety is the same if not better, but I'm out of my medicine school.

(CROSSTALK)

BENISHEK:
Let me just go on to another issue. Dr. Shulkin, what exactly -- give me -- can you give me an example of how you're taking the environment where we have this -- some good hospitals and some good directors and some good processes, and the variability, what have you done so far on the job. I know you just started a little while ago, to make this better, to get the best practices from one facility to another. Can you give me a specific thing, because we touched on this issue many times -- discussions here, and I just want to get some ideas, specifically what have you done to make that better.

SHULKIN:
As I mentioned before, we have a measurement system that we call cell which is -- which is a metric system that puts together all these quality measures so we can identify high performers and low performers, then we're putting the high performers together with low performers. We're actually going on site with low performers

and sitting down with their leadership team to make sure they understand what the data says, understand the reasons why they're not able to adapt to the best practices, whether it's hiring reasons, competency reasons, training reasons.

BENISHEK:
What level are we talking about here now, is this department director -- can you...

SHULKIN:
We have -- out of our central office, we have a quality organization that is led by physicians. Those physicians actually travel to the sites of low performers, they bring the data, they meet all day with the leadership team, they set an action plan in place, and then they revisit whether there's improved performance. They are using what really the independent assessment has recommended, a continuous quality improvement process cycle, but we're setting goals and objectives and we're using the strengths of the best practice sites to help teach the lower performers.

And this is why we saw 44 percent of our medical centers make significant improvement over the last year.

BENISHEK:
I just want to relay one anecdotal problem to you, as long assessment I have your attention. And that is I still have contacts within the V.A. system from physicians who relay to me that they try to improve, for example, the colonoscopy performance rate, and yet they are being pressured by a peer review process to not complain so that the discipline does not appear to be related to the complaints but is something different in their practice -- I just want to be sure that you're aware of that, that's going on in a -- a lot of complaints from physicians about that issue. So I just want to bring that your attention today.

SHULKIN:
I appreciate that. I have yet to meet doctors that are afraid to complain, so they're usually pretty good particularly when it deals with patient issues. So I always encourage doctors to speak up...

BENISHEK:
That's very important because we provide the information that leads to better care and faster and more efficient care, and we'd just like to see those changes implemented rather than punished.

SHULKIN:
If you get those calls, please have them call David or me and would be happy to jump on them.

BENISHEK:
Yup.

MILLER:
Gentlemen, thank you very much for being here today. Thank you for the work that you've all done, both on this $68 million study, and Mr. Secretary, honestly we thank you for what you do. Dr. Shulkin, I think is a great partner in this process. I think you want to do the right thing. I think many of us are still concerned that the culture within the system is so hard to break. I don't know that there is a buy-in yet at the mid-level, as it relates to construction of facilities as you said to build one in Japan versus one in the United States. I think that is the appropriate -- many schools do that, so that they're all the same, and I just you know -- we want to be a partner in this process.

We do have to look backwards in order to go forward as well, and I know that is not what you would like to do, but we don't want to get into the mess we found ourselves in over a year ago. This committee is in a bipartisan fashion committed to working together to give you the tools that is necessary to serve the veterans of this country. Without objection, all members will have five legislative days with which to revise and extend their remarks or adding extraneous material. And Ms. Brown would like to say something.

BROWN:
Absolutely, Mr. Chairman. And let me thank the committee for being here, and I want to thank the Chairman that has agreed that we are going take a field trip to Denver Regional Complex Center -- lots of discussions and I think it will be good for the committee to go and visit with the facility. And then I think it would be good to stop by New Orleans to see how that is progressing also. So with that, I am very interested in, and the last closing remarks about you are on track.

I understand what the homelessness -- closing it out, and I wonder in the study, one of the problems that I found when I went to L.A., that was 400 units just standing there for over two years because the state did not have the funding even though we had provided the grant. So in the studies that they -- look at some of our partners like different states as we move forward, because they play a vital role in making sure that we move forward with the veterans programs.

MCDONALD:
We have fixed that. And in fact, the Mayor Garcetti recently announced -- I think it was $100 million that he's putting against homelessness in L.A. If we don't fix the problem in L.A., we won't fix it nationally, so we're all laser-like focused on it.

BROWN:
Thank you, and Thank you, Mr. Chairman.

MILLER:
Thank you, Ms. Brown. And for the record, I saw the Secretary's eyes get wide a second ago, I wasn't talking about a full committee field hearing out at the Denver Regional Facility. What I was doing was saying Ms. Brown to go out there any time she would like to. This time, this hearing is adjourned.

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