RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Shulkin, after serving at the Department of Veterans Affairs (VA) for about 20 months, what do you see as the most significant challenges facing VA and what would be your highest priorities if confirmed as Secretary?

Response. Our most significant challenge will be to address the systemic challenges that face VA. Over the past 18 months that I have served as USH we have been focused on addressing the acute issues that VA inexperienced with the crisis in access and the erosion of confidence with the American people. We have made real progress, and have turned the corner in numerous areas. However, it is now time to address the systemic issues that are required in business transformation.

My highest priority would be to work with the Administration and Congress to develop a sustainable plan for VA's transformation. This would involve working together to create a true integrated network of care, a system supported by an engaged workforce and modern technology solutions,and accountable for improving outcomes and efficiencies.

Specifically, I would target improvements to ease of the use of our services by decreasing non value added rules and regulations, implement industry best practices that lead to improved quality and efficiencies. I also want to accelerate our efforts in suicide prevention, homelessness, women's healthcare, continue to decrease the claims backlog and work on appeals modernization.

Question 2. Dr. Shulkin, would you please detail what experiences you have had while serving as Under Secretary for Health that you believe have helped prepare you for this broader role at VA?

Response. Most significant in preparing for the role of SECVA has been the opportunity to visit, spend time listening and learning about the needs of the veterans we serve. During my 18 months as USH I have seen firsthand the unique services and programs that VA offers to Veterans. As a practicing VA physician, I have been able to use and see the systems our clinician rely upon to treat Veterans. With this opportunity, I have learned what works and what needs to be changed. I have also seen all too often where we have fallen short of the trust and confidence that veterans has placed in us

VA has been working hard to act more as an integrated enterprise and in doing so I have worked closely with my colleagues in VBA, NCA and the Board of Veterans Appeals. I understand that veterans see us all as one VA and not separate administrations and therefore having a seamless experience is critical to us fulfilling our mission. During my time as USH, I have been able to contribute to efforts that improve services to veterans who utilize VBA and NCA. If confirmed, I would buildupon my foundational understanding of these issues to accelerate change in all three administrations.

Question 3. Since 2010, veteran homelessness has decreased by 47 percent. If confirmed, how do you intend to continue to prioritize efforts to prevent and end veteran homelessness?

Response. While these statistics indicate tremendous progress in ending Veteran homelessness and that the efforts of VA and its partners are producing successful outcomes for many Veterans, more must be done to accelerate progress. No one entity can end homelessness among Veterans alone. To achieve this goal, we need continued urgency and commitment from leaders in every community. There has been unprecedented support from the Administration, Congress, and state and local leaders to provide both the funding and human resources needed to end Veteran homelessness and much of our progress has come from the VA's collaboration with community leaders focusing efforts on the implementation of evidence based proven practices that are reducing homelessness among Veterans. But we know that ending Veteran homelessness is not a single event in time; rather, it is a deliberate effort made to achieve the goal, and continued follow-up efforts to make sure that progress toward achieving the goal is maintained.

We must continue our commitment to our efforts around rapid rehousing and permanent supportive housing for Veterans who fall into homelessness so that their homelessness is rare, brief, and nonrecurring. The ultimate goal is to make sure that every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services and that Veteran homelessness in the future is prevented whenever possible.

But housing Veterans is not the end of the journey. These Veterans, especially Veterans who have experienced chronic homelessness, need ongoing intervention and case management. Therefore, we must commit to continue to fully support our homeless programs such as HUD-VASH and Supportive Services for Veteran Fami-

lies (SSVF) and the current efforts to transform our homeless Grant and Per Diem (GPD) program. These programs provide data driven essential services designed to support Veterans with obtaining and maintaining housing stability. With our full commitment to stay the course that has proven successful to date, we can and will end Veteran homelessness and provide the blueprint for solving all homelessness.

Question 4. Legislation was enacted last fall to authorize VA to implement its master plan for the West Los Angeles campus. This new model for the campus, with a focus on housing and supportive services for veterans, could become a model for future VA campuses. If confirmed, how would you safeguard against mismanagement, which has occurred in the past, and ensure the master plan is implemented in a transparent, responsible way that best serves veterans and that will be an example for other VA campuses?

Response. In September 2016, Congress passed the West Los Angeles Leasing Act of 2016, which is historic legislation essential to VA's ongoing effort to revitalize the West Los Angeles campus. Through such legislation, VA envisions providing approximately 1,200 permanent supportive housing units and Veteran focused services on the campus, particularly for homeless, severely disabled, aging, and female Veteran populations. Within the next 30 days, we plan to execute the first Enhanced-Use Lease agreement for the campus, which will provide approximately 55 new housing units for Veterans.

Enactment of this legislation was based on unprecedented collaboration and cooperation between the Department, Congress, Veteran Service Organizations, the community, and other stakeholders. Our ultimate goal is to fully revitalize the campus, so that it is both a 21st Century facility that provides convenient healthcare, benefits, and services, and serves a home for our Veterans and their families. As noted in the framework Draft Master Plan that Secretary Bob McDonald publicly announced in January 2016, VA is working to ensure that future third-party land-use agreements are Veteran focused and provide fair market value, from both a monetary and in-kind consideration standpoint.

Currently, the West Los Angeles Leasing Act of 2016 requires VA to notify Congress 45 days before entering or renewing any leases or sharing agreement on the campus. The bill also requires VA to provide annual reports to Congress for the leases and sharing agreements carried out at West LA. In that regard, we have instituted a process where all proposed land-use agreements undergo thorough review of subject matter experts at both the medical center and VA headquarters, before approval and execution. And as required under the legislation, any revenues generated from such agreements will remain on campus, to maintain and renovate facilities to serve Veterans of greater Los Angeles. Additionally, the legislation expressly prohibits VA from disposing of any of the land at West LA. We are also required to submit annual audits to Congress, for any leases and Sharing Agreements executed on the campus.

Through this process, VA has recently executed new agreements with our local medical affiliate, the University of California at Los Angeles, as well as the Brentwood School, and the city of Los Angeles. These agreements are part of our overall intent, to create irreversible momentum in a collaborative and transparent manner, where the campus is used consistent with the principles of the 1888 deed, which conveyed the property to the United States.

We have established a new Community Veteran Engagement Board for the campus, where pertinent Veteran organizations and representatives will meet regularly, to discuss any and all matters of interest regarding our mission and operation of serving Veterans on the campus; to include the framework Master Plan and campus development.

A number of efforts are underway to support the implementation of the framework Draft Master Plan. In October, 2016, VA hired Concourse Federal Group (CFG) to assist with project management. CFG and their team of subject matter experts provide daily, on the ground support to VA for campus optimization and utilization, land use matters, and external communications. In December 2016, we also formed a VA Integrated Project Team, to begin the next phase of working to finalize the master plan for the campus. Experts from pertinent offices such as VHA; VA's Office Of Construction And Facilities Management; Office Of Asset Enterprise Management, Office of General Counsel, and the Office of the Secretary, will be working in unison, to ensure that the next steps such as environmental, historic, traffic, and utilities due diligence, occurs in an open and inclusive process. VA will continue to hold town hall and public hearing events, to enable us to receive valuable input from Veterans, Veteran service organizations, our community partners, and local neighbors. Through this process, we envision a campus that includes not just permanent supportive housing units for Veterans and their families, but complimentary

services to promote Veteran wellness, education, vocational training, rehabilitation, and peer interaction.

We are also working with local philanthropists, specifically a 501(c)(3) entity known as the "1887 Fund," to allow them to raise funds and provide donated expertise to restore the historic Wadsworth Chapel, and other landmark historic facilities on the campus.

In coordination with the Los Angeles National Cemetery, we are working to commence the planned columbarium expansion project at the campus, to provide up to 10,000 new niches for Veterans wishing for the campus to serve as their final resting place.

We are also pleased to advise that the campus is under new leadership. In February 2016, Ann Brown was appointed to serve as the Medical Center Director at West LA. Before coming to the campus, she served as the Director at the Jesse Brown VA Medical Center in Chicago, Illinois. Before that, she was the Director in Martinsburg, West Virginia; the Acting Deputy Network Director for VISN 9; the Associate Director for Operations in Nashville, Tennessee, and the VISN 23 Business Office Manager in Lincoln, Nebraska. Through her leadership and during her brief tenure, the West LA campus now has a new Acting Associate Director, a Chief of Staff, an Associate Director for Patient Care Services, and an Assistant Director. We look forward to Ann continuing to build her team at the campus, to successfully carry out the charge we have for her and other VA personnel, which is to continue to put Veterans at the center of everything we do.

Our sustained focus, commitment, and collaboration with the Department of Housing & Urban Development, the Department of Labor, local housing authorities, the former plaintiffs to the West LA litigation, local philanthropists, Veteran stakeholders, and the local community, has resulted in a 57% decline in Veteran homelessness in greater Los Angeles, since 2011. We know that in order to end Veteran homelessness nationwide, we must end it in Greater LA. Through our continued and collective efforts, I am confident that West LA will become a 21st-century, state-of-the-art model for other campuses nationwide, and make us all proud as we continue to serve and honor our nations Veterans.

Question 5. Women constitute an ever-growing segment of the Armed Forces and, consequently, the overall veteran population. What do you see as the primary challenges to appropriately treating and serving women veterans in VA facilities?

Response. The primary challenges to caring for women Veterans in VA facilities include: ensuring providers are well-trained to provide women's health services, ensuring an open and welcoming culture, including environment of care/facility issues, and outreaching to women Veterans prevent suicide.

Access

- Since 2014, VA has made tremendous strides in providing enhanced services and access for women.
  - 100% of medical centers and 90% of Community Based Outpatient Clinics have Designated Women's Health Providers
  - 130 VA medical centers have gynecology services on-site
  - VA tracks quality by gender and has reduced or eliminated several key disparities
    - o On some important quality measures, VA is better than the private sector (breast and cervical cancer screening)
- To meet increasing demand, VA needs to hire and train additional Designated Women's Health Providers per year.
  - Convincing VA providers to train in Womens Health is difficult due to:
    (1) increased provider workload;
    (2) few incentives for those who have been seeing only men for decades.
  - Recruiting external providers is difficult due to:
    (1) shrinking national workforce of Primary Care physicians;
    (2) persistent perception of limited opportunity to care for women in VA settings.

Culture

- VA is now engaged in an enterprise-wide effort to ensure its language, practice, and culture is inclusive of women Veterans.
- A 2015 national survey of women Veterans showed high satisfaction for those in VA care, perceived lack of Womens Health services among those not in VA care.
- VA has launched multiple campaigns aimed at inclusivity and recognition for women Veterans.

Suicide Among Women Veterans

In 2014, an average of 20 Veterans died by suicide each day. Six of the 20 were users of VHA services.

- Between 2001 and 2014:
  – The age-adjusted rate of suicide climbed much more rapidly for women Veterans than for women in the civilian population.
  – The rate of suicide for women Veterans in VA care, however, climbed more slowly than did the rate for those not using VA services.

VA's Office for Suicide Prevention partners with organizations to target services to women Veterans and ensures all outreach materials are inclusive.

Question 6. In response to the mismanagement and cost overruns at the new Denver VA Medical Center, Congress mandated that all major construction projects over $100 million be managed by the US Army Corps of Engineers. Additionally, VA made numerous changes to its policies and procedures for major construction projects. If confirmed, would you make it a priority to continue these and additional reform efforts to ensure that VA major construction projects are on budget and on schedule?

Response. VA's Office of Construction & Facilities Management (CFM) is responsible planning, designing, constructing and acquiring major facilities, and setting design and construction standards. VA recognizes that there is a need for continued improvement in the management of its major construction program and for adopting best practices to avoid cost overruns and lengthy delays encountered on some recent major projects.

Since 2014, VA has put in place sound construction management processes based on best practices from private industry and other Federal agencies including recommendations from the Government Accountability Office, VA's Office of Inspector General, and the US Army Corps of Engineers (USACE). VA has also partnered with, and embarked on process improvements based on recommendations from construction industry partners such as the National Institute of Building Sciences and the Associated General Contractors of America. The following improvements were put in place to ensure future success in the major construction program:

- Incorporating integrated master planning to ensure projects address gaps and meet agency goals;
- Requiring major medical construction projects to achieve at least 35% design prior to establishing cost and schedule estimates or requesting funds;
- Implementing rigorous requirements control and change management processes, and structured decisionmaking at key acquisition milestones;
- Using a Project Management Plan for delivery—from planning to activation—to ensure clear communication throughout the life of every project;
- Conducting pre-construction reviews of major construction projects throughout the design, to evaluate design and engineering factors and ensure constructability within given budget and schedule parameters;
- Integrating Medical Equipment Planners into construction project teams from concept through activation; and
- Putting in place metrics tools that will help monitor and manage performance and identify and mitigate emerging risks on large projects.

By accepting and incorporating best practices and recommendations from these organizations, CFM has been on a path of continuous improvement with the goal of achieving successful execution of our major construction projects.

Additionally, VA and USACE have a long history of working together to advance VA's facility construction program and share best practices. VA has engaged USACE to support our non-recurring maintenance and minor construction programs at more than 70 of our medical centers and national cemeteries across the enterprise. In December 2014, VA entered into an agreement to transition the Denver project to USACE for completion. Since then, VA has entered into agreements with USACE that now include VA utilizing USACE as Construction Agent on several major construction projects. This partnership continues to develop and mature, and the two agencies are working together to ensure the success of those partnered projects.

VA continues to address concerns from Congress and other entities and will continue to work to ensure the VA construction program is delivering quality, sustainable facilities on-time and on-budget into the future. VA is also interested in improving the planning and execution of its entire capital program to better address its aging infrastructure and meet the needs of Veterans with state-of-the art facilities and services

Question 7. What do you see as the role of this Committee in conducting oversight regarding VA and what steps would you take to ensure that the Committee is promptly notified of any emerging trends, issues, or developments at VA?

Response. The Committee's responsibility to the American public is to provide oversight of the Veterans Administration on all Veterans affairs issues to include budget, health care, benefits and cemetery affairs. If confirmed, I would seek to increase communication and collaboration with the Committee and its members and reduce the internal barriers that delay our responses and partnership with SVAC. I would also seek to make available my senior leaders and subject matter experts to answer your questions and be a resource that you need to do your job.

Since joining the VA as Under Secretary, I have worked to provide quality and timely responses that meets the needs of the Committee. I will ensure that we notify your committee of concerning issues, trends and developments in a timely manner. We will continue our work on decreasing case work response time and ensure that you have the information you need to provide oversight necessary.

Question 8. The National Cemetery Administration (NCA) has repeatedly earned the highest customer satisfaction score among the private or public sectors, yet the American Customer Satisfaction Index ranked the Department of Veterans Affairs third last in customer satisfaction among Federal agencies for 2015. What factors set NCA so far apart from the rest of VA and how would you leverage their best practices to improve customer satisfaction across the rest of the department?

Response. NCA continues to perform at a high level and builds its customer service culture around VA's core values, ICARE-Integrity, Commitment, Advocacy, Respect, and Excellence. In 2016, NCA received the highest ranking for any organization-public or private-on the American Customer Satisfaction Index (ACSI). With an index score of 96, NCA scored 28 points higher than the aggregate Federal Government score of 68.The following is a brief overview of the key processes underlying NCA's high customer satisfaction ratings.

1. Commitment from top leadership to be the best.
2. Define Excellence using input from all levels of the organization.
    a. NCA has established a formal Organization and Assessment (OAI) program to assess performance and the overall organizational health of National Cemeteries, Memorial Service Networks (MSNs), and Central Office components. Using Malcolm Baldrige National Quality Award criteria as a management framework, it enables NCA to document, track, monitor, and report progress toward successful achievement of NCA Operational Standards and Measures in the key cemetery operational areas of interments, grounds maintenance, headstone/marker operations, equipment maintenance, facility, maintenance, and safety.
    b. NCA applies OAI to each organizational entity annually and records performance as a scorecard.
    c. Long Range Plan (FY 2016–2021) developed which focuses on five specific goals that will enhance service to Veterans and their families.
3. Train employees on how excellence is defined and provide tools to succeed.
    a. Conduct front-line training at NCA's National Training Center in St. Louis
        i. 48-week Cemetery Director intern program
        ii. Cemetery Caretaker training
4. Hold employees and management accountable.
    a. Cascade performance expectations in performance plans.
5. Establish continuous customer feedback loop and adjust OAI surveys.
    a. Quarterly Customer Satisfaction Surveys
    b. Refresh operational standards and measures based on feedback
        i. Annual Lessons Learned Conference
        ii. Communities of Practice website
6. Commitment to employing Veterans.
    a. Workforce embodies the culture of Veterans serving Veterans
        i. Almost 75% of NCA employees are Veterans
        ii. Over 28% are disabled Veterans

The Veterans Health Administration (VHA) does, in fact, utilize the American Customer Satisfaction Index (ACSI) to understand how Veterans who have used VA healthcare services rate their customer experience, and compares that experience with that of private sector hospitals. For over a decade, VHA ACSI scores have outpaced that of the private sector (see Table 1 below). Many factors undoubtedly influence those scores—but certainly the high quality of VHA services along with their affordably are powerful drivers. But VHA is not content to rely solely on the ACSI to judge its performance, and we believe that the best way to compare ourselves is not with other Federal agencies, but rather, the U.S. health care system at large.

Across private hospitals, physician groups, and plans in this Nation, the principal measure of patient experience is the Consumer Assessment of Health Providers and Systems (CAHPS) survey, which VA administers using an outside contractor. Our CAHPS surveys indicate VHA does have more work to do in the area of Access, although other areas, such as Comprehensiveness of Care, i.e., care for Veterans that focuses on all of their needs and preferences are, in fact, superior.

Regarding best practices, while I was Under Secretary, I commissioned the Diffusion of Excellence initiative as an endeavor that focuses on achieving consistency of best practices throughout the VHA. During my first few months in office, I visited a number of facilities that had very unique ways of engaging both veterans and the employees who served them—even in sites that struggled to perform overall. I knew that if we identified the practices that worked best for veterans—both clinical and business-related—that we would be able to improve customer satisfaction throughout the system.

The Diffusion model has not only identified over 100 best practices within VHA alone for improving the veteran experience—it actually provides a framework that allows us to replicate those change efforts in other areas throughout the system.

As of today, these best practices have been replicated over 300 times across different sites in the system. The Diffusion model has gained traction, and is featured in an article that I wrote for the Journal of the American Medical Association, published just a couple of weeks ago.

In addition, a major enabler of establishing and spreading these best practices is an electronic platform (called the Diffusion Hub) that not only helps with implementing methodologies—it also provides a library of tool kits for specific solutions that we would like to see everywhere. This platform not only includes projects within VHA—but projects that originated out of NCA and VBA, for spread in other administrations as appropriate. As of now, there are already several best practices in customer engagement that NCA has contributed to this platform through Secretary McDonald's Leaders Developing Leaders (LDL) initiative.

Table 1: VHA Trends in the American Customer Satisfaction Index

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
VHA Inpatients	83	84	83	85	84	85	85	84	84	81	86
VHA Outpatients	80	82	83	81	83	82	83	82	82	79	80
Private Sector Hospitals	71	74	77	75	77	73	76	76	78	76	74

Table 2: VA comparisons on Consumer Assessment of Health Providers and Systems

(adjusted for differences in age, education, and health status)

CAHPS Composite	VA vs. Private Sector
Access (based on % always getting carewhen needed)	6 points ***lower*** than private sector
Communication	About the same
Provider Discusses Medical Decisions	About the same
Self-Management Support	About the same
Comprehensiveness (attending to mental and emotional health as well as physical health).	6 points ***higher*** than private sector
Office Staff	About the same

Question 9. The Veterans Choice Program, created by section 101 of Public Law 113–146, the Veterans Access, Choice and Accountability Act of 2014, would expire August 7, 2017, without Congressional action. Going forward, how do you envision expanding veterans' access to non-VA care while preserving within the Veterans Health Administration (VHA) the care and services VHA performs well?

Response. One of the most critical needs facing our Veterans is access to community care. VA's long-term vision for the future state is delivering timely, high-quality community care. It will make it easier for Veterans to access community care and easier for community providers to work with VA.

Our goal is to deliver community care that is easy to understand, simple to administer, and meets the needs of Veterans and their families, community providers, and VA Staff. VA has developed a long-term strategy as a starting point that allows for a balance between community care and care in the VA, purchasing community care when VA does not provide the service or cannot provide it when clinically needed. VA needs local market assessments to determine the availability of care both in the VA and in the community to ensure the appropriate mix of care.

We are making immediate improvements today, while seeking longer-term solutions. Together with Congress's support and funding, VA will continue working to streamline and transform VA Community Care to improve the community care experience.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 10. Dr. Shulkin, what is your view on the role of the Secretary of Veterans Affairs? If confirmed, would you seek to be an independent advocate for veterans or would you be the executor of the Administration's policies relating to veterans?

Response. The Secretary of VA is responsible to ensure that our Nation's veterans receive the highest level of service and care that we can provide. The Secretary also serves to ensure that the President and Congress' policies and laws are carried out to the best of their ability. If confirmed, as Secretary, I would work tirelessly to see that these objectives are fulfilled. As Secretary, if confirmed, I would be a strong and independent advocate for veterans and for policies that would support the interests of veterans. Once laws and policies are put in place, the Secretary should serve to ensure that these are carried out to the best of his or her ability

Question 11. Dr. Shulkin, what are your top three goals as Secretary of Veterans Affairs?

Response. If confirmed, my top goals as Secretary would be:

1) To ensure that the right people are in place to serve veterans, whether that be senior management or front line staff.

2) To ensure that the right resources, tools, and systems are in place to deliver these services to our veterans

3) To ensure that veterans are receiving the highest quality and character of services that they have earned and deserve.

Question 12. Dr. Shulkin, after serving nearly two years as Under Secretary for Health, how will you broaden your focus for VHA to the entire organization? What do you foresee as your biggest challenge in that endeavor?

Response. If confirmed, my goal for VA is to work as a seamless organization to meet the needs of our veterans. From a veterans perspective, they do not care if their services come from VHA, VBA, or NCA, but rather they care their issues are being addressed. The real strength of VA comes from the ability to meet physical, social, economic, and the holistic needs of the veteran.

VA has been working hard to act more as an integrated enterprise and in doing so I have worked closely with my colleagues in VBA, NCA and the Board of Appeals. I understand that veterans see us all as one VA and not separate administrations and therefore having a seamless experience is critical to us fulfilling our mission. During my time as USH I have been able to contribute to efforts that improve services to veterans who utilize VBA and NCA. If confirmed, I would buildupon my foundational understanding of critical issues to accelerate changes in all three administrations and implement a singular veteran centric service model for VA.

The largest challenge to working as an integrated enterprise is the ability to accelerate our journey to be a veteran centric organization and to challenge the status quo.

Question 13. Dr. Shulkin, one of the Secretary's major roles on an annual basis is developing and then defending VA's budget for a given year. Please explain your role in this endeavor under Secretary McDonald.

Response. My role was to develop, submit and defend the budget for VA's Medical Care appropriations—the Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities accounts, as well as for the Medical and Prosthetic Research appropriation.

The VA Medical Care budget is largely driven by the VA Enrollee Health Care Model, an actuarial model that estimates demand for health care services for the more than nine million Veterans enrolled with VA.

One of our challenges in developing this budget is that many Veterans have multiple options for health care, including Medicare, TRICARE, and employer health insurance.

We estimate that enrolled Veterans get a little more than one third of their total health care from the VA; however, this demand level can change rapidly based on economic conditions and availability of VA services.

We have seen steady growth in Veteran reliance on VA health care over the last several years, and anticipate that trend will continue in the future.

In addition to the modeled amounts, we developed estimates for other significant requirements, including:

- State Home programs
- Homeless prevention programs
- Readjustment Counseling Services (Vet Centers)
- Non-Recurring Maintenance for VA's aging health care facilities
- Activation of new health care facilities (initial outfitting of equipment, furniture and supplies, and new staff when applicable)
- Medical information technology support requirements, including VistA Evolution
- CHAMPVA and related programs (Spina Bifida, Foreign Medical Program, and Children of Women Vietnam Veterans)
- Caregivers support programs
- Indian Health Service agreements
- Health care services for Veterans exposed to toxic water at Camp Lejeune
- Medical and Prosthetic Research programs

a. Do you anticipate working within the limits established by the Office of Management and Budget or going to the President to advocate for the level of funding that is needed to fully fund the Department in the coming year?

Response. It is essential that the Secretary be a strong advocate for the resources that are required to do the job of serving our country's veterans. It is also essential that the Secretary ensure that those resources that are allocated are spent in an efficient and effective manner.

As I know you understand, the Office of Management and Budget must balance the needs of all Federal Government agencies against the total annual budgetary resources established by Congress. Therefore, increases in the VA budget may need to come at the expense of other agencies.

Question 14. Dr. Shulkin, if confirmed, what will be your plan to work with employee unions? Do you believe they play an important role in bridging communication between VA employees and management?

Response. As the USH, I have seen the value in working to engage with the employee unions and there have also been challenges The five national unions within the VA represent approximately 285,000 VA employees. VA has also negotiated master collective bargaining agreements with four of the national unions. Therefore, engaging with the unions, including bargaining on some policies that change employees' conditions of employment, is not only a statutory or contractual requirement, but when done effectively it creates a labor-management environment that enhances VA's ability to communicate our policies and initiatives to our employees.

Question 15. Dr. Shulkin, what is your view on the role of whistleblowers? If confirmed, will you encourage whistleblowing by the Department's employees?

Response. I support the Whistleblower Protection Act of 1989. VA has established a Whistleblower Protection Program that ensures employees, contractors, and grantees who disclose allegations of serious wrongdoing or gross mismanagement are free from fear of reprisal for their disclosures. If confirmed, will you encourage whistleblowing by the Department's employees? Yes. Leaders are responsible for establishing a workplace atmosphere in which employees are comfortable highlighting and sharing their successes—as well as identifying areas in which we can improve. Whether that means notifying managers and supervisors of isolated gaps or bringing attention to larger, systemic issues that impede excellence, it is important that all employees are encouraged to report deficiencies in care or services we provide to Veterans. Relatively simple issues that front-line staff may be aware of can grow into significantly larger problems if left unresolved. In the most serious cases, these problems can lead to and encourage improper and unethical actions.

Across VA, I expect workplace environments that enable full participation of employees. I expect employees to bring to the attention of their managers and supervisors shortcomings in the delivery of our services to Veterans or any perceived violations of law or official wrongdoing—including gross waste, fraud, or abuse of authority. And I will make clear that intimidation or retaliation against whistleblowers—or any employee who raises a hand to identify a legitimate problem, make a suggestion, or report what may be a violation of law—is absolutely unacceptable. I will not tolerate it. Protecting employees from reprisal is a moral obligation of VA leaders, a statutory obligation, and a priority for this Department. We will take prompt action to hold accountable those engaged in conduct identified as reprisal for whistleblowing, and that action includes appropriate disciplinary action.

Question 16. Last Congress, this Committee considered a number of legislative proposals that would have provided the Department with authority to sanction employees—both general schedule and Senior Executives—that is not available to other Federal agencies. Do you believe that, in order to best manage the Department's workforce, it needs expedited firing authority that would reduce an employee's right to appeal?

Response. What we need is an employee discipline and appeal process that provides enough due process to pass constitutional muster but allows us to take action faster than we can under the current process and affords more deference to the Agency's decisions than Merit Systems Protection Board judges often do. Ideally we'd like to see an overall reform of employee discipline and appeals rules throughout the Federal Government, not something that singles out VA employees for harsher treatment than their peers in other agencies, because we want to be able to attract and retain good people from all over rather than lose them to other agencies. We'd like to see a change in the agency's burden of proof on appeal to the MSPB, so we can sustain our actions based on substantial evidence rather than the higher and harder-to-prove preponderant evidence standard that applies today. That small change would allow us to take discipline more expeditiously and sustain our well-founded actions on appeal.

Question 17. Dr. Shulkin, have you spoken to the President-elect about your vision for the rest of the leadership team at VA? What is that vision?

Response. Yes, I have spoken to President Trump about my vision for the leadership team at VA. We seek to fill our leadership positions with people that have outstanding values and ethics, people that are passionate about serving veterans, people with superb experience and competence, and people who understand the needs of veterans.

Question 18. Dr. Shulkin, will you commit to quarterly meetings to update this Committee on progress the Department has made on recommendations from OIG, GAO, OSC, and other investigative reports? Who is responsible within VA for tracking and ensuring that these recommendations are implemented?

Response. Yes, I will commit to these quarterly updates. Each Administration is responsible for tracking and ensuring recommendations are implemented. If confirmed I would ask that the Office of Congressional and Legislative Affairs be responsible for communicating the recommendations from these reports and the resulting actions taken by VA to comply with these recommendations.

Question 19. Dr. Shulkin, the President-elect's vision to reform VA included the following statement, "Ensure our veterans get the care they need wherever and whenever they need it. No more long drives. No more waiting backlogs. No more excessive red tape. Just the care and support they earned with their service to our country." If confirmed, how will you achieve this vision—do you have more specifics on the President's 10-Point plan for reforming and modernizing VA for the 21st Century?

Response. If confirmed, I will immediately begin working to define the options that would work toward the improvements in VA that the President, Congress, and the American public seeks. In terms of the 10 point plan, I am still studying the various proposals and options that have been laid out by the President.

Question 20. Secretary McDonald has been lauded by Veterans Service Organizations and military service organizations for his attentiveness to their concerns.

a. Please describe your past VSO and MSO interactions.

Response. My interactions with Veteran Service Organizations (VSOs) and Military Service Organizations (MSOs) have been very positive and collaborative in nature. I have met with the Big 6 VSOs (Disabled American Veterans, The American Legion, Veterans of Foreign Wars, Paralyzed Veterans of America, AMVETS and Vietnam Veterans of America) as well as Iraq and Afghanistan Veterans of America (IAVA) on a monthly basis to share best practices and proactively address major VSO issues. Senior VA leaders have also met with the Post-9/11 VSO Groups: Got Your Six, Team Rubicon, Team Red, White and Blue (RWB), Student Veterans of America, Travis Manion Foundation and many MSOs such as Military Officers Association of America (MOAA) and Fleet Reserve Association (FRA) to build coalitions and address Veteran issues as well. VA Leaders have traveled to the major conventions and annual meetings and met individually with each of the VSO groups on a routine and reoccurring basis to solicit feedback and opportunities that VA can take to improve services for Veterans. On the local level, VA medical center facilities meet with our VSO partners on a monthly basis to capture feedback and improve the care and delivery of health care services to Veterans in the community.

Some of the initiatives that we have worked closely with MSOs/VSOs included *MyVA* Transformation, *MyVA* Access and Suicide Prevention. A direct measure of

the improvement that we have made with our MSO/VSO partners is with rebuilding trust. Nearly 60 percent of Veterans surveyed in June 2016 "trust VA to fulfill our country's commitment to Veterans" which is up from 47 percent in December 2015.

b. Please give specific examples of how you anticipate involving the VSOs and MSOs.

Response. We expect the same level of partnership and engagement with our VSOs/MSOs colleagues to continue as we work to continue the progress/momentum that we have gained with *MyVA* Transformation.

Question 21. Dr. Shulkin, will you commit to making data public, including the Monday morning workload report and wait times by medical facility?

Response. I am a strong believer of transparency of data. I am committed to making public our wait times by medical facility and our patient satisfaction scores related to access by facility. I am not familiar with the workload report, but if confirmed would be willing to consider looking at this suggestion.

Question 22. Dr. Shulkin, if confirmed, will you direct your agency to timely and fully respond to all reasonable Freedom of Information Act requests submitted by the American people?

Response. Yes, as stated earlier I believe in transparency.

Question 23. Dr. Shulkin, will you commit to sharing with committee staff VA organizational charts, for the administrations and staff offices, which include names and contact information, so that staff can get timely answers to concerns?

Response. Yes

Question 24. Dr. Shulkin, as you know, RAND recently reported that VA health care is as good or better than health care provided by the private sector. After nearly two years as Under Secretary of Health at VA, do you agree with this finding? Please explain.

Response. Statements related to the comparison of quality between VA and the private sector has been studied by numerous independent research groups. These research finding speak for themselves. My interpretation of these studies is that clearly in some areas, VA outperforms the private sector. Areas of superior performance generally include the comprehensive nature of VA care and include measures related to health screening, primary care, outpatient measures, safety and behavioral health. However, there are other areas of healthcare performance where VHA lags. If confirmed as Secretary, I would continue to focus my efforts on improving the quality and safety of VA healthcare, and continue to pursue improvement efforts utilizing private sector benchmarks.

Question 25. Many veterans, especially those with complicated health issues, rely upon the specialized services of the VHA. Many of these services, like spinal cord injury, blind rehabilitation, and prosthetics, are not widely available in the private sector. In an era of declining budgets and decentralization of funds, please describe your views on VA's responsibility to maintain capacity in these programs. What is your perspective on the future of VA specialized services (spinal cord injury, polytrauma, blinded rehabilitation, mental health)?

Response. With regard to mental health care, VA comprises an unparalleled system of comprehensive treatments and integrated services to meet the needs of each Veteran and the family members who support the Veteran's care. These services support Veteran resilience, identify and treat mental health conditions at their earliest onset, address acute mental health crises, and provide recovery-oriented treatments. VA provides a continuum of forward-looking outpatient, residential, and inpatient mental health services across the country. In FY 2016, more than 1.6 million Veterans received specialized mental health treatment from VA; This number has risen each year from over 900,000 in FY 2006. VHA provides mental health care integrated within its Primary Care clinics at VHA medical centers and large and very large community clinics with 15% more Veterans receiving Primary Care Mental Health Integration services in 2016 than in 2014. The integration of mental health services into primary care settings is designed in part to help overcome some Veterans' reservations about seeking mental health services. It also provides an opportunity to deliver mental health services to those who may otherwise not seek them and to identify, prevent, and treat mental health conditions at the earliest opportunity. Through the Measurement Based Care in Mental Health Initiative, VA is working toward the nationwide implementation of measurement based care (MBC). Fifty-eight champion sites, representing 18 Veterans Integrated Service Networks, have been selected to help develop and refine the infrastructure for this implementation. With MBC, Veterans assess their wellness through a standardized set of questions, with the resulting data then used to individualize and enhance their mental health care. To our knowledge VA is the largest mental health system implementing MBC.

A key VHA strategic principle is to ensure access, continuity, and quality for special emphasis and vulnerable populations in VHA, such as Veterans with spinal cord injuries and disorders (SCI/D), where VHA has expertise not found in the community. VA provides world class care to Veterans with SCI/D so they can achieve the highest possible health, independence, quality of life, and productivity throughout life.

A unique strength of the VA SCI/D System of Care, not found elsewhere in the private sector, is that the full continuum of care is provided to Veterans with SCI/D throughout life. This includes rehabilitation, acute care, ongoing primary care, preventive care (including comprehensive annual evaluations), lifelong medical management, outpatient care, home care, telehealth, respite care, long-term care, and end of life care. That care is coordinated through a hub and spokes model; similar coordination is not available outside of the VA.

There is no better place for Veterans with an SCI/D to get care than one of the 24 regional VA SCI/D Centers, where care is provided through highly dedicated and committed teams of knowledgeable and skilled professionals from different disciplines. In addition, VA facilities without an SCI Center have trained SCI/D teams that work closely with SCI Centers to deliver primary and limited specialty care. This hub and spoke model of care provides integrated and coordinated regional and local care throughout the US. Geographical access is further enhanced by dedicated SCI/D home care and telehealth programs. There are unique dedicated SCI/D long-term care units in VA that are not available anywhere else in the country. There are superior critical services provided in VA, such as prosthetics, bowel and bladder care, ventilator care, Home Improvement and Structural Modifications (HISA) grants, and travel.

In 2000, a report "VA Spinal Cord Injury and Disorders: A Comparison of Program Data Collected Across Four Modes of Care" demonstrated that the VA SCI/D System of Care was more comprehensive and offered superior resources, care, and training as compared with other large SCI Systems of Care in the U.S. and in Europe. Analyses of outcome data collected since then show that VA provides care that meets or exceeds internal and external benchmarks in all areas, including outcomes related to quality of life. Over the past 20 years, studies, surveys, anecdotal evidence, and behavior have demonstrated that Veterans with SCI/D highly value VA care.

- A will maintain our commitment to ensure these Veterans receive the specialized services they need. Such services are not widely available in the private sector—if at all.
- VA has established programs and systems of care to maintain and ensure the provision of lifelong specialized care and services for these severely disabled Veterans
- VA's systems of care for Polytrauma/Traumatic Brain Injury (TBI), Amputation, Spinal Cord Injury and Disorders, and Blind Rehabilitation are strong:
  - Specialized services are provided across tiered networks of specialty rehabilitation centers that serve as regional referral centers for acute inpatient rehabilitation for severe injuries.
  - Ongoing care and services are provided for Veterans in VA facilities with specialized interdisciplinary teams closer to the Veteran's home community.
- These VA programs uphold the highest standards of rehabilitation, such as CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation for inpatient rehabilitation facilities, and participating in HHS 'Model Systems' for VA's TBI and SCI programs (consortium of premiere private and academic rehabilitation centers).
- VA is further committed to ensuring Veterans continue to receive the prosthetic items and services they need. In FY 2016, VA expended $2.8 Billion to provide 20 million medical items, prosthetic devices and items to 3.3 million Veterans.
- With regard to mental health care, VA comprises an unparalleled system of comprehensive treatments and integrated services to meet the needs of each Veteran and the family members who support the Veteran's care.
- These services support Veteran resilience, identify and treat mental health conditions at their earliest onset, address acute mental health crises, and provide recovery-oriented treatments.
- VA is committed to ensuring continuing access to a full spectrum of mental health care for our Veterans.

Question 26. VHA has made undeniable progress over the past two years in integrating more community care into the VA health care system. Do you believe that a veteran's primary care clinician should continue to be part of the VA system or can s/he be any clinician a veteran chooses?

Response: VA has developed a model of personalized, proactive, primary care for Veterans. It provides a comprehensive approach to caring for the Veteran. Every Veteran is assigned to a primary care provider when they begin participating in VA health care to ensure their care is coordinated. This approach is critical to ensuring the Veterans health. However, in many parts of the country, Veterans live too far or face other obstacles in getting to the VA for their primary care. If Veterans receives primary care in the community, VA needs to ensure that all of the care is coordinated and the provider quality is the same or better than the VA.

Question 27. As we have discussed on numerous occasions, the roll-out and execution of the Veterans Choice Program in Montana and many other states has been nothing short of a disaster. In fact, the same issues have remained largely unresolved for two years and have left veterans, community providers and VA employees frustrated and angry. As many of these issues remain the responsibility of the Third Party Administrators in Choice, what are you going to do to hold them accountable for a continued failure to meet the terms of their contract, and to meet the basic expectations of veterans? Do you continue to believe that VA becoming the primary payer of Choice for all veterans and community care spending flexibility are critical to ensuring that the Choice program operates as intended?

Response. The VA uses several strategies to evaluate contractor performance and imposes penalties on contractors when they fail to meet the terms of their contracts. The Quality Assurance Surveillance Plan (QASP) is a recurring assessment of contractor performance throughout the term of the contract. When contractors fail to meet the metrics established in the QASPs, letters of correction and financial penalties, also called equitable adjustments, are assessed against the contractor. Equitable adjustments have been, and will continue to be, used to move the contractor toward meeting the metrics outlined in the contract.

Congress can assist in simplifying the claims processes through a change in the law that makes the VA the primary payer. This change would lead to greater efficiencies in claims submission by our community providers and subsequent payment by our contracting partners. This change would also eliminate the labor intensive process of identifying and communicating other insurance coverage on the front end. A transition back to VA being primary payer should be a relatively smooth transition since the original framework of our Consolidated Patient Account Centers (CPAC) was built upon this premise. This change will allow our CPACs to operate as originally designed by recouping costs from third-party payers after care has been rendered.

Question 28. Dr. Shulkin, the Commission on Care rejected the idea of granting veterans who use the VA unfettered choice in seeking care outside of the VA. Do you agree with this position, or do you believe that a veteran who is eligible for VA health care ought to be provided with a voucher to seek care wherever s/he chooses, with VA footing the bill?

Response. My belief is that every veteran that relies upon VHA for their healthcare must have access to the best quality healthcare in a timeframe that meets their clinical needs. We must utilize care within the VA and outside the VA to meet this objective. In terms of total unfettered access, I think given the models considered by the Commission and the subsequent economic modeling done by their economists, that the Commission came up with the reasonable conclusions. However, if confirmed, I would plan to explore different options that would allow veterans greater choice while maintaining the unique character and services of VHA. These proposals will require additional analysis before they can be fully considered.

Question 29. Dr. Shulkin, are you in favor of the Commission on Care recommendation that would grant veterans with other-than-honorable administrative discharges eligibility to access VA health care on at least a temporary basis?

Response. If confirmed, I would take a serious look at such a proposal and confer with both the White House and Congress about ways that we might address this population.

a. Have you spoken to President-elect Trump about how he intends to handle services for veterans in need who have bad paper discharges?

Response. No

Question 30. President-elect Trump's plan for veterans talks about embedding satellite VA clinics within other health care facilities in rural and other underserved areas. With existing government acquisition, leasing, and contracting laws, how do you intend to make this happen quickly?

Response. The Department has various means for providing care or embedding "clinics" in affiliates or other healthcare facilities to provide healthcare for Veterans in rural and other underserved areas:

VA providers only—VA provides healthcare out of non-VA's healthcare sites through the sharing of staff/resources, not real property. This is a similar model to how VA partnered with the Department of Defense (DOD) to do exit exams. A VA doctor would perform exams in a DOD facility, but VA would not have real property interest in the site, it would be purely resource sharing.

Real Estate Solutions—VA could utilize tools such as revocable licenses and permits as quick, short-term real estate agreements to occupy third-party space for VA providers. Such agreements do not have to be competitively sourced but can only provide a interim solution—up to 5 years in certain circumstances but typically much shorter. For any type of long-term, presence, VA would acquire space from a third party through leasing. With current competitive requirements, it may take longer to go through the process. VA would lease a portion of space and staff it with VA personnel as a standard clinic. The competitive procurement process would dictate the final location from within a VA specified geographic area, but requirements could be written to help narrow down the scope. This issue could be streamlined with legislative changes to allow sole source leasing with affiliates and state and local governments. In that case, it would still be a lease, but could be non-competitive if it were with an affiliate location or applicable local government.

Question 31. Dr. Shulkin, do you intend to modify Secretary McDonald's *MyVA* priorities or "breakthrough initiatives?"

Response. The *MyVA* priorities were established through consultations with VA management and staff, veterans service organizations, community groups and The *MyVA* advisory Committee. Progress has been made in many of these areas and in some cases the goals have been achieved. If confirmed as Secretary, I would continue progress in those areas where progress is still needed, establish new and bold goals for other priority areas, and continue to consult with veterans and the organizations that represent their interest to modify and evolve these initiatives.

Question 32. In your opinion, what more do you believe needs to be done to improve personnel recruitment and retention at VA health care facilities?

Response. VHA is continually striving to improve personnel recruitment and retention at VA health care facilities, and has a robust and multi-pronged approach to recruitment. Local facilities have in-house human resources departments, as well as nurse recruiters, who reach out to and coordinate with applicants on a local level, including outreach to nearby training programs and hosting open houses when needed to facilitate hiring. Facilities also produce job advertisements in local, state and national publications, journals, newspapers, radio advertisements, hold local career/job fairs, and attend local and regional job fairs. VHA also has a National Recruitment Program (NRP), 100 percent staffed by Veterans, that employs private sector best practices to fill VHA's top five most critical clinical and executive positions.

Our major challenge is the unnecessary hiring complexity caused by VA having three different hiring authorities. As Secretary, I'd like to continue to explore with the Congress establishing an Alternative Human Resources (HR) System for VA, converting VA to Title 38. Additionally, for our clinicians, a single Federal credentialing system, coupled with national reciprocity for credentialing, would greatly improve our ability to hire and retain clinicians, improve the hiring process from the applicant's perspective, and allow us to more easily deploy our clinicians to meet surge needs as the may arise across VHA.

Finally, the prudent use of recruitment, retention and relocation incentives has been an important tool for VHA hiring and retention. Removing these incentives from the CARA award caps would restore our ability to appropriately deploy these important flexibilities to improve our ability to compete with the private sector.

Question 33. There has been increasing pressure in recent years for VA to contract for services in local—especially rural—communities where VA facilities are not easily accessible. Mental health is one area of particular emphasis in this regard. What do you believe is VA's responsibility for meeting the needs, including mental health needs, of rural veterans? If confirmed, what emphasis would you place on this issue?

Response.

- VHA is committed to meeting the health care needs, including mental health, of all Veterans, regardless of where they live.
- Rural Veterans deserve a special focus as they have a higher risk of suicide than Veterans in urban areas.
- Other challenges of rural Veterans include:
  - Provider shortages
  - Geographic barriers
  - Lack of transportation options

– Rural community hospital closures
• VHA is taking steps to address mental health provider shortages in rural areas by establishing regional telemental health hubs
• In 2016 VHA established four regional telemental health (TMH) hubs to enhance Veteran access to mental health care for Veterans residing in rural areas
– The four hubs are in South Carolina, Utah, Pennsylvania, and Washington-Oregon area.
– Six additional hubs are planned to come online in 2017.
– This will extend mental health services to up to 200 sites of care where more mental health capacity is needed.
• VHA has also expanded capacity to serve rural Veterans at home, issuing tablets for the delivery of care, including mental health, to nearly 3,000 Veterans.
• Standardized training on suicide prevention guidelines in face-to-face clinical settings and during telephone contacts specifically for clinicians who work with rural Veterans
• Integrating evidence-based practices and existing VA programs (e.g., suicide risk management in primary care, crisis support, firearm safety, and the Home-Based Mental Health Evaluation program) into a comprehensive portfolio of best practices to prevent rural Veteran suicides.
• We recognize there are workforce shortages in rural areas and will continue to pursue strategies to meet these workforce gaps, including:
– Expanded scope of practice for advanced practice registered nurses
– Expanding workforce training programs in rural VA locations
– Leveraging the VA ECHO (Extension for Community Health
Outcomes) program to ensure primary care providers in rural sites can access specialty training and consultation
– Hiring of highly trained Veteran combat medics and corpsmen

Question 34. What is the appropriate level of oversight and responsibility that VA has for the care veterans receive from community providers?

Response. VA needs to ensure we provide a full network of care, including appropriate quality in the network. The Request for Proposal (RFP) that was released on December 28, 2015 includes requirements for the networks to be accredited and for providers to be credentialed. The contractor must establish a variety of quality, network adequacy, patient experience and operational efficiency plans. There are over 20 in total that will be required as part of the contract. In addition, VA will establish certain quality measures to be included based on industry standards. A Quality and Patient Safety Model and Framework was created to establish the baseline for moving to a value-based model of care, based on the Institute of Medicine (IOM). These measures will move the VA forward in ensuring appropriate quality when community care is provided.

Question 35. Female veterans are the fastest growing population in the VA today and will continue to grow over the next several years. The President-elect has stated his intent to better meet the needs of female veterans, which I support.

a. During your time at VA, what have you done to improve the physical and mental health care access, quality of care, and address privacy, security, as well as the transition for female veterans?

Response.

Physical and Mental Health Care Access

• Since 2014, VA has made tremendous strides in providing enhanced services and access for women.
– 100% of medical centers and 90% of Community Based Outpatient Clinics have Designated Women's Health Providers
– 130 VA medical centers have gynecology services on-site
– VA offers a full continuum of gender-sensitive mental health services to women Veterans
– VA has deployed large scale initiatives to train current VA physicians on Women's Health core curricula and priority topics, including Mental Health
– All Primary Care and Mental Health providers are also trained in the care of Veterans who have experienced Military Sexual Trauma

Quality of Care

• VA tracks quality by gender and has reduced or eliminated several key disparities
• On some important quality measures, VA is better than the private sector (breast and cervical cancer screening)

Privacy and Security

• VHA has committed to ensuring all facilities meet Privacy Standards—to include physical and auditory privacy—and to increasing the accountability of facilities to follow these standards.

• By policy, all Veterans' personalized health information is protected with the same level of privacy and security regardless of gender.

• VA's focus also goes beyond physical security to ensure the entire experience of women Veterans is positive.

• VA has launched multiple campaigns aimed at recognizing the service of women Veterans and is now launching an even more direct effort to increase civility and respect through the "End Harassment" campaign.

b. Will the President-elect's desire to "fully equip" every VA hospital with women's health services bump other projects for the SCIP list to achieve this goal?

Response. For the past several years, one of VHA's goals has been to incorporate women's health into various aspects of our capital initiatives. Just a few of our numerous examples include dedicating a women's health exam room into the PACT design model; converting existing multi-bed inpatient rooms to single bed inpatient rooms; updating VA's Women's Health Design Standard and Guide for separate women's clinics; and including a women's health sub-criteria in the Strategic Capital Investment Planning (SCIP) scoring process to increase points for any capital initiative focusing on women's health.

In addition, in the SCIP 2018 cycle, VHA narrowed the first year capital initiative focus to only include leases and projects under the following umbrellas: Women's Health, Inpatient Medical/Surgical Bed Conversion to Single Beds, Primary Care and Outpatient Mental Health, Safety, and Infrastructure. The impact of this focus for first year projects and leases resulted in approximately a 1/3 reduction in capital initiatives compared between the SCIP 2017 cycle final list and SCIP 2018's preliminary list. This allowed women's health type projects and leases to better compete for limited construction and leasing funding.

VHA plans to continue this narrowed focus with the same categories for the SCIP 2019 cycle in an effort to continue to support VHA's goals, which includes converting existing deficient space and/or adding more space, resulting in state-of-the-art, modern environments for VA to provide women's health.

Question 36. During your time at VA, what have you specifically done to reduce the number of veteran suicides? What do you still hope to accomplish if confirmed as Secretary?

Response. Accomplished:

• Convened a Call to Action on Preventing Veteran Suicide in February 2016—included Congressional members, Federal partners, non-profits, VSOs, survivors of suicide prevention; led to recommendations that have been implemented throughout VA and communities

• Completed most comprehensive analysis of Veteran suicide to date: "Suicide Among Veterans and Other Americans"—examining more than 55 million Veteran records from 1979 to 2014 from all 50 states and 4 territories.

• Convened several public-private partnership strategic planning sessions to seek input and dialog about our partnership strategy.

• Signed Memoranda of Agreement with Johnson & Johnson, Give an Hour, Bristol Myers Squibb Foundation, IBM, Wounded Warrior Project, Psych Armor, and Project Hero expanding the reach of VA mental health programing.

• Developed and implemented REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), to identify and intervene with Veterans who are at a statistically elevated risk for suicide and other adverse outcomes.

• Designated the month of September for Suicide Prevention Awareness and led "Be There" campaign across Federal, VSO, and corporate partners.

• Elevated VA's suicide prevention efforts and redirected resources, and personnel to create a new Office for Suicide Prevention to reach across entire department and lead a comprehensive strategy on suicide prevention

In Progress

• Implement state-of-the-art best practices for risk assessment, treatment, crisis management and quality improvement for VHA users in all clinics that treat Veterans at elevated risk.

• Continue to deploy comprehensive solutions, including targeted screening, risk assessment, predictive analytics, outreach, and innovative programming to identify Veterans at elevated risk and offer care as appropriate.

• Enhance enterprise-wide awareness and training of all staff (clinical and non-clinical) in recognition and intervention for Veterans at risk for suicide.

• Ensure ease of Veteran experience and quality of clinical care in VCL-Suicide Prevention Coordinator care continuum. Expand programming of Suicide Prevention Coordinators (SPCs) based on identified areas of need.
• Execute a public-private partnership program to increase coordination of available suicide prevention resources for Veterans not enrolled in VA.
• Expand existing outreach campaigns to target highest-risk Veterans and increase overall reach.
• Create new and update existing IT infrastructure to provide rapid access to data that inform suicide prevention effort
• Develop data-sharing strategies specific to Veteran suicides to engage our Federal, non-profit, and corporate partners to work together on better understanding Veteran suicide

Question 37. Veteran homelessness decreased by 47 percent between 2010 and 2016, largely due to funding from Congress and the hard work of local communities, yet on any given night, nearly 40,000 veterans remain homeless. Ensuring veterans have permanent housing is incredibly important.

Response. While there has been tremendous progress in ending Veteran homelessness and the efforts of VA and its partners are producing successful outcomes for many Veterans, there is still work to be done to ensure that no Veteran is without a place to call home. We know that ending Veteran homelessness is not a single event in time; rather, it is a deliberate effort made to achieve the goal, and continued follow-up efforts to make sure that progress toward achieving the goal is maintained. We must continue our commitment to our efforts around rapid rehousing and permanent supportive housing for Veterans who fall into homelessness so that their homelessness is rare, brief, and nonrecurring. The ultimate goal is to make sure that every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services and that Veteran homelessness in the future is prevented whenever possible.

While several states and nearly 40 communities have met the Federal benchmarks and criteria for ending veteran homelessness, I have heard from communities that have reached the goal earlier that maintaining a system that can rapidly house newly homeless veterans takes nearly the same level of effort and resources as housing unsheltered veterans to meet the goals. Even as the number of unsheltered veterans decreases, will you commit to evaluating resource needs based on existing populations and projections as you consider budget proposals for these programs?

a. If confirmed, will you commit to ensuring that this work remains a priority at VA?

Response. I am committed to ending Veteran homelessness and if confirmed it will remain a priority at the VA.

Question 38. According to the VA's National Center on Homelessness Among Veterans, the fastest growing subpopulations of homeless veterans are female veterans and those who have deployed to Afghanistan and Iraq under OEF/OIF/OND in the last decade and a half. What will you do to ensure that VA homelessness programs address the needs of these specific groups?

Response. Last year, the National Center on Homelessness Among Veterans conducted a study to look at population projections of Veterans likely to either be a risk of or actually become homeless and access VA care over the next 10 years. Women Veterans and Veterans who had served in the OEF/OIF era were identified as two subpopulations projected to grow in number while those older than age 55 were projected to decline. It should be noted that even with this growth, the majority of homeless Veterans is still projected to be predominantly single and male (85–90% in 2025). The National Center has commissioned two subsequent studies to map both current need profiles of homeless women Veterans served within VA and outcomes associated with different program utilization patterns. We expect to have results from these studies within the next six months which will be essential to accurately mapping where we need to strategically direct resources to address this projected demand. At this time, we do feel that current VHA program capacity, particularly in the Supportive Services for Veterans and Families (SSVF) and HUD-VASH programs which provide the bulk of services for women Veterans who are homeless or at-risk for homelessness, is sufficient to support these projections for at least the near term.

Question 39. Over the last 15 years, Congress has worked to improve health care, benefits, and care coordination for our most seriously wounded, ill and injured servicemembers, veterans, and their caregivers/family members to ensure a seamless transition between the DOD and VA systems and to provide continuity in care and services. How do you plan to strengthen collaboration and cooperation between these two agencies and improve upon the existing health and benefit systems?

Response.

• VA, in partnership with DOD, has taken significant steps to address the transition of seriously wounded, ill and injured Servicemembers and Veterans. We will continue to build on this work by:

– Leveraging the VA/DOD Interagency Care Coordination Committee (IC3), a subcommittee under the VA/DOD Joint Executive Committee, was formed to improve care coordination and reduce transition gaps.

– Enhancing care coordination through the Lead Coordinator role who serves as the primary point of contact for Servicemembers and Veterans and their caregivers during recovery and transition between DOD and VA;

– Community of Practice—connecting the DOD and VA clinical and non-clinical case managers of recovering Servicemembers and Veterans enabling collaboration and best practices to be shared;

– Implementing Interagency Comprehensive Care Plans—serves as a single, interoperable, individualized plan that assists managing the patient's goals thus reducing the need to retell their story as they transition and relocate. We will work to establish an IT solution for the Interagency Comprehensive Plan.

– Enhancing health information exchange:

• A Veteran's complete health history is critical to providing seamless, high-quality integrated care and benefits.

• Today, more than 220,000 VA health care and benefits professionals have access to Joint Legacy Viewer, which VA and DOD clinicians can use to access the health records of Veterans and Active Duty and Reserve Servicemembers

• We are currently deploying EHMP (Electronic Health Management Platform) which will integrate health data from VA, DOD, and community care partners into a customizable interface that provides a holistic view of each Veteran's health records.

– Disability claim filing pathways: (not sure this is the right place, but including here just in case)

• VA and DOD are dedicated to improving the processes for individuals in the IDES and Separating Servicemember (SSM) disability claim filing pathways.

• The Service Treatment Record (STR) is the common data information source critical to support both claimant groups.

• Efforts are actively underway to ensure the STR can be electronically transferred from the DOD to VA systems, relieving the need for the Servicemember to hand-carry their records to VBA for claim support.

• VA and DOD have re-engineered the Separating Servicemember claims workflow and it will be piloted by DOD and VA facilities in the National Capital area starting in March 2017.

Question 40. Accurate forecasting of usage of veterans benefits is essential in planning for resources to administer those benefits. If confirmed, what would you do to ensure that VA provides accurate and timely forecasts of the need for additional staffing resources so that Congress is able to appropriate resources in a timely manner?

Response. A workforce analysis is the foundation of any good workforce plan as it directly aligns the organization's needs with outcomes. VBA's workforce analysis is an ongoing effort, and as new data becomes available (such as the Veterans Benefits Management System (VBMS) transactional-level data and National Work Queue (NWQ) post-implementation data), it is incorporated in VBA's Resource Allocation Model (RAM) which is a systematic approach to distributing field resources each fiscal year.

The RAM utilizes a weighted model to assign compensation and pension Full Time Equivalent (FTE) resources based on regional office (RO) workload, including rating inventory; and rating, non-rating, and appeal receipts. The RAM incorporates several variables to accurately align with VBA's transformation to a paperless, electronic environment, where receipts can be assigned and managed at the national level. These variables include station efficiency (claims completed per FTE), quality, and RO capacity.

VBA leaders use the model as a guide, making adjustments for special circumstances or missions performed by individual ROs. Special missions include:

• the Appeals Management Office (AMO),
• Benefits Delivery at Discharge (BDD) sites,
• Integrated Disability Evaluation System (IDES) processing sites,
• Quick Start processing locations,
• National Call Centers (NCCs),
• foreign claims processing locations,
• radiation processing locations,

- Camp Lejeune Contaminated Water (CLCW) processing locations, and
- Pension Management Centers (PMCs).

With the exploration and analysis of future workload management functionality, VBA will work closely with DOD to collaborate on drawdown estimates and aggregate demographics of forces so VA has an early picture of the Veteran population profile. Data will be assessed at a more granular level to understand employee production and prioritize the integration of additional enhancements in the NWQ. VBA submits its annual Staffing Levels report to Congress in late March, detailing the staffing levels at each RO.

Question 41. The current appeals process for veterans benefits is broken. More than 450,000 appeals are pending. The current appeals process is complex, inefficient, and confusing. Most importantly, it no longer serves veterans and their families. In 2016, VA worked with eleven VSO and non-VSO stakeholders to create a framework to reform the appeals process. Do you support reforming the current appeals process? If confirmed, will you prioritize reforming the current appeals process? Do you support the 2016 framework as described above?

Response. I fully support reforming the current appeals process. Comprehensive reform is necessary to replace the current lengthy, complex, confusing VA appeals process with a new appeals framework that makes sense for Veterans, their advocates, VA, and stakeholders. This reform is crucial to enable VA to provide the best service to Veterans and, if confirmed, I will prioritize reforming the current appeals process.

I support the framework developed collaboratively by VA and a wide spectrum of stakeholder groups in 2016. I believe that the engagement of the organizations that participated in development of the new framework ultimately led to a stronger proposal, as we were able to incorporate their feedback and experience having helped Veterans through the complex appeals process.

The current VA appeals process takes too long. Appeals have no defined endpoint or timeframe and require continuous evidence gathering and re-adjudication. On average Veterans are waiting 3 years for a resolution on their appeal. For cases that reach the Board of Veteran's Appeals (Board), Veterans are waiting on average 6 years and thousands of Veterans are waiting much longer. The current appeals process is also too complex. Veterans do not understand the process, it contains too many steps and it is very challenging to explain to Veterans. Additionally, accountability does not rest with one appellate body; rather, jurisdiction over appeals is split between the Veterans Benefits Administration (VBA) and the Board.

The new framework, which I fully support, steps away from an appeals process that tries to do many unrelated things inside a single process and replaces it with differentiated lanes, which give Veterans clear options after receiving an initial decision on a claim. For a claim decision originating in VBA, for example, one lane would be for review of the same evidence by a higher-level claims adjudicator in VBA; one lane would be for submitting new and relevant evidence with a supplemental claim to VBA; and one lane would be the appeals lane for seeking review by a Veterans Law Judge at the Board. In this last lane, intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. As a result of this new design, the agency of original jurisdiction (AOJ), such as VBA, would be the claims adjudication agency within VA, and the Board would be the appeals agency.

This new design would contain a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which a Veteran requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim.

This disentanglement of process would be enabled by one crucial innovation. In order to make sure that no lane becomes a trap for any Veteran who misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If the Board decision was not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the

AOJ in a supplemental claim without fearing an effective-date penalty for choosing to go to the Board first.

To fully enable this process and provide the appeals experience that Veterans deserve, VBA, which receives the vast majority of appeals, would modify its claims decisions notices to ensure they are clearer and more detailed. This information would allow Veterans and their representatives to make informed choices about whether to file a supplemental claim with the AOJ, seek a higher-level review of the initial decision within the AOJ, or appeal to the Board.

The new framework would not only improve the experience of Veterans and deliver more timely results, but it would also improve quality. By having a higher-level review lane within the VBA claims process and a non-hearing option lane at the Board, both reviewing only the record considered by the initial claims adjudicator, the output of those reviews would provide a feedback mechanism for targeted training and improved quality in VBA.

The legislation should be enacted now. It has wide stakeholder support and the longer we wait to enact the Appeals Reform legislation more and more appeals will enter the current, broken system. The status quo is not acceptable for our Nation's Veterans and taxpayers. The new framework will provide much needed comprehensive reform to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair.

Question 42. There was a recent Congressional Budget Office report released that suggested that significant savings could be realized in VA compensation expenditures by streamlining who is considered service-connected. Of particular note, the report suggests that a number of presumptive conditions, such as Multiple Sclerosis, should not in fact be presumptively considered for service-connection. Do you support the recommendations offered by CBO targeting service-connected disabled veterans compensation?

Response. This recommendation would alter the fundamental principles of the VA disability compensation program, specifically the definition of "line of duty" as it relates to determing service-connection for diseases or injuries related to military service. While this principle has been debated and studied over the years, VA still believes and Congress has historically maintained support for the current definition of line of duty. That is, servicemembers who contract any injury or illness while on duty or on authorized leave, that is not the result of willful misconduct or drug and alcohol abuse, are entitled to service-connection for such conditions. The basic premise is that Servicemembers are on duty 24 hours a day, seven days a week and such individuals are subject to the Uniform Code of Military Justice at all times and in all places, including while on leave. VA believes that the government should continue to support those who have made enormous sacrifices and answered the call to defend their country by maintaining the current definition of line of duty.

Additionally, VA does not support eliminating the presumption of service-connection for certain conditions such as Multiple Sclerosis. The establishment of presumptive disabilities is based on extensive medical evidence and sound scientific research which identifies certain medical conditions that manifest years after the Veteran's exposure. VA believes these individuals are justly considered for service-connected benefits as it relates to these conditions.

Question 43. VA's FY 2017 budget request for major and minor construction of $1.025 billion is a significant decrease from FY 2016 request of $1.675 billion. The Department testified that it was taking a "strategic pause" regarding construction awaiting the report by the Commission on Care. Now that the report has been published, what do you think the Department should do to modernize and replace its aging and substandard facilities?

Response. In FY 2017 the Department did not request funding for any new construction projects. Instead, VA's FY 2017 budget request focused on fixing what we have by directing resources to fund the continuation or completion of minor construction and non-recurring maintenance (NRM) projects initiated in prior fiscal years.

The reason for not funding any new projects was because VA was waiting to receive the recommendations from the Commission on Care (which we received in July to determine if resources would need to be reallocated or requested to implement infrastructure strategies accordingly. In addition, VA wanted to ensure maximum future flexibility by not committing to a long term solution prior to the release of the report.

In August 2016, the President and VA responded to the Commission's report. The Department agreed that the Commission's facilities recommendations were critical to enable a successful transformation of VA's healthcare system to an integrated network to serve Veterans. VA stated that a strong suite of capital planning pro-

grams, tools, and resources would be needed to be able to fully realize the benefits and Veteran outcomes expected from implementing an integrated healthcare network.

Currently, VA is working toward the goal of high performing networks that take into account current and expected future services by developing a structure to integrate community care and VA-provided healthcare on a market by market basis. The Department kicked-off an effort with private sector healthcare experts to design an approach for integrated healthcare delivery decisions based on Veteran population, demand, internal capacity, and external public and private sector health care resources and capacity. Once the approach is validated, tested, piloted, and deployed nationwide, a national infrastructure realignment strategy will be developed accordingly to establish an objective process to appropriately realign VA's capital infrastructure. Through this process, VA will also identify the resources, tools, and authorities that are needed to enable the divestiture of assets and to streamline capital project execution. VA is committed to pursuing the appropriate capital resources to serve Veterans and ensure that a successful realignment strategy is implemented.

Question 44. VA's vocational rehabilitation and employment program is one of the smallest, yet most important, programs within the Department. It is the linchpin for helping veterans who incur service-connected disabilities achieve a fulfilling and gainful future. I am deeply committed to making sure that this program lives up to its full potential, especially when individuals who have sustained serious injuries in combat are concerned.

What are your thoughts on the role that vocational rehabilitation plays in terms of the total rehabilitation of an individual recovering from severe combat-related injuries and on how VA's current efforts might be improved?

Response. "What are your thoughts on the role that vocational rehabilitation plays in terms of the total rehabilitation of an individual recovering from severe combat-related injuries":

– The Vocational Rehabilitation and Employment (VR&E) program provides comprehensive services and assistance to enable Veterans and Servicemembers with service-connected disabilities to include physical, cognitive, mental, and emotional disabilities as well as an employment handicap to prepare for, find, and maintain suitable employment. For Veterans with service-connected disabilities so severe that they cannot immediately consider work, the VR&E program offers services to improve their ability to live as independently as possible in their homes and communities Nearly one quarter or more of VR&E participants recently studied, by cohort, have a primary rating for Post-Traumatic Stress Disorder (PTSD). (VR&E Longitudinal Study Annual Report 2016, 2015). VR&E participants in the longitudinal study also reflect an average disability rating of 60%; participants have a range of physical and emotional barriers and disabilities.

– VR&E's service delivery model works to best support Veterans where Veterans are located. VR&E employs over 1,000 professional Vocational Rehabilitation Counselors (VRCs) and Employment Coordinators (EC). These personnel provide services to Veterans and transitioning Servicemembers through a network of over 350 locations. VR&E's service delivery model include operations at 56 regional offices (ROs); the National Capital Region Benefits Office; approximately 142 out-based offices; 71 Integrated Disability Evaluation System (IDES) installations and 94 VetSuccess on Campus (VSOC) schools/sites. VR&E is also able to provide individualized services based on the Veteran or Servicemember's unique individualized needs.

– VR&E has two special missions focused on reaching critical populations via targeted outreach and support—IDES and VSOC. VR&E actively collaborates with the Department of Defense to provide VR&E services to Servicemembers through the IDES program. Vocational Rehabilitation Counselors are located on 71 military installations and work directly with transitioning Servicemembers to provide VR&E services. VR&E is committed to ensuring that the needs of seriously injured Veterans and Servicemembers are met in a timely manner by providing priority processing of applications for these populations. Automatic entitlement to VR&E services for wounded, ill and injured Servicemembers, a provision of Public Law 110–181(NDAA; Congress has renewed annually), allows for streamlined support and assistance for this critical population. Veteran Success on Campus (VSOC) Counselors provide on-campus access to VA benefits and services/support for 78,000 Veteran students on 94 campuses across the country.

Response. "How could VA's current efforts be improved"

– As part of ongoing VR&E Transformation, VR&E has several initiatives currently in development to improve service delivery to Veteran clients. VR&E Service is currently developing a new case management system and process that will be fully electronic and paperless, with planned pilot/deployment in FY 2017. VR&E

also deployed tele-counseling Nation-wide in 2015, and continues to work to increase the use of this enabling technology to better serve both Veterans and their counselors. VR&E is also working on initiatives to streamline administrative processing and support for VR&E in the VR&E program.

– To continue to better understand the VR&E population, VR&E continues to execute the congressionally mandated 20-year VR&E Longitudinal Study of Veterans who began their VR&E programs in 2010, 2012, and 2014. Reports are submitted to Congress annually on the long-term benefits of participating in the VR&E program. The study allows VR&E to continuously analyze trends among participants receiving services, and respond with initiatives that improve and adapt services to their changing needs.

Question 45. VA granted the presumption of service-connection for conditions associated with exposure to Agent Orange to recipients of the Vietnam Service Medal until 2002 when criteria was restricted to those who had "boots on the ground." What are your views on granting the presumption of service-connection to veterans who served in the bays, harbors, and territorial seas?

Response. VA honors the service and dedication of U.S. Navy and Coast Guard Veterans who served aboard ships on the offshore waters of Vietnam. However, current laws are intended to compensate Veterans for Agent Orange exposure related diseases when there was an actual potential for such exposure. That potential existed for Veterans who served within the land boundaries of Vietnam, including its inland waterways, where Agent Orange use occurred.

The United States Court of Appeals for the Federal Circuit upheld this definition in *Haas* v. *Peake* (2008). Available evidence does not support such potential exposure existed for service aboard ships operating on Vietnam's open water bays, harbors, and territorial seas. The distinction is based on the fact that aerial spraying of Agent Orange and other tactical herbicides over Vietnam was used to destroy enemy food crops, reveal enemy positions by defoliating jungle and riverbank cover, and create vegetation-free security zones around military bases. No such use of Agent Orange occurred over the offshore waters of Vietnam.

To better understand possible Agent Orange exposure among Navy Vietnam Veterans, VA tasked the National Academies of Science (NAS) with investigating and determining whether there were any potential routes of exposure, such as through aerial spray drift or sea water contamination from river water runoff. The NAS report, Blue Water Navy Vietnam Veterans and Agent Orange Exposure (2011), determined that there was insufficient evidence to confirm that these potential routes resulted in any significant exposure. U.S. Navy and Coast Guard activity during the Vietnam War involved large open water ships conducting operations off the coast of Vietnam [often referred to as the "Blue Water Navy"] and smaller vessels conducting operations on the inland bays and river system of Vietnam [often referred to as the "Brown Water Navy"]. Some Blue Water ships temporarily entered Vietnam's inland waterways to conduct naval gunfire support of ground operations or to deliver supplies.

Although there is insufficient scientific evidence to grant a blanket presumption of Agent Orange exposure for all U.S. Navy Vietnam Veterans, VA has a liberal policy of presuming exposure for all Veterans who served aboard Brown Water vessels operating on Vietnam's inland waterways and for those Veterans serving aboard Blue Water ships that temporarily entered the inland waterways. Additionally, if evidence shows that a Blue Water ship off the Vietnam coast sent crew members ashore for duty or visitation, any Veteran on the ship at that time will receive the presumption of exposure if they state that they personally went ashore. The Veterans Benefits Administration (VBA) maintains a list of ships that entered Vietnam's inland waterways or otherwise sent crew members ashore for duty or visitation. This list is based on evidence found in ship histories or deck logs, which are received from the Department of Defense's Army and Joint Services Records Research Center (JSRRC) or other credible sources. The list is available online and can be quickly updated by VBA's Compensation Service to reflect the most up-to-date research.

Question 46. VA currently uses the criteria of 170,000 un-served veterans within a 75-mile radius for purposes of establishing new national cemeteries. In the past, the Senate has supported this standard and has authorized new cemeteries based upon VA's recommendations. Do you believe this should continue to be the standard practice? In the absence of a VA recommendation, do you believe Congress should legislate the location of new national cemeteries?

Do you believe this should continue to be the standard practice?

Response. VA changed the criteria used to establish new national cemeteries in FY 2011. The current standard, which was approved by Congress, reduced the Vet-

eran population threshold required to build a new national cemetery from 170,000 to 80,000 within a 75-mile radius. As a result of this change, VA will construct 5 new national cemeteries designed to serve over 550,000 Veterans.

In addition, VA established burial access policies in 2011 and 2013 that will allow for construction of five Columbarium-only national cemeteries in certain urban locations where time and distance barriers make it difficult for Veterans to use the existing national cemeteries. VA will also establish a national cemetery presence in eight rural areas where the Veteran population is less than 25,000 within a 75-mile service area. The proposal targets those states in which: 1) there is no open national cemetery within the state; and 2) areas within the state are not currently served by a state Veterans cemetery or a national cemetery in another state.

In the absence of a VA recommendation, do you believe Congress should legislate the location of new national cemeteries?

Response. VA opposes any legislative action that would direct the location of a national cemetery. The placement of national cemeteries is based on objective criteria that address the maximum number of unserved Veterans in a given area. This approach has been very successful. To date, 91.7% of the total Veteran population—approximately 20 million Veterans—has convenient access to a burial option. When all planned national and state Veteran cemeteries currently in queue are opened, 95% of the Veteran population will be served.

Question 47. What is the future of VHA's electronic health record?

Response. The future of VHA's electronic health record (EHR) is a modern system that improves health outcomes for Veterans on a platform that can seamlessly adopt technological advances.

VA is carefully considering the future of VistA. In the context of current budgetary constraints, we are evaluating all options from adopting a commercial off the shelf (COTS) EHR to retaining an enhanced and standardized VistA. We are actively gathering key information and expert feedback, and recruiting a Chief Health Informatics Officer with extensive commercial EHR experience to help VHA craft an informed EHR strategy within the first 100 days of the new Administration. The goal is to make a decision that will best serve Veteran's needs.

OI&T has been working in partnership with VHA to develop the foundation for a modern health platform—the Digital Health Platform (DHP). This new initiative successfully completed a proof-of-concept. Over time, this approach will address the interoperability and integration challenges for Veterans by integrating information gathered from mobile applications, devices, wearable technology, along with data from Veterans' VA, military and commercial electronic health records in real-time.

We are not waiting for a decision to enhance the care Veterans are receiving today. Interoperability between VA and DOD is better today than at any point in the history of the Departments with the deployment of the Joint Legacy Viewer (JLV). JLV is not a vision for the future or a plan on paper. JLV is available to all clinicians in every VA facility in the country. It is a web based user interface that provides the clinician an intuitive interface to display DOD and VA healthcare data on a single screen. Providers from a variety of specialties have provided positive feedback and user stories are proving that we are successfully sharing information seamlessly between the departments. We have also invested in a longer term interoperability solution known as the Enterprise Health Management Platform (eHMP).

eHMP builds on the interoperability success of JLV, and is a modern web based user-interface that will improve access to health information by integrating health data from VA, DOD, and community care partners into a customizable interface that provides a holistic view of each Veteran's health records. A version of eHMP has been installed at 130 sites.

ADDITIONAL PREHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 48. In response to question 11, you note that you are still studying the various proposals and options that have been laid out by the President. At this point, how would you recommend fleshing out his plan?

Response. If confirmed as Secretary, I would immediately engage with the Administration to discuss ways to implement the President's plan. It is my understanding that the transition team has formulated some approaches already, but these have not yet been shared with me, as I have not yet been confirmed. If confirmed, I would then engage with both the Senate and House as well as others such as Veteran Service Organizations to gain their perspectives and suggestions for improving

healthcare to veterans. I have gone on record about my belief that we must develop an integrated system of care, utilizing what is best about VA and best from the private sector. My commitment in this process is to be open to new ideas and approaches as long as they improve access and quality of care for veterans. I would ensure that any solutions that I would recommend for consideration would be consistent with my values to support policy that is in the best interest of our veterans and advances our system toward higher levels of performance.

Question 49. In response to question 12, you note that VA will expect the same level of partnership and engagement with the VSOs and MSOs to continue the progress/momentum that VA has gained with the *MyVA* Transformation. Can you please provide specific examples of the partnership and engagement you anticipate having with the VSOs and MSOs? For example, will you continue to have monthly meetings with the groups outlined in your response?

Response. I am committed to full transparency, cooperation and coordination with our MSO/VSO partners to maximize input from the widest range of appropriate stakeholders and to facilitate an open exchange of opinion from diverse groups to improve our programs to assist Veterans. During my tenure as USH, I engaged and solicited input and feedback from MSOs/VSOs on key issues, best practices or opportunities to improve policies, programs, service quality and meet Veteran needs.

We host monthly VSO breakfast meetings with our senior leadership team, have participation and representation of VSOs on our workgroups and planning teams within our VA Program offices and also meet with VSOs on a frequent basis as specific issues or needs arise. In addition, I personally traveled to each of their national conventions and meetings last year. All of these engagements are necessary and will continue as VSOs are an important partner in helping us understand what improvements we can make to better deliver care and services to our Nation's Veterans.

Question 50. With regard to question 20, can you please clarify what options you are considering in order to provide veterans with greater choice than they have now?

Response. The Choice program has been essential for VA to have made improvements in access to care. However, we have learned that the program as it currently exists is too complex and as a result is not working well enough for many veterans. We must fix this. Furthermore, in designing a healthcare system, it would not be my recommendation to use mileage and wait times as the criteria for determining eligibility. My goal is to design a system that is both easier to use and supports greater choice for our veterans. However, we must do this in a way that ensures that veterans are receiving high quality care and that is affordable to the taxpayer. If confirmed, I would present several specific options on how to achieve these goals by improving upon the design of our current Choice system and in recommending alternative eligibility criteria to mileage and wait times. I would not want to prematurely offer specifics on these proposals at this time as I believe they must first be studied and modeled and appropriate input from stakeholders must be obtained before these are discussed in a public forum.

Question 51. With regard to question 25, can you please provide what emphasis you would place on meeting the needs, including mental health needs, of rural veterans?

Response. I am committed to meeting the health care needs of all Veterans, regardless of where they live. Rural Veterans face unique challenges in accessing care and it would be my priority to refine telehealth, community care, and home health options as a means of providing these Veterans access to health care when and where they need it.

Question 52. With regard to question 27, can you please reference what you have done, during your tenure at VA, to improve the physical and mental health care access, quality of care, and address privacy, security, as well as the transition for female veterans?

Response. During my tenure as Undersecretary for Health, VHA committed to ensuring all facilities met Privacy Standards—to include physical and auditory privacy—and to increasing the accountability of facilities to follow these standards. VHA created a policy to ensure that personalized health information is protected with the same level of privacy and security regardless of gender. We also launched multiple campaigns aimed at recognizing the service of women Veterans and will be soon launching an even more direct effort to increase civility and respect through the "End Harassment" campaign.

Question 53. In response to question 34, can you please clarify your personal belief?

Response. My read of the statutory language at title 38 U.S.C. section 105 leads me to the conclusion that any disability resulting from injury incurred in or aggra-

vated by service shall be service-connected. There is no requirement of causation. This conclusion has been reviewed by Federal courts and found to be accurate.

At times, both the Congress and VA have established presumptions of service connection for certain disabilities and diseases that are shown by sound scientific and/or medical evidence to have resulted from exposure to a contaminant while in service or, in the case of amyotrophic lateral sclerosis (ALS), service itself. All such disabilities are covered unless it is a result of willful misconduct or an abuse of alcohol or drugs. Multiple sclerosis is one example of this type of disease.

Question 54. In response to question 35, please describe what you believe the Department should do to modernize and replace its aging and substandard facilities.

Response. As stated in VA's FY 2017 Budget Request, based on the current mission, the Department has an identified need of approximately $41 to $50 billion to close critical performance gaps in the areas of safety, security, utilization, access, seismic safety, facility condition, space, parking, and energy. Once the Department develops and implements its integrated healthcare delivery model, a national infrastructure realignment strategy will be developed to align VA's infrastructure to match the approach to provide care to Veterans. At that time, VA will determine what inpatient and outpatient facilities are needed, as well as what renovation/construction is needed to implement the realignment. Depending on the realignment, a significant portion of the $41 to $50 billion infrastructure gap will still need to be addressed through renovation or replacement. This effort will require a combination of substantial investment in VA-owned and operated infrastructure and disposal/reuse of unneeded facilities. This effort will require a combination of substantial investment in VA-owned and operated infrastructure and disposal/reuse of unneeded facilities and continued reliance on care in the community.

Question 55. In your response to question 39, you note that VA is actively "gathering key information and expert feedback" to help VHA craft an informed EHR strategy within the first 100 days of the Administration. You note that you are recruiting a Chief Health Informatics Officer to help in this effort. How will the hiring freeze impact the recruitment of the Chief Health Informatics Officer?

Response. I have had discussions with the White House on the hiring freeze, at this time those discussions have centered on ensuring that we are able to hire for positions that require direct patient care. If confirmed, I will evaluate other positions to see if others would require a request an exception to the freeze.

Question 56. With regard to question 13, given the level of depth provided in other areas of this questionnaire on issues and items not currently within your direct purview of Under Secretary of Health, can you please review the tracking mechanism of disability claims production widely-known as the Monday Morning Workload Report and respond to whether under your leadership you would continue to make public this report?

Response. Yes, The Monday Morning Workload Report is a public report. It is our transparent communication to share with the public how VA is performing in our mission to deliver benefits to our Nation's Veterans.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JERRY MORAN TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 57. Dr. Shulkin, how would you describe the culture and functionality of the highest echelon in the VA Central Office? What changes would you make in the VA Central Office? Please be specific and candid.

Response. Over the past 18 months as Under Secretary of Health, I have come to understand the issues involving VA management and organization of our Central Office. While I have made several important organizational changes, I made a deliberate decision not to undergo large scale organizational changes, I wanted the organization to focus on addressing our wait time issues and other organizational priorities that I had established. Organizational change in important, but it can also be very distracting, and I wanted the organization to know our top priority was to address the clinical needs of our veterans. Also during my tenure as Under Secretary, I named 20 new senior leaders to my top 22 management positions. Each leader has been instructed to assess their organization and to present their assessments. We have begun a formal organizational review and assessment. If confirmed, I am prepared to make the necessary changes at VACO and the field to ensure more efficient and effective operations. Specifically I plan to address the separation between policy and operations at VACO which has resulted in duplicative and sometimes confusing direction to the field.

Question 58. Dr. Shulkin, what distinguishes you from the current VA leadership team? Do you plan to lead and manage the VA differently than the current VA leadership team? What are the differences? Please be specific.

Response. The Secretary of VA is responsible for ensuring that our nations veterans receive the highest level of service and care that we can provide. The Secretary also serves to ensure that the President and Congress' policies and laws are carried out as intended to the best of their abilityIf confirmed, as Secretary, I would work tirelessly to see that these objectives are fulfilled.

With a new Administration and Congress, we have the opportunity to address systemic issues that have not been fully addressed in the last Administration. If confirmed, I would seek to work collaboratively with the new Administration, Congress, and Veteran organizations to implement systemic changes for VA that would improve service, quality and value. Given that there will be new leadership in place at the White House, Congress, and VA, this will be different than the last Administration. The mandate from the country to do better for our veterans is clear and now is the time to take on the tough issues and propose bold solutions. I am ready for this opportunity and challenge.

Question 59. Dr. Shulkin, once the replacement for a new Undersecretary of the Veterans Health Administration (VHA) has been identified, what are the top three priorities that individual should consider in this position overseeing the VHA? What are the biggest challenges facing the VHA?

Response. As Under Secretary for Health, I established five priorities for VHA. I firmly believe that these priorities are critical to the continued improvement of VHA. These five priorities were 1) Improve Access to Care, 2) Improve employee engagement and filling VA management vacancies, 3) Implementing industry best practices, 4) Developing a integrated network of care between VA and community care, and 5) Enhancing trust among veterans.

My instructions to a new Under Secretary for Health will be to prioritize Quality. Quality involves three important components of care: access, clinical outcomes, and service levels. Specifically with the focus on quality, we want to accelerate efforts in suicide prevention and treatment of behavioral health conditions, and women's healthcare.

Question 60. How many rural VA facilities have you visited? Please identify the locations.

Response I have visited a number of rural facilities: Dublin, Georgia; Augusta Maine; Bangor Maine, Caribou Maine, and Lebanon, Pennsylvania. In addition I conducted a number of listening sessions in Alaska during my visit there in 2015. I also practice internal medicine, via telehealth, in Grants Pass Oregon, which is a rural area that has a shortage of primary care physicians.

Question 61. How many VA employees are currently on administrative leave? Of those currently on administrative leave, how much has the VA exhausted on their salaries while they have been on administrative leave and unable to fulfill the duties for which they were hired?

Response. Attached for your review are the personnel actions as of 12/16/2016.

[Privileged and Confidential for use by US Government only, which cannot be printed in the public record.]

Question 62. Dr. Shulkin, in your experience in the VA Central Office, are there VA employees you believe are toxic, corrosive or indifferent to VA culture reform? If so, would you remove some or none of these individuals from the VA? If so, what authorities do you possess and would utilize to remove these individuals from the VA? If you believe you do not have the authority to remove them, explain why. If you believe you need additional authority to remove them, explain in detail the authority you believe is required.

Response. Yes, I believe that there are employees that have deviated from the values that are essential for us to serve veterans. As Secretary, I would work to remove these employees from our workforce. The process to remove employees is currently too long and too cumbersome. While it is essential that there is due process, I would seek the authority to remove these individuals in a more expedited manner.

Question 63. Please provide information regarding the Office of General Counsel, to include: FY09-FY 2017 funding levels, full-time personnel and their duty station, and job descriptions for the positions within the Office of General Counsel. Please also describe and explain the breadth of the Office of General Counsel's work and advisement. If the Office of General Counsel advises you take a position or make a decision that is counter to President-elect Trump's positions and commitments to reform the VA, will you follow the advisement of the Office of General Counsel? Is the Secretary of the VA required by law to execute the position or decision advised

by the Office of General Counsel? Explain options available to the Secretary of the VA to take a position or make a decision counter to the advisement of the Office of General Counsel.

Response. OGC's annual budget of approximately $114M ($94M BA, $20M RA) supports +/- 700 FTE. Roughly 400 of OGC's personnel work in the District Chief Counsel Offices that provide legal support to VA's Medical Centers, Regional Offices, National Cemeteries, and other field operations; approximately 85 represent the Department in litigation before the US Court of Appeals for Veterans Claims; and the balance are assigned to VA Central Office and provide subject-matter-specific legal support to VA leadership on all issues arising from VA policies and programs, including information law, personnel law, procurement law, real estate law, Veterans' benefits law, torts and administrative law. The OGC workforce includes approximately 480 attorneys and 220 non-attorneys, including paralegals, legal assistants, and other administrative staff.

OGC's authorizing statute, 38 U.S.C. §311, provides for the appointment of a General Counsel by the President, with the advice and consent of the Senate, to serve as the chief legal officer of the Department and to provide legal assistance to the Secretary concerning the programs and policies of the Department. OGC's authorizing regulations, provided in 38 CFR Part 14, provide that the General Counsel is responsible to the Secretary for the following:

(a) All litigation arising in, or out of, the activities of the Department of Veterans Affairs or involving any employee thereof in his or her official capacity.

(b) All interpretative legal advice involving construction or application of laws, including statutes, regulations, and decisional as well as common law.

(c) All legal services, advice and assistance required to implement any law administered by the Department of Veterans Affairs.

(d) All delegations of authority and professional guidance required to meet these responsibilities.

(e) Maintenance of a system of field offices capable of providing legal advice and assistance to all Department of Veterans Affairs field installations and acting for the General Counsel as provided by Department of Veterans Affairs Regulations and instructions, or as directed by the General Counsel in special cases. This includes cooperation with U.S. Attorneys in all civil and criminal cases pertaining to the Department of Veterans Affairs and reporting to the U.S. Attorneys, as authorized, or to the General Counsel, or both, criminal matters coming to the attention of the Regional Counsel.

(f) Other matters assigned.

OGC provides advice and counsel to the Secretary and other VA officials regarding the legal framework within which those officials may act. Because actions taken in contravention of applicable laws may put the Department at unnecessary risk of litigation or other adverse outcomes, OGC endeavors to provide an analysis of available options rather than to simply advise for or against a single course of action. OGC strives to give useful, practical advice, couched in terms of "yes, if . . ." rather than "no, because." This approach generally avoids putting the Secretary in the position of having to choose between carrying out the President's agenda and complying with the law. As Secretary, I intend to work with my General Counsel to identify legally defensible means of accomplishing the reforms to which the President-elect has committed for the benefit of Veterans and taxpayers.

Question 64. If the VA Inspector General (IG) provides a report with findings of wrongdoing and criminal action, do you intend to notify Congress prior to or in tandem with the disclosure of the IG's report? In detail, please explain the authorities and actions you will execute to hold accountable the employees identified in the IG's report. Regarding similar instances under the leadership of Secretary McDonald, he refused to execute and utilize authorities provided to him. Do you intend to break with this precedent and use the authorities granted to the Secretary of Veterans Affairs?

Response. With respect to utilizing the statutory authorities for employee accountability that are at my disposal, I am aware that the expedited Senior Executive removal authority contained within the Veterans' Access, Choice, and Accountability Act of 2014 has come under question in the courts and may be found to be unconstitutional. Because the Choice Act authority supplemented rather than replaced other, more defensible authorities for holding employees accountable, Secretary McDonald chose to use the other authorities rather than the Choice Act once the constitutional issue became clear. We do still have a number of options for holding employees accountable, including traditional processes under Title 5 and Title 38 and the expedited process that came with the Choice Act. As frustrating as it is for me as a leader and for Congress as an authorizing body to see that authority chal-

lenged, it really doesn't serve Veterans or taxpayers well if we take an action that we know we'll have trouble defending in court. So while I will consider all of the authorities at my disposal to hold misbehaving and under-performing employees accountable, I will approach each case with an eye toward ensuring that the action taken will withstand appeal.

Question 65. In July 2015, the VA requested authorities from Congress to transfer $3.5 billion from the Choice Program to fund a shortfall in non-VA health care. Despite knowledge of such a debt as early as February 2015, VA officials waited until July to disclose the situation, providing a one-month notice of the potential lapse in health care for veterans due to insufficient funds. Do you agree with the VA's strategy to leave Congress little time to assess and address the $3.5 billion shortfall? If not, please explain how this situation should have been handled? If a shortfall scenario were to occur again as some have insinuated, what can we expect you to do differently from previous VA leadership?

Response.

• VA's budget plan early in FY 2015 was based on the Choice Program being operational more quickly than what was ultimately possible and a higher anticipated use by Veterans of Choice Program funds. VA pushed forward with plans for providing Care in the Community as part of the effort to improve Veterans access to care. The planned increase in workload was not able to be supported within the Choice Program operations established at that time. As a result, VA's non-Choice Care in the Community program's increased execution was at a rate that exceeded the 2015 plan. Program execution visibility was hampered by limitations of the financial management systems as well as the uncertainty of the program's cost in 2015 from both unreported obligations and over-obligations associated with medical authorizations.

• Regrettably, the process to clearly define the specific shortfall required more time than would have been preferred and significantly shortened the response time made available to the Congress. Secretary McDonald was made aware of the shortfall in May 2015 when VA staff confirmed there would be funding shortfalls in Care in the Community. Congress was informed in briefings in June and July that the non-Choice Care in the Community account was executing at a rate well beyond the 2015 funded plan.

• In June 23, 2015 letters to the Committees on Veterans Affairs and the Appropriations Committees and subcommittees, VA requested authority to use available Choice Act funding and to transfer existing funds from other medical programs to address the shortfall in non-Choice Community Care requirements.

• VA requested Congressional flexibility to use section 802 funds on a limited authority basis in the amount of $2.5 billion as the estimated cost exceeding the Care in the Community 2015 budget and use $500 million for Hepatitis C treatments. VA could also make a $348.5 million transfer from Medical Facilities to the Medical Services account for Community Care, all totaling $3.48 billion.

• Congressional action provided VA the authority to use up to $3.3485 billion of Choice Act funds to meet the shortfall in the non-Choice Care in the Community FY 2015 budget.

What is different now?

• Significant advancements have been made in refining processes for the utilization of Choice Program funds.

• VHA is completing monthly Financial Management System—Fee Basis Claims System (FMS-FBCS) reconciliations that are certified by VISN directors and Chief Financial Officers.

• For FY 2017, VA requested and received a separate appropriation for Community Care which will improve transparency and Congressional oversight.

• The FY 2017 appropriation provided VA with new authority to transfer funds to the Medical Community Care account from other VA discretionary accounts.

• VA is in the process of modernizing the Financial Management System, which along with improvements in methods and processes in the various automation systems that feed into the financial management system, will give VA senior management the ability to more easily identify this type of problem in the future.

• A congressional action that would assist VA is legislative language allowing VA to record the costs of Care in the Community at the time of payment, like some other Federal agencies, as opposed to the current practice requiring funds to be obligated at the time of authorization for care.

The planning and budget execution review processes that are now in place, will provide the necessary early warning of any similar funding issues and will allow for possible internal corrections. Additionally, I will be provided with the necessary

information regarding the development of such an issue and will inform the Congress of it in a much more responsive manner.

Question 66. If the Senate Veterans' Affairs Committee requests the presence of VA employees to testify regarding a matter that was investigated by the Inspector General, will you make those personnel available to testify? Would you refuse to make VA employees available and advise they invoke their Fifth Amendment right against self-incrimination as Deputy Secretary Sloan Gibson did with several VA employees that the IG found were manipulating the VA system regarding relocation and financially benefited. Would you have made these employees available to testify before the House Veterans' Affairs Committee? What would you have done in this specific situation?

Response. I am committed to sharing information about VA policies, programs and activities with the oversight committees. The issue sometimes is one of timing: would testimony before the Committee during an active IG investigation potentially compromise a criminal proceeding, or violate an individual witness's Constitutional right against self-incrimination? We have to balance those competing interests in an effort to do the right thing in each case.

In the VBA relocation cases, it is my understanding that those employees retained private attorneys who advised them to invoke their Fifth Amendment rights. The Fifth Amendment right against self-incrimination is personal to individuals, not subject to invocation or waiver by one's employer, including the Deputy Secretary.

The problem in that case was timing. At the time that the employees' testimony was requested, the IG had referred the case to the Department of Justice for possible criminal prosecution, and DOJ had not yet determined whether it would take the case. As a result, HVAC's demand for those employees' testimony on the same issues that had been referred for potential criminal prosecution posed a real—not hypothetical—threat to their constitutional right against self-incrimination. In the interest of providing the Committee the information it needed, the Deputy Secretary asked the Committee to defer the hearing until after DOJ disposed of the case so the employees' Fifth Amendment rights would not be implicated. When the Committee declined to postpone the hearing, the employees invoked their right against self-incrimination.

Question 67. How do you define unusual and excessive burden as it relates to the clause within the Choice Act? Do you consider it is an unusual and/or excessive burden for an 80 year old veteran without a vehicle to arrange transportation for a 200 mile drive to receive a shingles shot at a VA hospital facility? In this specific case, would you permit this veteran access to a shingles shot in his community by utilizing the unusual and excessive burden clause in Choice?

Response. As defined in the Veterans Access, Choice and Accountability Act (VACAA), the Unusual or Excessive burden provision is for a Veteran who resides 40 miles or less from the closest VA medical facility and the Veteran faces an unusual or excessive burden in accessing such a facility. If the Veteran lives 200 miles from the closest VA medical facility, they would be able to use the Choice program for all of their care under the distance provision of VACAA. If the Veteran lived 40 miles or less from the closest VA medical facility and has a medical condition that impacts his ability to travel to that facility, the Veteran would be eligible to receive all of their care through VACAA. The Unusual or Excessive burden provision did not account for transportation issues in making a determination regarding eligibility. The Unusual and Excessive burden provision does not take into account the availability of services in local market. VA believes that eligibility requirements should allow for the use of community care in instances where clinicians have determined there is need and VA cannot provide the service or provide the service timely.

Question 68. Do you believe the Choice Program should be extended? Should the criteria for eligibility be altered? Do you have recommendations to improve Choice? If so, please provide a summary.

Response. Yes, VA would recommend that the Choice Act be amended to make full expenditure of the Choice Fund the sole basis for the expiration of the Veterans Choice Program (VCP) while utilizing existing eligibility criteria. This change would serve as an interim measure while Congress continues to consider VA's long term plans as well as the recommendations of the Commission on Care.

VA's long term plan would consolidate all of its community care programs (both VCP and other programs, since VCP is only about 25% of total community care) into a single program that meets the needs of Veterans, their families, and community providers. This new program would clarify eligibility requirements, build on existing infrastructure to develop a high-performing network, streamline clinical and business processes, and implement continuum of care coordination services. This new

program will provide enrolled Veterans increased flexibility, greater choice and faster access to health care in the community.

VA has also identified several shorter-term legislative measures that offer immediate improvement for VCP. Those proposals include making VA the primary payer for VCP. We urge Congress to enact those changes, as well as adjust the termination provisions in the Choice Act. Addressing the sunset date issue in the coming weeks will accomplish three significant objectives that VA believes all stakeholders can agree on: 1) allowing Veterans to benefit from every dollar already appropriated by Congress to improve Veterans' access to care; 2) providing the new 115th Congress, the new incoming Administration, and Veteran stakeholders more time to chart the course for the future of community care, including ensuring the financial resources are available to carry out that course; and 3) time for VA to work with Congress and stakeholders to ensure a smooth transition with minimal disruption for Veterans moving from VCP to VA's new consolidated community care program.

Question 69. Do you consider front-line medical facility positions, including direct patient care positions, to be positions that are low risk and do not require a heightened sensitivity level to conduct an investigation and/or criminal background check? Do you believe the policies within 5 CFR 731 that govern suitability of covered positions in the VA provides sufficient guidance and specific direction to determine whether an individual is "favorable" to hire and should be in contact with veterans? What would you change in the VA credentialing process, please be specific, to better protect veterans from individuals who may cause them harm

Response. Provision of high-quality, safe patient care is the foremost mission of the VA. A critical component of providing safe care is the hiring and appointing of qualified healthcare providers. This begins before the provider is offered a position through the intense onboarding process.

The onboarding process is comprised of many steps which are all in place to ensure the applicants have the qualifications to meet VA standards and perform the duties for which they are being hired. The onboarding process includes the Human Resource process of investigating background to reveal criminal convictions, civil judgments, and exclusions from participation in Federal and State Health Care Programs, qualifications and basic eligibility determination, interviews, reference checks, and at minimum, a National Agency Check with Written Inquiry (NACI) level background investigation.

Another distinct and separate component of the onboarding process is the credentialing and privileging of the provider. This is an extensive process in which the training, education, work history, clinical references, and licensure are primary source verified. During the credentialing process the National Practitioner Data Bank (NPDB) is queried as well as the Federation of State Medical Boards (FSMB) (for physicians) to identify any licensure actions, medical malpractice payments, adverse clinical privileges actions, health care-related criminal convictions and civil judgments and exclusions from participation in Federal or state health care programs. Licensed Independent Practitioners, such as physicians and dentists, are also enrolled in the NPDB's continuous query program and FSMB's Disciplinary

Alert Service so that the facility is instantly notified if any report is made by any entity (VA or non-VA) to either organization so that immediate action can be taken as necessary.

VA utilizes an electronic credentialing software platform, VetPro, in which the primary source verified credentials for over 300,000 licensed, registered, or certified healthcare provider are stored and maintained. These files are easily shared and transferred between VA facilities to expedite the credentialing process for providers who move within the agency. The sharing of these files also assists in ensuring providers who have had substantiated clinical care concerns do not easily move throughout the system as their VA clinical history is available to anyone with access to their file.

The selecting official at the facility level has all of this information to review and consider when making a decision of whether or not to hire the provider and if they are a good fit for the patient care needs of the facility.

Once hired, all Licensed Independent Practitioners are continuously monitored through a Focused Professional Practice Evaluation process and then through an Ongoing Professional Practice Evaluation process. These are screening tools (required for any Joint Commission Accredited facility) used to evaluate all providers who have been granted privileges and to proactively identify quality of care issues.

VA is committed to the thorough vetting of all providers who will treat our patients and we will continue to provide education, guidance, and tools to help the leaders at the VHA facilities make informed hiring decisions. VA meets and exceeds the Joint Commission accreditation standards for credentialing of healthcare providers that are utilized by healthcare organizations throughout the country.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 70. What steps will you take to establish a fully interoperable record-sharing system between the Department of Defense and the Department of Veterans Affairs, and to move beyond the use of the Joint Legacy Viewer to trade screenshots of records?

Response. In accordance with requirements in the FY 2014 National Defense Authorization Act, DOD and VA were required to be interoperable by December 2016. This was certified ahead of schedule on April 8, 2016.

- The DOD/VA Joint Legacy Viewer (JLV) is a clinical application that provides an integrated, chronological display of the complete longitudinal health record from DOD, VA, and Community Care providers in a customizable viewer.
- JLV is not a "screenshot" sharing technology. It uses and displays (near real-time) computable data that can be organized as each user requires for their current and future workflow needs.
- JLV shows all patient data, regardless of the source (VA, DOD, community partners) in one place.
- Veterans Benefits Administration (VBA) offices use JLV to expedite benefit claim processing, and other staff from Office of Inspector General (OIG), Office of Medical Legal Affairs (OMLA), and Office of General Counsel (OGC).

Today, more than 228,000 VA health care and benefits professionals have access to JLV and have used it to view more than 2 Million Veteran records. A preliminary VHA review found that patients reported 14% higher customer satisfaction when providers were using JLV because they were more familiar with their medical history.

Next steps in interoperability—eHMP:

- JLV has been a critical first step in connecting VA and DOD health systems with a read-only application, however, it is limited in its functionality.
- VA has developed Enterprise Health Management Platform (eHMP) which will deliver urgently-needed clinical functionality, while incorporating all of the data interoperability achieved with JLV.
- Through eHMP (which is a platform and not an EHR), clinicians will have a powerful Google-type record search that encompasses VA, DOD, and Community partners, as well as the ability to write notes, order laboratory tests, and communicate with improved tracking to ensure follow through on tasks.
- VA has deployed the initial version of eHMP (version 1.2) across the entire VHA enterprise.
- By "sitting" on top of the VA's 130 separate VistA EHR's, eHMP can maintain a consistent user interface while the supporting EHR systems underneath are modernized and/or changed.

Question 71. Do you support overturning the decades-old ban on allowing VA to cover the costs associated with in vitro fertilization and other assisted reproductive technology services?

Response. VA's goal is to restore and improve the quality of life for Veterans in accordance with evidence based medical standards and to the greatest extent the law will permit.

- In the past, IVF has been legislatively excluded from the medical benefits package.
- Recent passage of Pub. L. 114–223 enables VA to provide counseling and treatment using Assisted Reproductive Technologies (ART), including IVF to Veterans (and their respective spouse) with a service-connected (SC) condition that renders them unable to have children without the use of fertility treatment.
- VA subsequently amended its regulation with publication of an interim final rule on January 19, 2017 that authorizes the same. VA will provide ART treatment, including IVF, to these affected Veterans and spouses.
- VA estimates that nearly 400 total Veterans will be provided ART (including IVF) treatment over the remainder of this fiscal year and FY 2017.

Note: The most common single cause of battle injuries is explosive devices (36.3%). Such trauma frequently results in genito-urinary injuries. For example, 1 in 5 warriors were evacuated from Operation Enduring Freedom combat in October 2011 with a genito-urinary injury.

Question 72. What is your assessment of VA's protections against retaliation for reporting sexual assault within the VA system?

Response. VA's protections against retaliation for reporting sexual assault within the VA system is deeply rooted in its commitment to creating a culture, embedded

in our mission and core values, which engages and inspires employees to their highest possible level of performance and conduct.

Sexual harassment in the workplace is prohibited by law, and sexual assault is a serious form of sexual harassment. Reporting sexual harassment (or harassment on the basis of race, color, religion, national origin or age) is an activity that is protected by law. Retaliation against any individual for reporting such conduct is prohibited. VA managers at the highest and lowest level and employees are prohibited by law from retaliating against any employee for reporting sexual assault. There are consequences for engaging in such behavior.

In VA's Office of Resolution Management, there is an enterprise-wide Anti-Harassment Office (AHO), which provides centralized tracking, monitoring and reporting to proactively respond to all allegations of harassment. The AHO ensures that all harassment allegations are reported to VA leadership. Such a report outlines prompt corrective measures taken to decrease harassing behavior in the workplace. The AHO is committed to establishing transparency and accountability at every level of employment.

VA has also established enterprise-wide anti-harassment policies and procedures to ensure that an allegation of harassment, including sexual assault and retaliation for reporting sexual assault, receives a prompt, thorough and impartial investigation; and that VA takes immediate and appropriate corrective action when it determines that harassment has occurred.

By doing this, VA can proactively prevent harassing conduct before it becomes severe or pervasive. The EEO complaint process is also designed to make individuals whole for discrimination, that has already occurred, through damage awards and equitable relief, and to prevent the recurrence of the unlawful discriminatory conduct. While the EEO complaint process does not require an agency to discipline its employees, VA through the AHO, requires that immediate and appropriate corrective actions are taken to eliminate harassing conduct regardless of whether the conduct violates the law or whether an employee pursues an EEO complaint. The AHO focuses solely on whatever action is necessary to promptly bring the harassment to an end or to prevent it from occurring at all.

An employee who believes that he or she has been subjected to harassing conduct, for reporting sexual assault or for any other reason, can report the matter to his or her immediate supervisor (or second-line supervisor if the immediate supervisor is the alleged harasser); to the Anti-Harassment Coordinator (AHC) for his or her specific office; or to the AHO. Employees who witness potential harassment are encouraged to report it. Supervisors or managers who are notified of harassment or witness potential harassment are required to report it immediately, and also to assess the situation immediately in consultation with the AHO or AHC.

All reports of hostile or abusive conduct and related information is maintained on a confidential basis to the greatest extent possible. The identity of the employee alleging violations of the Anti-Harassment Policy will be kept confidential except as necessary to conduct an appropriate inquiry into the alleged violations or when otherwise required by law. Anonymous allegations of harassment will also be investigated and monitored to the fullest extent possible.

VA is dedicated to protecting its employees from retaliation for reporting sexual assault and all other unlawful discrimination, and VA has in place an effective mechanism and policy to ensure that our employees are protected. For the sake of everyone, including the Veterans we serve, we want to provide a safe working environment for every VA employee.

Question 73. Do you support expanding the caregivers program to cover caregivers of veterans from all eras? What is your assessment of the program as it stands and how can it be further streamlined and improved?

Response.

• The Caregivers and Veterans Omnibus Healthcare Services Act of 2010 allows VA to provide services to qualified family caregivers of eligible Post-9/11 Veterans who incurred or aggravated a serious injury in the line of duty, including a monthly stipend paid directly to designated primary family caregiver, and coverage under CHAMPVA if eligible.

• VA has developed multiple public/private partnerships in support of family caregivers of Veterans to provide training, education, and support to caregivers of Veterans of all eras.

• The Caregiver Support Program is currently involved in program review and evaluation with VA researchers to evaluate the short-term impacts of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and the Program of General Caregiver Support Services by assessing the impact of current program-

ming on the health and well-being of Veterans and caregivers. This work is ongoing and will impact current as well as future programming.

• According to RAND's report "Hidden Heroes," the needs of family caregivers of Pre 9/11 Veterans are different than the Program of Comprehensive Assistance for Family Caregivers provides.

• Based on current budget models, VA estimates the annual cost of expansion to be approximately $3 billion annually.

• I would support providing equitable programming for caregivers of Veterans, regardless of the Veteran's era of service or the reason why the Veteran requires assistance from a family caregiver. I would welcomes collaboration with Congress to make enhancements, including legislative changes, to the current program which may allow for expansion to caregivers of Veterans from eras.

Question 74. What is your assessment of the program as it stands and how can it be further streamlined and improved?

• As it stands, the Program of Comprehensive Assistance has provided services to more than 30,000 family caregivers of Veterans, far exceeding the original vision.

• Despite the attention focused on the Post-9/11 Program, VA has very successfully implemented many other services and supports to family caregivers who do not qualify for the Comprehensive Assistance Program, including multiple trainings, peer support, and a very active telephone support line.

– 350 Full Time Caregiver Support Coordinators at medical centers across country

– 4,000 caregivers of Veterans of all eras have completed self-care training

– Active peer support mentoring program, telephone education groups, on-line trainings

– Caregiver Support Line has received more than 276,000 calls, continuing to average more than 250 calls per day

• The legislation could be improved. One specific example is the use of the word "injured," in the Law, which excludes caregivers of Veterans with ALS, MS, and other debilitating illnesses.

• Another idea for improvement may be focusing the caregiver support for aging Veterans in need of home-based care which may help delay long-term institutional care.

Question 75. With the policy change last year to open all military professions to women and to allow transgender individuals to serve, what steps must VA undertake to ensure the system is prepared to handle an increasingly diverse veteran population?

Response.

• VA must continue education and training of providers

• VHA's LGBT (LGBT), Health Program, Women's Health, Center for Women Veterans, Center for Minority Veterans, and Office of Health Equity have led national campaigns to raise awareness about the healthcare needs of lesbian, gay, bisexual and transgender women, African Americans, and rural Veterans.

– The VHA LGBT Health Program has developed fact sheets for Veterans and providers on LGBT Veteran health care available here: (http://www.patientcare.va.gov/LGBT/VA_LGBT_Outreach.asp)

• VHA strongly supports training for providers so they can have tools to deliver clinically and culturally competent care for our diverse group of Veterans.

– The VHA LGBT Health Program has developed and promoted several clinical trainings for providers in sexual health, transgender healthcare, as well as lesbian, gay, and bisexual Veteran healthcare (http://www.patientcare.va.gov/LGBT/LGBT_Veteran_Training.asp).

– A national transgender e-consultation program and a transgender SCAN-ECHO program has been implemented. To date, 55 interdisciplinary healthcare teams encompassing nearly 400 providers have been trained

– The VHA LGBT Health Program has been working with Pentagon officials about training military healthcare providers in transgender care utilizing the VA model.

• In 2016, VA established an LGBT Veteran Care Coordinator at every facility. These Coordinators help train local staff and ensure that the facility provides appropriate clinical services for LGBT Veterans.

• A demographic field for Self-Identified Gender Identity (expected Feb 2017) in the electronic health record will help providers and staff better communicate with a diverse veteran population.

Question 76. What benefits has VA seen from its Child Care Pilot Program and what steps could be taken to permanently establish this program at VA facilities around the country?

Response. The Caregivers Act of 2010 required a Child Care Pilot program be established in at least three VISNs over two years. The VHA sites selected were:

- Buffalo, New York; opened 10/2011
- Northport, NY; opened 4/2012
- American Lake-Puget Sound (American Lake), Washington; (9/2012)
- Dallas, TX became an additional pilot site in 3/2013

The four pilots have continued to provide child care services with congressional authority extensions, most recently the Department of Veterans Affairs Expiring Authorities Act of 2016, authorizing services through December 31, 2017.

- VHA is not able to conclusively demonstrate a relationship between use of the child care pilot sites and impact on no-show rates
  - – However, despite limited data, Veterans did voice this service improved access to their appointments.
  - – The pilot program is highly successful based on Veteran satisfaction with child care provided and allowed Veterans greater access to appointments.
  - – While women Veterans are the most frequent users, it is notable that male Veterans users also use the service.
- VA is on record as asking for permissive authority legislation. There is no legal authority to expand the pilots or to add additional childcare in VA.
- In order to expand the program, Congress would need to enact legislation granting permanent discretionary authority to the Secretary to provide child care assistance for Veterans accessing health care at facilities. The Secretary's authority should include the ability to establish the types of child care providers to participate in this program, the scope of child care assistance, and the location of child care services.

Question 77. The Integrated Disability Evaluation System (IDES) integrates the Department of Defense (DOD) and Department of Veterans Affairs (VA) disability systems to improve and expedite processing of servicemembers through the disability evaluation system.

a. What is your assessment of the need to further streamline and improve the IDES?

Response. The Integrated Disability Evaluation System (IDES) is a joint DOD/VA Program that can certainly be presented as a success story of integrated, inter departmental cooperation. This program is designed to assist the DOD in determining whether wounded, ill, or injured Servicemembers (SMs) are fit for continued military service or if found unfit by the DOD, separate or retire the SM for their service-connected disability. IDES further showcases the unified efforts of DOD and VA working together to ensure all medically required evaluations, medical supportive services and full VA entitlements are made available to SMs found to be unfit. From the Program's Initial Operating Capabilities (IOC) to date, over 190,061 Servicemembers have been processed via the IDES Program. In FY 2016, the IDES program averaged approximately 2453 cases per month. By continuing to provide this expeditious, yet comprehensive level of service to our SMs participating in the IDES Program, potential opportunities for continued improvement and streamlining include:

- – Ongoing early identification and thorough evaluation by DOD of SMs that may not meet the retention standards established by their specific military service.
- – Offering enrollment in VA Healthcare to all IDES Program participants as a mechanism for maintaining uninterrupted access/healthcare coverage post separation from military service.

SMs approaching normal separations/discharge or retirement from the service may also be eligible for VA benefits. These SMs may apply for VA benefits and compensation after they have separated from the service or may file a claim for VA compensation and benefits while still in the service by participating in the VA's Benefits Delivery at Discharge (BDD) or the Quick Start Program.

BDD allows a Servicemember to submit a claim for disability compensation 60 to 180 days prior to separation, retirement, or release from active duty or demobilization. BDD can help the SM receive VA disability benefits sooner, with a goal of within 60 days after release or discharge

- *Separation Health Assessment (SHA) Initiative.* Although part of the BDD Program, VA and DOD commenced an initiative in 2013 that further assists SMs by allowing them to choose which Department (DOD or the VA) will conduct their final

separation from service examination. If a SM chooses to have their SHA examination performed by the VA, they must file a claim for benefits no later than 90 days prior to their scheduled separation. Once completed, the examination results are provided to the DOD, who in turn will review and accept the examination results as the final separation from service examination. The goal of this initiative is to provide VA disability benefits to the SM within 60 days after release or discharge.

– Quick Start allows a Servicemember to submit a claim for disability compensation 1 to 59 days prior to separation, retirement, or release from active duty or demobilization. By submitting a disability compensation claim before discharge makes it possible to receive VA disability benefits as soon as possible after separation, retirement, or demobilization. SMs with 1–59 days remaining on active duty or full time Reserve or National Guard service, or SMs who do not meet the Benefits Delivery at Discharge (BDD) criteria requiring availability for all examinations prior to discharge, may apply through Quick Start.

b. If confirmed, how would you work with the DOD Secretary to ensure both DOD and VA ensure that veterans move smoothly through the multi-step disability evaluation process?

Response. Our approach would include continued holistic reviews of the IDES program, specifically focusing on a more robust feedback process from current and former participants of IDES and their families to ascertain:

– Transition improvements that can be made to the Program. Conduct a comprehensive review of all phases of the program and re-evaluate the challenges faced by both the SMs and their supporting chain of commands to remove or modify administrative processes identified as "very challenging" by Program participants and commanders alike.

– Review current services, programs and assistance provided by both the VA and DOD with a specific focus on the families of separating SMs, to better prepare them for their spouse's transition from military service.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 78. Dr. Shulkin, as Under Secretary for Health, you stated to Virginia's Daily Press that privatization "would be a terrible mistake, a terrible direction for veterans and for the country, to essentially systematically implement recommendations that would lead to the end of the VA health-care system," As Secretary of the Department of Veterans Affairs, would you continue to oppose efforts to reduce the Federal role in providing health care services to veterans?

Response. I have consistently stated my support for an integrated system of care for veterans. I wrote about this in my New England Journal of Medicine article in 2016. This integrated network would support and enhance services that are essential to veterans within the VA that either cannot be readily found in the private sector. The integrated system would also utilize care in the community that may be more accessible or higher quality of care than found in the VA. It is my firm belief that this integrated system of care will provide the best outcome for our veterans and the best value for taxpayers. Each community has different needs and capabilities and therefore such a system will require local needs assessments. Nationally, VA currently utilizes 31% of its' care in the community, demonstrating that we are able to both support a strong VA and work effectively with community providers.

I also believe that the VA health care system is essential to fulfilling our commitment to our Nation's veterans. All of my efforts would be directed to making our system work better on behalf of our veterans. I do believe that with thoughtful and proactive planning we can enhance and strengthen services, and eliminate waste and duplication by accelerating our efforts through an integrated system of care that serves veterans.

Question 79. In respect to the Choice Program, I hear two main concerns from Vermont veterans. First, is that there are delays in third party administrator (TPA) authorizations for care, which have led to critical medical appointments being delayed or missed entirely. Second, miscommunications between VA and the TPA on authorizations and billing have led to multiple Vermont veterans being sent to collections by local health care providers. As Secretary, how would you address these issues to ensure veterans get the care they need when they need it, without their credit being adversely impacted?

Response. VHA is committed to ensuring that all Veterans have timely access to care. In June 2016, the Office of Community Care implemented a contract modification to improve the appointing requirements and processes for Veterans

Choice Program services. In accordance with the modification, the initial appointment for an episode of care must be scheduled within five (5) business days of the contractor's receipt of a 10–0386 "VHA Choice Approval for Medical Care" form (or similar VA-generated request), all applicable clinical documentation, and the Veteran has opted in for VCP. The appointment must take place within 30 calendar days of the initial scheduling unless the desired appointment date is otherwise noted on the referral.

VHA continues to work with the contractors and VA staff to ensure clear and concise communication is the utmost importance to for our Veterans to have timely access to care. The Office of Community Care has worked on the development and modifications of the VHA form 10–0386 to make the request for care clear and concise for our Veterans. The form has several mandated fields that require VA staff members to ensure the request has all the pertinent information needed for the contractors to provide the best care to our Veterans.

VA understands that any situation resulting in delayed payments or accumulation of debt due to inappropriately billed claims is stressful for Veterans and unacceptable. We are working hard to correct these errors and offer assistance to our Veterans immediately.

We were able to pull the following data specific to VISN 1 and Vermont: In the past 90 days (Oct-Dec 2016), Community Care received a total of 139 Adverse Credit Reporting (ACR) requests for VISN 1.

Question 80. Treatment courts can play an important role in ensuring veterans with histories of substance misuse get a second chance. What do you see as VA's role in ensuring veterans can benefit from these programs?

Response. Incarceration as an adult male is the most powerful predictor of homelessness. VA services for justice-involved Veterans are therefore provided through two dedicated national programs, both prevention-oriented components of VA's Homeless Programs: Health Care for Reentry Veterans (HCRV) and Veterans Justice Outreach (VJO). Known collectively as the Veterans Justice Programs (VJP), HCRV and VJO facilitate access to needed VA health care and other services for Veterans at all stages of the criminal justice process, from initial contact with law enforcement through community reentry following extended incarceration.

VJO Specialists serve Veterans at earlier stages of the criminal justice process, with a three-pronged focus on outreach to community law enforcement, jails, and courts. All VJO Specialists must be licensed independent clinicians, and the vast majority are social workers. Differences (in size, structure, openness to outside partnerships and to treatment-based criminal justice interventions, etc.) between local criminal justice systems, as well as the partnership-driven nature of the work, mean that the VJO program can look significantly different from one location to the next. VJO Specialists at each VAMC work with Veterans in the local criminal courts (including but not limited to the Veterans Treatment Courts, or VTCs), conduct outreach in local jails, and engage with local law enforcement by delivering VA-focused training sessions and other informational presentations.

VA supports VTCs through the participation of its VJO Specialists as members of VTC treatment teams, and through the health care services it provides to Veteran defendants, most of whom would otherwise receive care at county expense. The Specialists assess Veteran defendants' treatment needs, assist as needed with the VA eligibility and enrollment process, link Veterans with appropriate VA treatment services, and (with the Veterans' permission) provide regular updates to the court on their progress in treatment. The VJO Specialists' (and VA's) role in a VTC is limited to the treatment-related aspects of the court process; although VA eligibility may be a court-imposed requirement for admission, VA does not decide which Veteran defendants should be admitted to a VTC or define the level of offenses (e.g., misdemeanor vs. felony) that a VTC will accept. VJO Specialists work closely with justice system partners as they plan new VTCs, informing the partners about VA services that would be available to Veterans defendants locally or regionally. However, as with all VJO-related services, the Specialists do not advocate specifically for the use a particular model or set numerical targets for desired VTC growth, but instead encourage communities to plan proactively to meet the needs of justice involved Veterans using approaches that best fit local circumstances. VA also does not provide grant funding or other financial support to VTCs or other Veteran-focused courts.

Question 81. It can sometimes be challenging for rural veterans, like those in my home state of Vermont, to have all their health care needs met. Under your leader-

ship, how would VA maximize its telehealth capabilities to ensure rural veterans can assess quality VA-provided care closer to—or even in—their home?

Response. Telehealth is a key component of the strategy to address access issues, especially in rural areas where it can be difficult to hire providers.

- VA is expanding services through enterprise-wide initiatives, including by the expansion of Primary Care, Tele-Mental Health, and specialty care hubs that each service many sites of care.
- In Fiscal Year 2016, VA provided more than 2 million Telehealth visits to over 700,000 Veterans across more than 50 specialties.
  - Approximately 315,000 of these Veterans were located in rural areas, including approximately 1,500 in rural areas of Vermont.
- While most Veterans currently access Telehealth services in their local VA Community-Based Outpatient Clinic, VA's Veteran-centric approach has led the Department to pursue expansion of services directly into Veterans' homes.
  - VA Video Connect, VA's home Telehealth program, provided more than 39,000 encounters direct to Veterans' homes last year, of which over 40% were rural.
  - For Veterans without an Internet-connected device at home, VA has implemented a system to provide tablets for home Telehealth use.
- As VA works to expand established Telehealth services, the Office of Rural Health and Office of Connected Care also partner with clinical program offices to foster innovative Telehealth programs that specifically increase access for rural Veterans.
  - In FY 2016, rural Telehealth programs provided care to over 85,000 Veterans in remote areas across the country. This number is expected to increase to the hundreds of thousands in FY 2017.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 82. As of December 31, 2016, there were over 450,000 cases pending in VA's appeals system. Last year, Secretary McDonald convened a group of stakeholders including VSOs to attend a multi-day event to collaborate on how to fix the VA appeals system. Department of Veterans Affairs Appeals Modernization Act of 2016, which I introduced last Congress put the results of that collaboration into legislation and the Disabled American Veterans, the American Legion, the Veterans of Foreign Wars, the Paralyzed Veterans of America, AMVETS, the Military Officers Association of America, the National Association of County Veterans Service Officers, and the National Association of State Directors of Veterans Affairs supported the legislation.

Do you support the reforms contained in that legislation as a path forward for improving the appeals process, if not, why not, and how would you reform the process?

Response. I fully support reforming the current appeals process. Comprehensive reform is necessary to replace the current lengthy, complex, confusing VA appeals process with a new appeals framework that makes sense for Veterans, their advocates, VA, and stakeholders. This reform is crucial to enable VA to provide the best service to Veterans and, if confirmed, I will prioritize reforming the current appeals process.

I support the framework developed collaboratively by VA and a wide spectrum of stakeholder groups in 2016. I believe that the engagement of the organizations that participated in development of the new framework ultimately led to a stronger proposal, as we were able to incorporate their feedback and experience having helped Veterans through the complex appeals process.

The current VA appeals process takes too long. Appeals have no defined endpoint or timeframe and require continuous evidence gathering and re-adjudication. On average Veterans are waiting 3 years for a resolution on their appeal. For cases that reach the Board of Veteran's Appeals (Board), Veterans are waiting on average 6 years and thousands of Veterans are waiting much longer. The current appeals process is also too complex. Veterans do not understand the process, it contains too many steps and it is very challenging to explain to Veterans. Additionally, accountability does not rest with one appellate body; rather, jurisdiction over appeals is split between the Veterans Benefits Administration (VBA) and the Board.

The new framework, which I fully support, steps away from an appeals process that tries to do many unrelated things inside a single process and replaces it with differentiated lanes, which give Veterans clear options after receiving an initial deci-

sion on a claim. For a claim decision originating in VBA, for example, one lane would be for review of the same evidence by a higher-level claims adjudicator in VBA; one lane would be for submitting new and relevant evidence with a supplemental claim to VBA; and one lane would be the appeals lane for seeking review by a Veterans Law Judge at the Board. In this last lane, intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. As a result of this new design, the agency of original jurisdiction (AOJ), such as VBA, would be the claims adjudication agency within VA, and the Board would be the appeals agency.

This new design would contain a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which a Veteran requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim.

This disentanglement of process would be enabled by one crucial innovation. In order to make sure that no lane becomes a trap for any Veteran who misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If the Board decision was not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the AOJ in a supplemental claim without fearing an effective-date penalty for choosing to go to the Board first.

To fully enable this process and provide the appeals experience that Veterans deserve, VBA, which receives the vast majority of appeals, would modify its claims decisions notices to ensure they are clearer and more detailed. This information would allow Veterans and their representatives to make informed choices about whether to file a supplemental claim with the AOJ, seek a higher-level review of the initial decision within the AOJ, or appeal to the Board.

The new framework would not only improve the experience of Veterans and deliver more timely results, but it would also improve quality. By having a higher-level review lane within the VBA claims process and a non-hearing option lane at the Board, both reviewing only the record considered by the initial claims adjudicator, the output of those reviews would provide a feedback mechanism for targeted training and improved quality in VBA.

The legislation should be enacted now. It has wide stakeholder support and the longer we wait to enact the Appeals Reform legislation more and more appeals will enter the current, broken system. The status quo is not acceptable for our Nation's Veterans and taxpayers. The new framework will provide much needed comprehensive reform to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 83. As a result of the Veterans Access, Choice and Accountability Act of 2014, veterans have been charged fees for seeking care in the community through the Choice Program. In some cases these fees have been turned over to collection agencies, putting the veteran's credit score and sometimes livelihood at risk. Under your direction what steps will the VA take to ensure that veterans have a clean financial bill of health?

Response. The Choice Act requires VA to be secondary payer when a Veteran receives community care for a non-service-connected condition and has other health insurance (OHI). In these cases Veterans are responsible for their co-pay or deductible as part of their participation with their OHI.

There have been cases when the delayed payment to the community care provider is inappropriately billed to the Veteran directly. The Choice contracts clearly identify billing timeframes for the Choice contractors and VA. The contractors have 30 days to pay a submitted claim or to deny the claim with an explanation of additional

information needed to process. VA has 14 days to pay the contractors—this is a new addition to the contract in order to address the backlog of payments.

VA understands that any situation resulting in delayed payments or accumulation of debt due to inappropriately billed claims is stressful for Veterans and unacceptable. We are working hard to correct these errors and offer assistance to our Veterans immediately.

a. Additionally, I hear concerns from medical providers who have had reimbursements delayed by the VA for months. This has caused providers to stop taking veterans, many of whom live in rural areas and are in need of care. Under your direction, what steps will the VA take to improve reimbursements rates for care in the community?

Response. Currently there are no reports of providers refusing to see Veterans as a result of non-payment from VA. We have however received reports of providers who are refusing to see Veterans because of non-payment from the third party contractors. We are 100% current with Choice payments to the TPAs and have been for over 4 weeks.

In February 2016, the Office of Community Care created the Provider Rapid response Team. The purpose of this team is to quickly respond to any issue with provider payment or anything else that might affect Veteran's access to care in the community. This team liaises directly with leadership with the contractors to quickly and effectively solve provider issues.

Question 84. The Diffusion of Best Practices initiative has shown promise in standardizing veterans' care and experience at VA medical facilities. If confirmed as VA Secretary, what is your vision for continuing to build on that process?

Response. Diffusion of Excellence is an initiative that carried out one of my major priorities as Under Secretary: achieving consistency of best practices across the system. In your home state, Cleveland has a simple but impactful best practice that involves non-clinical employees spending time with veterans throughout their journey through the hospital: with this program, employees not only witness the experience of veterans firsthand, but they also get to know the veterans more closely and hear their stories throughout their service.

If confirmed I would ask Dr. Elnahal and his team to build the Diffusion of Excellence initiative out for the entirety of VA. This is an easier endeavor than it might seem: throughout the last 18 months, hundreds of best practices have been compiled with an online information sharing tool called the Diffusion Hub, which included many projects commissioned over the last year at VBA and NCA during a major leadership development initiative. We will establish a similar performance improvement and governance framework for the entirety of VA, and strategically target areas where we need the most improvement.

Appendix: Diffusion Activities occurring in Ohio:

Current Diffusion Efforts Impacting Your Veteran Constituents

Will also leverage model for private sector best practices, which will offer Ohio facilities even more options.

Office of EXCELLENCE

Practices Submitted from Ohio Facilities for November 2016 USH Shark Tank Competition

- Twenty-Nine Practices were submitted from five facilities
- Eight were selected as Semifinalists, and one was designated a Gold Status Practice

Chillicothe VAMC	Women Veterans Ladies Night Event	Veteran Experience
	Bike Share Project	Veteran Experience
	Nurse First	Care Coordination
	RPIE NVCC Emergency Consult	Care Coordination
	Veteran Orientation	Veteran Experience
Cleveland VAMC	Systems Redesign Approach	Access
	ALS System of Care to improve access, address unique patient needs, and improve delivery of care	Access
	Veterans Engagement Reconnecting Employees with America's Heroes (Implementing sites: VISN 17)	Employee Engagement

Office of EXCELLENCE

Gold Status Practice selected in the November USH Shark Tank

Question 85. In your current role, you continue to hold medical appointments with veterans. Why is that important to you and what have you learned from that experience that would enhance your ability to lead VA?

Response. During my career as a healthcare executive I have always maintained an active practice of internal medicine. I have found it is the best way for me to

remain connected to the mission of helping those in need and in learning how systems of care actually work. Being a practicing physician also allows me to understand and communicate better with our staff and to understand how the system allows them, or fails them in their job to care for veterans. Practicing medicine at the VA, in both New York City and via telehealth in Grants Pass Oregon, has allowed me to better understand the needs of the veterans that we serve and how our system of care is different than what I have experienced in the private sector. It has given me firsthand knowledge of the integrated nature of our system, that provides not just physical care, but also addresses the social, psychological and economic needs of our veterans. I've also come to appreciate the specialized services offered by VA such as prosthetics and adaptive sports programs that are essential to the well being of many of the veterans that we have the honor of serving.

Question 86. With each new generation of warfighters confronts issues of exposure to toxic and hazardous materials during service. Will you commit to addressing the full scope of health issues faced by veterans and their families as the result of exposure to things like Agent Orange, burn pits, or nuclear material?

Response. The Department of Veterans Affairs (VA) honors the national service and sacrifice of our Veterans and is committed to providing compensation and health care benefits for disabilities that were incurred or aggravated by that service. This includes any disability resulting from exposure to environmental toxins or hazardous materials.

VA regulations and policies have long addressed environmental exposure issues that include World War II-era radiation from atomic bomb use and testing; Vietnam-era Agent Orange herbicide use; Gulf War desert particulate matter and burn pit toxins; and Camp Lejeune contaminated water during the 1950s–1980s.

Specifically, these regulations govern and address benefits for:

(1) Radiation exposure-related disabilities and for participation in radiation-risk activities and exposure to ionizing radiation;

(2) Diseases associated with exposure to Agent Orange herbicide for those Veterans who served in or visited Vietnam, or on its inland waterways, between January 9, 1962 and May 7, 1975; for service in a military unit operating on the Korean demilitarized zone between April 1, 1968 and August 31, 1971; for regular and repeated contact with a post-Vietnam C-123 aircraft used for aerial spraying of Agent Orange in Vietnam; and for involvement with testing, storage, transport, or other use of Agent Orange;

(3) Disability patterns associated with service in the Southwest Asian Persian Gulf War theater. These include undiagnosed illnesses and diagnosable medically unexplained chronic multi-symptom illnesses, as well as certain infectious diseases. In addition, our regulations also provide benefits for other diagnosable conditions associated with burn pit and Southwest Asia desert hazards; and

(4) Disabilities associated with service at the US Marine Corps' Camp Lejeune, NC, based on evidence of exposure to contaminated water from the mid-1950s to the mid-1980s. Free health care is already available for certain associated diseases and a VA regulation is pending that would provide presumptive service connection for eight diseases.

VA will continue to work with the Department of Defense to monitor and respond to any indication of toxic or hazardous environmental exposures experienced by Veterans during their military service and provide benefits for any resulting disabilities.