THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

December 17, 2001

The Honorable Steve Buyer
Chairman
Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

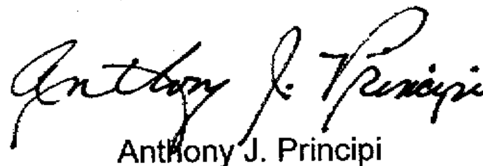
Dear Mr. Chairman:

Enclosed are the Department of Veterans Affairs' responses to the post-hearing questions you submitted from the Field Hearing in Indianapolis, Indiana, on September 5, 2001.

I apologize for the delay in providing this information and understand that Ken Greenberg from the Office of Congressional and Legislative Affairs advised your staff that the response would be provided by December 17, 2001. During that conversation your staff requested that the response to question 8 include national hiring figures as well as ones for the Northern Indiana Health Care System. The enclosed contains the national figures and the local Indiana figures will be furnished later this week. You have my assurance that the Department will continue to explore ways to improve timeliness of replies.

If your staff needs further assistance, please have them contact Ken on 202-273-5628. I look forward to continuing to work with you.

Sincerely yours,



Anthony J. Principi

Enclosure

Post Hearing Questions -- Indianapolis, Indiana Field Hearing
September 5, 2001
For the Honorable Anthony J. Principi
Secretary of Veterans Affairs
From Representative Steve Buyer
Chairman, Subcommittee on Oversight and Investigations
House Committee on Veterans Affairs

Question 1: What is the average number of days that it takes the Indianapolis VA Regional Office to process a VA Form 21-526 for compensation and/or pension (C&P) benefits? And for reopened claims?

Response: The following table shows the average number of days for the processing of VA Form 21-526 at the Indianapolis Regional Office in Fiscal Year 2001:

Indianapolis Regional Office	
Type of Claim	**Average Days**
Original Disabilities (1 to 7)	220.6
Original Disabilities (over 8)	279.0
Original Pension	131.1
Reopened Compensation	163.9
Reopened Pension	122.5

Question 2: How many of the nine hundred new personnel in the Veterans Benefits Administration are actual decision makers? More specifically, give a breakdown by raters, administrative support, and decision-makers.

Response: During Fiscal Year 2001, the Veterans Benefits Administration (VBA) hired a total of 1,298 new employees. VBA hired 398 Rating Veterans Service Representatives (RVSR) and 900 Veterans Service Representatives (VSR), but no clerical support. These individuals are all decision-makers and we will see the impact of their efforts gradually as they will be performing to their fullest capacity within the next 2 years.

Question 3: Mr. William D. Jackson, Director of the Indiana State Department of Veterans Affairs, testified that the number one complaint he receives is the lengthy waiting time for a veteran to get an appointment. He further stated that the time span has been running about (6) months. Please provide waiting times for new ambulatory care appointments and all medical specialties for the last calendar year.

Response:
Primary Care Waiting Times

All primary (ambulatory) care waiting times are based on medical needs. For instance, new patients with a non-urgent medical need who are seeking care at the Indianapolis VA Medical Center (VAMC), Northern Indiana Health Care System (NIHCS) or respective Community-Based Outpatient Clinics (CBOCs) are given an appointment within 90 days. Alternatively, new patients with an urgent medical need are usually seen on the day they present.

Patients seeking return appointments in primary care are given appointments based on clinical need as determined by their provider. During the last 12 months, the next available appointment in primary care has been 45 days; the current wait remains constant. Alternatively, patients seeking return appointments who are presenting with an urgent medical need are usually seen on the day they present.

Specialty Care Waiting Times

Specialty care waiting times are also based on clinical need. Of the 102 specialty clinics at Indianapolis VAMC, 70 clinics had a next appointment waiting time of less than 30 days during FY 2001. Thirteen specialty clinics had a waiting time of between 30 and 45 days, and only 19 had a waiting time greater than 45 days. Even for those clinics with an average waiting time of greater than 30 days, patients with urgent clinical needs are seen sooner.

Of the 83 specialty clinics at NIHCS, 63 clinics had an average next appointment waiting time of less than 30 days. Nine specialty clinics had a waiting time of between 30 and 45 days, and only 11 had an average waiting time greater than 45 days. However, similar to the case with Indianapolis, patients presenting at the NIHCS with urgent clinical needs are treated sooner.

Question 4: Mr. Jackson also stated that based on the President's budget for Fiscal Year (FY) 02, Veterans Integrated Service Network (VISN) 11 is projecting a deficit of $33 million. Please provide specific budget shortfall for VISN 11.

Response: Network 11's allocation will decrease by .04 percent from the FY 01 level, which equates to approximately $2.8 million below last year's funding. This decrease will not cover the 4.6 percent pay raise, a general inflationary increase of 5 percent, and the anticipated continued growth in patient workload, which will prompt even greater demands for pharmaceuticals, specialty care, and other ancillary clinical services. These additional considerations create funding challenges for VISN 11. Nevertheless, a variety of management efficiencies are planned for implementation to address these challenges and include potential changes in the OWCP, pharmacy, and orthotic laboratory programs.

Question 5: Mr. Richard Griffin, the VA Inspector General (IG), identified in the VA's IG Combined Assessment Program (CAP) Review (Report No. 00-00709-88 dated May 31, 2001) three systemic concerns. The three areas of concern are (1) problems with reconciliation of government purchase cards; (2) inventory control problems with some of the more expensive drugs; and (3) problems with destruction of drugs that have outlived their shelf life. Please advise if the Department will adopt the recommendations made by the VA's Office of Inspector General (OIG) to prevent any further purchase card irregularities and to strengthen controls over narcotics on a Department-wide basis.

Response:
Problems With Reconciliation of Government Purchase Cards

As noted in the OIG's reply to the Director's comments in Report 00-00709-88 dated May 31, 2001, the Veterans' Health Administration (VHA) issued an updated Purchase Card Handbook in June 2000 to address some of the issues raised. The other

purchase card program weaknesses cited by the OIG were violations of local or national policy, including splitting orders to avoid purchase limits. Subsequently, the facility strengthened cardholder training and documentation as well as the audits performed to verify compliance with purchase card policy. Monthly national reports show that 90 percent of VHA facilities meet the primary goal for reconciliation timeliness each month. These monthly reports and the quarterly Financial Service Center Quality Review Staff summaries are distributed nationwide to network and facility management for their information and action.

Inventory Control Problems With Some of the More Expensive Drugs and Problems with Destruction of Drugs That Have Outlived Their Shelf Life

Management at the Indianapolis VAMC met with nursing staff and supervisors from the inpatient units to review all of the OIG recommendations in the CAP report. At these meetings, existing policies were carefully reviewed and reinforced. Controls that were in place have been strengthened for outdated drugs. OIG found the measures taken by the Indianapolis VAMC were acceptable and that their recommendations were sufficiently implemented. VHA will use the OIG report as a "lesson learned" and will communicate the findings to other VHA facilities.

Question 6: The IG report of May 2001 cited several areas that needed improvement at the Roudebush VAMC and made several recommendations to revise and strengthen the controls currently in place. Please advise what actions have been taken to strengthen controls over human research projects and surgical informed consent at Roudebush?

Response:
Human Research Project Informed Consent

Indianapolis VA research investigators now place human subject informed consents in the patients' charts instead of forwarding the completed forms to the medical record file room as was done prior to the IG Combined Assessment Program (CAP) visit. In addition, a system has been instituted to maintain a comprehensive list of individuals engaged in research protocols. Furthermore, a research nurse will be appointed before the year's end to (1) review opened studies at the VAMC and the affiliated university; (2) make recommendations to protect human subjects; and (3) conduct human subject informed consent training. These measures were reviewed by VA's Office of Research Compliance and Assurance and were found to meet or exceed practices designed to protect human subjects.

Surgical Procedures Informed Consent

The Inspector General reviewed a judgment sample of 24 surgical procedures selected from the November 1999 surgical log. Of these procedures, 23 had valid informed consents. The OIG noted procedural issues with the remaining chart. Based on these issues, the Indianapolis Surgery Service requested review of all of the patient's medical records. The review revealed that a valid telephonic consent from the next of kin was obtained prior to performance of the surgical procedure. This review also revealed that the requirements for physician and surrogate to physically sign the consent were not followed. As a result of these findings, all staff members involved in operative procedures, including nursing staff, have been instructed in proper protocol. Random samples of records continue to be monitored periodically.

Question 7: The IG report made several recommendations, including the need to hire a qualified food manager. Please provide all corrective actions taken to improve safety and storage of food at Roudebush.

Response: In July 2000, Indianapolis VAMC hired a registered dietician to supervise the food production and clinical dietetics sections of Nutrition and Food Service. Moreover, the medical center employs a certified supervisor responsible for food safety and infection control issues. Close attention is paid to the strict cleanliness and sanitation requirements for food service. Reviews within the service, as well as routine Environment of Care rounds, have identified only minor discrepancies, which have been corrected in a timely manner. The JCAHO review in 2000 identified no concerns in this area. At all times a registered dietician was responsible for ensuring compliance with food preparation and delivery standards as well as all nutritional standards.

Question 8: The Veterans Benefit and Health Care Improvement Act of 2000 gives VISN Directors the authority to recruit new health care personnel, and the leeway to offer current professionals an increase in pay. Please provide the number of new health care professionals that have been hired as a result of this law. The information you provide should include the number of nurses, physicians, pharmacists, and other health care providers.

Response:

Occupational Series	Hires in FY 2000	Hires in FY 2001
0400 - Research Basic Sciences	272	222
0601 – Health Sciences	512	499
0602 - Physician	2,401	2,342
0603 - Physician Assistant	282	312
0605 - Nurse Anesthetist	95	95
0610 - Registered Nurse	3,956	4,448
0620 – LPN	1,814	1,867
0621 - Nursing Assistant	1,311	1,821
0622 - Medical Supply Tech	119	143
0625 - Autospy Assistant	3	8
0630 - Dietician	244	228
0631 - Occupational Therapist	180	178
0633 - Physical Therapist	188	208
0635 - Corrective Therapist	9	16
0636 - Therapy Assistant	61	60
0638 - Recreation Therapist	29	47
0640 – Health Technician (various)	588	657
0642 - Nuclear Med Tech	4	5
0644 - Med Technologist	239	304
0645 - Medical Technician	264	284
0646 - Pathology Technician	23	28
0647 - Diagnostic Rad Tech	272	312
0648 - Therapeutic Rad Tech	16	14

0649 - Medical Instrument Tech	132	133
0651 - Respiratory Therapist	12	9
0660 - Pharmacist	812	771
0661 - Pharmacy Technician	479	515
0662 - Optometrist	128	129
0664 - Restoration Technician	2	2
0665 - Audiologist/Speech Path	386	287
0667 - Orthotest/Prosthetist	17	18
0668 - Podiatrist	150	150
0669 - Medical Records Admin	40	39
0670 – Health Systems Admin	52	55
0671 – Health Systems Specialist	26	41
0672 - Prosthetic Representative	3	3
0673 - Hospital Housekeeping Ofcr	4	4
0675 - Medical Records Clerk	239	172
0679 - Medical Clerk	866	1,039
0680 - Dentist	248	239
0681 - Dental Assistant	114	103
0682 - Dental Hygienist	21	14
0683 - Dental Lab Technician	40	17
0690 - Industrial Hygienist	11	11
0699 – Health Trainee (Misc.)	436	631
TOTAL Accessions in Health Care & Related Occupations:	**17,100**	**18,480**

NOTE: These figures include trainees, fellows, and residents nationwide.

Question 9: Current processing times for C&P exams exceeds 45 days at Roudebush. What is the current waiting time for a C&P exam? What are the specific changes that need to be implemented, and what are the target dates by which those changes are to be made?

Response: The waiting time for a C&P exam is dependent on the type of exam requested and the complexity of the veteran's claim. Routine general medical exams, orthopedic exams, psychiatric exams and neurology exams are usually scheduled within 30 days. Audiology exams are currently scheduled within 45 days. Veterans requiring unique specialty exams do experience longer waiting times. Please note that the average C&P examination cycle time for VHA nationally for FY 2001 was 32.6 days.

The action plan for reducing the exam processing time includes the following actions:

- Establishing wait time triggers whereby C&P staff would contact the Director's Office when wait time for C&P appointment exceeds predetermined time;
- Exploring use of fee services for tests that exceed trigger wait time;
- Considering securing additional audiology resources either by hiring additional staff or securing some services via contract;

- Having gynecological exams handled in-house through new Women's Health Program clinic;
- Trending requests on a monthly basis to ensure capacity is created equal to demand;
- Evaluating overall C&P functioning to determine organizational changes needed to ensure process is brought into line and remains in line with all required measures (timeliness, sufficiency and incomplete); and
- Considering recruitment of another physician examiner.

These actions are expected to bring exam times to 35 days or less by February 2002.

Question 10: The Indianapolis Regional Office's new rating specialists are using the VBA's new rating automation software, RBA 2000. Please provide the number of new specialists? How many long-time specialists are still using the old non-automated system? What are the specifics of the plan, including milestone dates, to complete full integration and implementation of RBA 2000?

Response: The Indianapolis Regional Office hired nine new RVSRs and all of them are using RBA 2000. Ninety-three percent of the journeymen RVSRs use RBA, and seven percent of journeyman use RBA 2000. Currently, there is no local implementation plan. The VA Claims Processing Task Force recently recommended that VBA review implementation of RBA 2000. Additionally, the Information Technology (IT) Task Force Sub-Team is addressing the issue from a corporate perspective. Therefore, we are waiting on the recommendations from the IT team before taking further specific action.

Question 11: Indianapolis is among the best in the nation in handling telephone inquiries with a ratio of abandoned calls by veterans at 2.23 percent. What specific management initiatives did the Regional Office undertake to accomplishment this success rate?

Response: Indianapolis is part of a Virtual Information Center (VIC) consisting of seven regional offices located in six states. Calls received in the VIC are forwarded to the next available Veterans Service Representative, regardless of location. Since the inception of the VIC in June 2000, the combined abandoned call rate for the stations within the VIC decreased approximately 50 percent.

Virtual Information Center (VIC)			
	FY99	**FY00**	**FY01**
* Abandoned	4%	2%	1.6%
** Blocked	31%	0%	0%

*Abandoned calls are the total number of instances where the caller disconnected prior to being assisted by a VA representative.

** Blocked Calls are calls that do not get through and the caller receives a busy signal.

Question 12: Dr. Murphy stated that "there is no plan of record to close beds, there is no plan document in preparation." The Subcommittee has reviewed a memorandum dated August 1, 2001, written by Mr. Robert H. Beller and Dr. V. N. Vitalpur that outlines several proposed program changes, including decreasing inpatient psychiatry patients. These statements are not consistent. Which statement is accurate?

Response: The memorandum of August 1, 2001 discusses the implementation of initiatives previously approved by VISN 11 and VHA Central Office. This memorandum is consistent with Dr. Murphy's statement as the memo, outlined below, focuses on reducing the average psychiatry daily census rather than closing psychiatry beds.

The initiatives outlined in the memorandum include consolidation of all nursing home care beds at the Marion campus of NIHCS, discontinuation of acute medicine admissions at the Marion campus of NIHCS, and focusing on a "return to community" care model for psychiatry patients, rather then an institutionalization model. The "return to community" psychiatry model is highly consistent with current practice throughout VHA and in the non-VHA psychiatric care community. Successful application of psychosocial rehabilitation should, over time, result in a lower inpatient census in psychiatry. Although the average number of inpatients in psychiatry at the Marion campus will be lower, this does not mean that the NIHCS plans to close psychiatric beds. The current contingent of psychiatric beds a Marion is to remain intact for the foreseeable future.

Question 13: Ms. Teri James, RN, President, AFGE Local 609, stated that the lack of staff at the Roudebush Medical Center has meant that "veterans are being denied access to care at the VA and veterans are being diverted to private sector hospitals at what we presume is a great expense to VA facilities." Please respond to AFGE's testimony and please include specific number of patients that Ms. James is referencing.

Response: Veterans presenting for care at the Indianapolis VA Medical Center are not being denied care. There are no known patients who have presented to Indianapolis VAMC in need of admission who are not hospitalized at VA.

Veterans are sometimes sent to community providers for tests and treatments. However, these veterans are sent to such providers only when the VAMC does not offer a specific program due to insufficient critical mass. In such situations, VA contracts with community providers to provide the required care. Alternatively, from time-to-time veterans present to their local private sector emergency rooms in need of admission to stabilize an urgent medical condition. Once the VAMC is notified by the private sector hospital of the veteran's admission, that patient is accepted for transfer to the VA facility as soon as the patient's medical condition permits and a bed is available. Medical Center staff will contact Ms. James to discuss the specific instances she is referencing.