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News Release

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VA Statement in Advance of Anticipated Office of Inspector General Release Today of Administrative Reports on Patient Wait Times Investigations

We expect OIG to release summaries of all 77 completed investigations, and to complete and report findings on more than 30 other site-specific investigations, over the next few months. Many of the investigations that have looked into potential scheduling irregularities examine a point in time going back to when the Department requested that OIG review the Access Audit findings from early 2014, almost two years ago.

The report summaries released today will present new information to many Veterans and other stakeholders. However, in response to these concerns, accountability actions have already been taken where appropriate, and additional training and efforts to increase access to care have been underway since 2014 when these issues were discovered.

It is important to note that OIG has not substantiated any case in which a VHA Senior Executive or other senior leader intentionally manipulated scheduling data. In 25 of the 77 OIG completed investigations, OIG found no scheduling irregularity. In 18 of the remaining 52 reports, OIG substantiated intentional misuse of scheduling systems and provided this information to OAR. In 12 of those reports, OAR substantiated individual misconduct warranting discipline. From those 12 reports, 29 employees have been disciplined with actions ranging from admonishment to removal. This includes three employees who retired or resigned with discipline pending.

Since 2014, VA has been working diligently to increase access to care and improve scheduling processes. We have increased capacity, both inside VA and by relying on more community care resulting in almost 20 million additional hours of care for Veterans.

VA is now well underway on the "MyVA" transformation, the most significant culture and process change at VA in decades, with the primary goals of putting Veterans first and becoming the top customer service organization in government.

As VA moves forward, we are focusing on improving the Veteran experience by addressing the needs of Veterans, especially those with the most urgent health care needs and reducing the number of Veterans waiting greater than 30-days for urgent care. The Veterans Health Administration (VHA) conducted its second nation-wide access stand down this past Saturday to continue working on this most important issue for Veterans.

We appreciate that, in many instances, the OIG found no intentional wrongdoing; nonetheless these reports demonstrated the need for standardized training on scheduling across VHA. As part of "MyVA" transformation, VA has worked to improve our employee experience by working to modernize and enhance our scheduling processes in Vista, and leveraging industry to explore other potential commercial solutions. We have also strengthened leader and management training through a focused "Leaders Developing Leaders" program, and adopted "Lean" as the centerpiece methodology for our process improvement effort. We have also ensured that all employees involved in scheduling are retrained, while improving our processes as we update scheduling software.

We have repeatedly said that where misconduct has been found, whether by the OIG or VA OAR, which has often moved ahead of reports from the OIG, VA will take appropriate action. In cases where OAR or VA have completed follow-up work on OIG-related wait time cases, the Department has provided this information to local stakeholders.

The Department appreciates the work of the independent OIG to provide VA with necessary feedback to help us improve. OIG's investigations give us the opportunity to make necessary changes and better serve Veterans. However, the pattern of releasing results of investigations nearly two years after the fact is not only unhelpful, it creates the false belief among many that these problems still exist and discourages Veterans from coming to VA for the care and support they need.

The Inspector General position has been vacant for over two years. There is a nominee currently awaiting confirmation in the Senate to provide guidance and leadership for this organization.

ADDITIONAL BACKGROUND INFORMATION

IMPROVING TRAINING AND SCHEDULING PROCEDURES

Many of the challenges identified in VA's Access Audit and referenced in the OIG summaries were caused by a lack of training and inconsistent scheduling procedures across VHA.

In May 2014, VA began retraining every employee whose position includes the responsibility of scheduling appointments in order to eliminate inconsistencies across VHA or within any VA facility. This training made clear that all scheduling of appointments must use the official VA scheduling software and Electronic Wait List so that we can better track demand and need for additional resources. The Department's Wait List numbers are published for facilities across the country on a bi-weekly basis, and have been since June 2014.

Additional training has been added and is provided to front-line staff on an on-going basis. To ensure compliance to required directives and policies, in August of 2015, VA again required a review of all schedulers to ensure that appropriate training was completed. Employees who were not properly trained had their scheduling authority removed and were blocked from scheduling until properly trained.

This spring, VA will launch a new two week enhanced training program specifically for schedulers and other front line staff that will add an additional focus on critical customer service skills.

Additionally, VA requires each VISN Director and Medical Center Director to conduct Scheduling Inspections on a regular basis at VA hospitals and clinics. Over 11,500 of these inspections have occurred and this practice will continue.

VA is currently in the process of deploying VistA Scheduling Enhancements (VSE), with broad availability planned for this summer. VSE

will update VA's legacy roll and scroll scheduling application with a modern graphical user interface. This capability will reduce the time it takes for schedulers to enter new appointments, and make it easier to see provider availability.

In the longer term, VA is assessing the best approach for modernizing our scheduling system to achieve objectives for improved access and optimal resource utilization.

INCREASING ACCESS TO CARE

We are making lasting improvements in access to VA care expanding capacity by focusing on staffing, space, productivity and VA Community Care.

Staffing in the Veteran Health Administration is up more than 14,100 net — over 1,400 more physicians and 4,100 more nurses.

We've activated over 3.9 million square feet in the past two years.

We've increased authorizations for care in the community 46% in the past two years.

Clinic production is up 10% as measured by the same productivity standard used by many private-sector healthcare systems. This increase translates into roughly 20 million additional hours of care for Veterans.

As we improve access to care, more and more Veterans are choosing VA care — for the quality, for the convenience, or for the cost-savings so even though we're completing millions more appointments, we continue to have more work to do.

This past weekend, VA facilities across the nation completed a second Access Stand Down to connect with Veterans that have urgent health care needs, address their needs and reduce the number of Veterans waiting greater than 30-days for urgent care. This event also aimed to improve our employee experience by streamlining access to care processes.