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VHA BEST PRACTICES: EXPLORING THE DIFFUSION OF EXCELLENCE INITIATIVE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

SEPTEMBER 7, 2016

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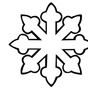

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VHA BEST PRACTICES: EXPLORING THE DIFFUSION OF EXCELLENCE INITIATIVE

WEDNESDAY, SEPTEMBER 7, 2016

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:31 p.m., in room 418, Russell Senate Office Building. Hon. Johnny Isakson presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Rounds, Sullivan, Blumenthal, Brown, Tester, Hirono and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call this meeting of the Veterans' Affairs Committee of the U.S. Senate to order. I want to start out by thanking Senator Brown and Senator Boozman for calling the VA's Diffusion of Excellence Initiative, what they are doing, and for asking us to have this hearing today.

You know, I was a businessman for 33 years. I was not a franchisee or a franchisor, but I ran a company that had a lot of branch offices. I know that if you can replicate where people—you have predictable quality and predictable service and predictable image wherever you go, you can build your brand and you can build your business. I think that is true also in a services business like VA health care.

I think this effort to find out the best practices that work in admissions and whatever it may be, and then to replicate them around the country, can help to build the brand of the VA. Unfortunately, for all our sake, the tragedies that took place in Phoenix, Denver, and in other places, the brand of the VA has been tarnished, not because of best practices but because of bad practices. That is the only image the public really has right now.

I am personally delighted to have this hearing so VA can talk about the success stories that it has discovered and the whole Diffusion of Excellence program they have. I want to underscore the fact that this is something that needs to be a continuation within the VA and throughout the VA health systems around the country so we have a brand that is recognized for the good things that it does, its quality and its predictability, rather than the stories we see on the news today.

I am glad you are all here today. Welcome to our members of the VA. Welcome, Dr. Clancy, for being here. I will introduce you in

just a second, but I want to turn to the Ranking Member for any comments he may have.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman, for holding this hearing.

Today's hearing focuses on two words, "the VA" and "excellence," not often mentioned in the same sentence, probably unfairly, but that is our world today. Giving us an opportunity to hear about some of the best practices, some of the success stories is really to give credit to the thousands of men and women who work in the VA day in and day out with all too little appreciation and thanks. Many of them are veterans who have served and sacrificed for this country. And they have been tarnished because of a small few in the bad practices.

Those bad practices deserve a spotlight and accountability. Accountability is very much needed and merited, but at the same time we should showcase the success stories because they will inspire others to follow them, to model them, and to replicate them, as our veterans truly deserve.

So, thank you for being here; and thanks to our colleagues, Senator Boozman and——

Chairman ISAKSON. Senator Brown.

Senator BLUMENTHAL [continuing]. Senator Brown, for bringing us here today.

Chairman ISAKSON [continuing]. Thank you, Senator Blumenthal.

I would like to welcome Dr. Carolyn Clancy, the Deputy Under Secretary for Health for Organizational Excellence, U.S. Department of Veterans Affairs. We are glad you that you are here.

You are accompanied by Dr. Elnahal, which we are glad that you are here, sir. Thank you for being here. Dr. Garner, welcome, and glad you are here. Mr. Bryant, you are the only non-doctor here, so we are glad to have you. [Laughter.]

As a non-doctor, I am glad to see somebody else with my status, so we are glad to have you today.

Dr. Clancy, we welcome your testimony of about 5 minutes. Anything you submit for the record will be accepted without objection.

STATEMENT OF CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SHEREEF ELNAHAL, M.D., SENIOR ADVISOR TO THE UNDER SECRETARY FOR HEALTH FOR BEST PRACTICES; KIMBERLY GARNER, M.D., J.D., ASSOCIATE DIRECTOR FOR EDUCATION AND EVALUATION FOR VISN 16, CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTER IN LITTLE ROCK, ARKANSAS; AND SCOTT BRYANT, INNOVATION SPECIALIST AND CHIEF OF QUALITY, SAFETY, AND VALUE, CHILLICOTHE VA MEDICAL CENTER, CHILLICOTHE, OHIO

Dr. CLANCY. Thank you.

Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee, thank you for the opportunity to discuss how the VA is improving veterans' health care by systematically spreading best practices.

Ensuring superb care through replicating best practices is one of Dr. Shulkin's top priorities. I am accompanied today by Dr. Shereef Elnahal, Senior Advisor, who led this initiative, the Diffusion of Excellence; Dr. Kimberly Garner, a recognized geriatrician from Little Rock; and Mr. Scott Bryant, Innovation Specialist and Chief of Quality, Safety, and Value at the Chillicothe, Ohio, VA medical center.

Spreading best practices is a challenge for all of American health care. Studies have shown that it takes, on average, about 17 years for new medical evidence to reach patients in the clinic or at the beside, and the VA is not exempt from this problem. But at the same time, large systems in the private sector face the same challenge. We have built a process of business rules and a governance structure that is solving this problem.

Diffusion of Excellence is designed to incorporate all organizations that identify best practices and offer a standardized path for front-line employees to learn about what is already being done well in other parts of the country. In this initiative, dedicated front-line employees are influencing VA care far beyond their individual workplaces. The goal is to identify clinical and administrative best practices, disseminate them to other sites of care, and achieve their standardization to deliver positive outcomes for veterans.

We have already seen 50 completed best-practice replications, hundreds of ongoing projects, and over 70 facilities participating in this initiative, all within less than 1 year since Dr. Elnahal's Diffusion Team began to work. We are changing culture, and doing so by celebrating the people who have dedicated their careers to serving veterans.

Dr. Garner and Mr. Bryant are outstanding examples of such employees, but they are not alone. They have taken it upon themselves to improve the system around them. These employees represent the best of American health care. Frankly, it is an honor to spread their—celebrate their accomplishments. Their energy, enthusiasm, and dedication have been the rocket fuel enabling this initiative to take off.

We are also breaking down cultural barriers like competition by creating systematic incentives to share what has worked with others in the system. The initiative identifies the best projects and prototypes that can be replicated. With the support of Innovators Network, front-line employees are designing new practices with veterans and other stakeholders.

Diffusion of Excellence also has a governance structure that cuts across organizational silos and reforms the bureaucracy to enable progress and allows for resources to be targeted to the front line, where they are really needed. We have also leveraged a Diffusion Hub to enable front-line employees to track their progress as they implement new practices, and to provide national visibility for all of us as they do their work. The result has been to enable employees to impact the system nationwide.

In Little Rock, Dr. Garner gathered veterans and groups to teach them about advance care planning and discuss their goals of care and what is important to them. This model empowers veterans to discuss how they would like to be cared for in the future, should they be too ill to communicate their wishes.

By having veterans work through these issues in groups, this practice provides them with the tools they need to discuss their wishes with family and caregivers in an efficient manner, expanding access to this high-value service. With Dr. Garner's help, this practice has been successfully replicated in Bedford, MA, and is being adopted rapidly in VISN 1 (VA New England Health Care System), and has been selected for national standardization.

In Chillicothe, OH, Mr. Bryant is a champion for the reapplication of a best practice developed at the VA San Diego called eScreening. In San Diego and other sites, this practice allowed clinicians to rapidly identify if there is a suicide risk and increase same-day access to mental health care and triage for urgent services by 21 percent simply by using an iPad questionnaire that veterans complete in the waiting room.

These electronic questionnaires allow clinicians to see responses to questions even before they walk into the veteran's room, helping them to make appropriate referrals. The practice has been successfully replicated in six other facilities and is in demand at another 50 sites, with a clear path to national spread.

We have created a path to standardization of best practices that have been developed by the front line for the front line to impact countless more veterans than individual employees could otherwise do by themselves. This is restoring trust in our system in line with both the MyVA and Under Secretary's priorities. We believe this will benefit millions of veterans and offer a model for other health systems.

Mr. Chairman, this concludes my testimony. Thank you again for the opportunity. We appreciate your support and are pleased to take questions you might have.

[The prepared statement of Dr. Clancy follows:]

PREPARED STATEMENT OF CAROLYN CLANCY, M.D., DEPUTY UNDER SECRETARY FOR ORGANIZATIONAL EXCELLENCE, VETERANS HEALTH ADMINISTRATION (VHA), U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee, thank you for the opportunity to discuss how the Department of Veterans Affairs (VA) is improving Veterans' health care by systematically diffusing operational best practices. As you may know, ensuring consistency and scale of best practices is one of Under Secretary for Health Shulkin's top priorities. We are delighted to discuss the main program addressing this priority, the Diffusion of Excellence Initiative. I am pleased to be accompanied today by Dr. Shereef Elnahal, Senior Advisor to the Under Secretary for Health and Initiative Lead for Diffusion of Excellence; Dr. Kimberly Garner, Associate Director for Education and Evaluation at the Veterans Integrated Service Network (VISN) 16/Central Arkansas Veterans Healthcare System Geriatric Research Education and Clinical Center in Little Rock; and Mr. Scott Bryant, Innovation Specialist and Chief of Quality, Safety, and Value at the Chillicothe, Ohio VA Medical Center.

With more than 1,700 sites of care and over 300,000 employees, it is inherently challenging to deliver care with consistent processes and outcomes across the Veterans Health Administration (VHA). Large systems in the private sector also face this challenge. While decentralized leadership provides discretion for individual facilities to address local issues, VHA and U.S. health care at large have experienced

challenges standardizing practices that maintain local flexibility, as appropriate, and consistently deliver value, no matter where they are applied.

Through the Diffusion of Excellence Initiative, dedicated front-line employees are now changing that story and influencing the system far beyond their individual workplaces. The goal of this initiative is to identify clinical and administrative best practices, disseminate these practices to other sites of care, and encourage standardization of practices that deliver positive outcomes for Veterans and their families. Ultimately, identifying and spreading best practices can be a major driver of consistent, high-quality health care for Veterans.

Because of the hard work, dedication, and passion of front-line employees like Dr. Garner and Mr. Bryant, Dr. Elnahal and his team have built an infrastructure that leverages our scale as a system to deliver positive outcomes to thousands of Veterans across the Nation. This infrastructure begins with innovation, proceeds to implementation, and after much vetting and analysis, crafts a pathway to standardization.

There are many program offices at VA that fuel innovation. One is the VA Center for Innovation, which sponsors the VA Innovators Network, a collaboration of highly-skilled change agents who lead and facilitate best practice implementation at VA's front lines. The Innovator's Network plays a key role in the first phase of innovation implementation and in the second phase, helping to scale practices once they have delivered positive outcomes for Veterans. Other offices, such as VHA's Office of Rural Health, play a key role in driving field-based innovation and best practice standardization for priority groups, including rural Veterans. The Diffusion of Excellence Initiative has created a governance structure that removes bureaucratic hurdles and allows for resources to be targeted to the front line in places where they are most needed.

Armed with successful innovation pilots, the Diffusion of Excellence Initiative identifies the best projects and prototypes that can be replicated. And, with the support of the Innovators Network, front-line employees are co-designing new practices with Veterans and other stakeholders, allowing VA to respond rapidly to Veterans' needs in front-line settings and accelerating our service delivery. This enables the best practices to rise to the top and spread. We have also leveraged a technology platform, developed by the Veterans Engineering Resource Center, that is useful for front-line employees as they begin implementation and allows for national-level oversight and transparency about progress.

In just the past year, this model has generated over 260 ongoing innovations in 70 facilities, including over 40 completed replications of 13 Under Secretary for Health Gold Status Best Practices (described in full below).

Identifying, selecting, and diffusing best practices is changing Veterans' lives. For example, in Madison, Wisconsin, Clinical Pharmacy Specialists (CPS) practicing at the top of their licenses furnished direct patient care that resulted in increased access for Veterans. CPS monitored patients with chronic diseases and managed medication in their own clinics, collaborating closely with Veterans' primary care physicians. As a result of this practice, the CPS were able to save primary care providers 20 minutes per new patient appointment, and were able to convert 27 percent of patient appointments from the primary care provider to the CPS, opening access on the primary care providers' schedules for other Veterans with acute care needs. Currently, over 30 VA and non-VA sites are either planning or have begun implementing this practice.

In Little Rock, Arkansas, Dr. Garner gathered Veterans to teach them about advance care planning and to discuss their goals of care. This model empowered Veterans to decide how they would like to be cared for in the future, should they be too ill to communicate their wishes. It also provided Veterans with tools to discuss their wishes with their families and loved ones. With Dr. Garner's help, this practice was successfully replicated in Bedford, Massachusetts and is likely to be adopted rapidly in VISN 1 (New England). Using the process described later in this testimony, this practice was selected for national standardization.

In Chillicothe, Ohio, Mr. Bryant championed the reapplication of a best practice developed at the VA San Diego Healthcare System through an Innovators Network grant. This best practice decreased the time to document suicide risk by half, and increased same-day access to mental health care and triage for urgent services by 21 percent, simply by using an iPad questionnaire that Veterans completed in the waiting room. These electronic questionnaires allow clinicians to see responses to questions before walking into the Veteran's room, helping them to make appropriate referrals. This practice has been successfully replicated in 6 other facilities and is in demand at another 50 sites.

Additionally, Mr. Bryant is in the process of implementing a bike-sharing program that helps Veterans and employees quickly commute across the large Chillicothe

campus. In addition, through a partnership with the Small Business Administration, this program gives Veterans entrepreneurial experience to start their own small businesses. The goal of this program is to help support Veterans in vocational rehabilitation and provide an opportunity for Veterans to learn an employable skill and start their own businesses. Mr. Bryant completed most of this program as an Innovation Specialist within the Innovators Network, and it will become an Under Secretary for Health Gold Status Best Practice.

In just the few sites where these best practice innovations originated, the results have been impressive. The potential is great to provide better health care to many more Veterans when these best practices are scaled across the system. For example, if direct patient care by a CPS is instituted nationally, this practice alone could open up more than 35,000 primary care appointments per year.

VA can also learn from the best academic and private sector medical centers. To that end, VA is partnering with the American College of Physicians (ACP) to exchange ideas. VA Innovators, like Dr. Garner and Mr. Bryant, who, without prompting, sought to improve the system for Veterans, will serve on regional advisory panels to guide ACP best practice infrastructure. Likewise, ACP will appoint clinicians and systems improvement experts to a Diffusion External Advisory Board, consisting also of Veterans and Veterans Service Organization representatives. This exchange is designed to diffuse VA best practices into the private sector and to enable VA to learn what some of the highest-performing and most prestigious institutions are doing to address emerging operational challenges in health care.

Another example of how VA is sourcing and learning from the private sector is through a recent VA partnership with the YMCA. VHA's Office of Community Engagement developed a Memorandum of Understanding with the YMCA that allows VA facility staff to partner with YMCAs locally to expand and enhance services for Veterans in their communities. These services include wellness and fitness programs, sports, recreation, and other activities that speak to veterans' holistic needs. In less than a year, 36 sites have developed or are in the process of developing local partnerships. Other partnerships are being fostered to achieve the same objectives: to educate private sector medicine about VA best practices, and to obtain best practices from American medicine that will improve our performance in VA.

HOW ARE WE ACHIEVING ALL OF THIS AT VA?

We are building an Innovation Ecosystem comprised of mutually reinforcing parts: the VA Center for Innovation (VACI), the Innovators Network, and the Diffusion of Excellence Initiative. VACI is an enterprise entity that works with all lines of business and focuses on delivering operational breakthroughs for strategic priorities, building innovation as a capability at VA, and driving future thinking. The Innovators Network, a VACI program, empowers front-line innovators with training; a tiered grant program, which seeds and cultivates specific innovations; and continued integration into agency strategy. The Diffusion of Excellence Initiative provides a critical link in this chain by identifying, prioritizing, and driving the dissemination of top innovations and best practices across VHA. Each element in this ecosystem performs a vital function.

Figure 1: Innovation and Diffusion

We are also implementing a permanent and sustainable diffusion process that allows us to continually identify and diffuse best practices across the system. VHA has achieved success in implementing this model by leveraging the following organizing principles: Process (a consistent framework for evaluation and reapplication of practices, with clearly-defined roles); Governance (ensures vertical accountability to agency priorities, with regular engagement to achieve consistency and sustainment of high performance)*; and Technology (enables rapid, transparent information flow across organizational boundaries and regions). These foundational elements underlie five steps to achieving a high performance, learning health system. Below, we describe the process we developed and how we are leveraging these principles to drive organizational improvement, enabling VHA to better serve our Veterans.

5-STEP PROCESS FOR IDENTIFYING AND DIFFUSING BEST PRACTICES

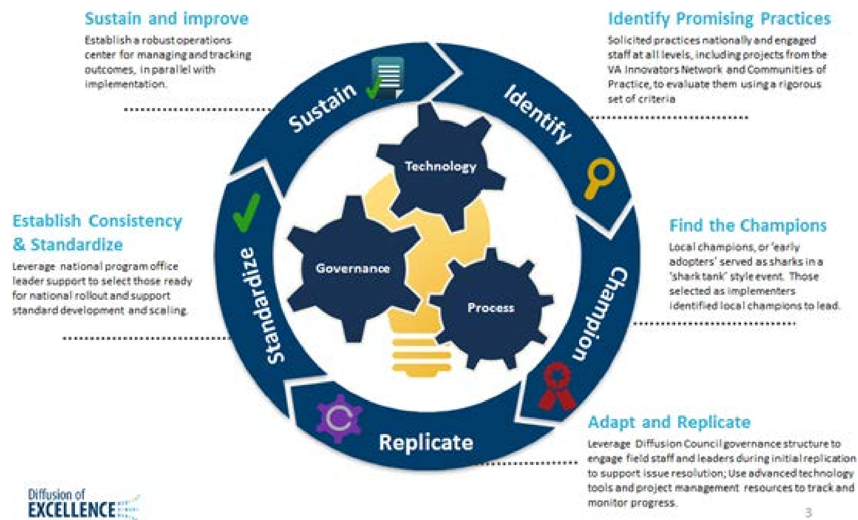


Figure 2: Diffusion Model

Step 1: Identify Promising Practices

We sought to identify promising practices by launching a national solicitation through an internal social media platform. This solicitation attracted over 250 submissions from front-line employees, each of whom changed their local environments to improve care. Selection criteria included: 1) sustained high-performance or improvement along strategic priorities; 2) efficient resource utilization; 3) applicability to different care environments; and 4) implementation feasibility within 6–12 months. The submissions were reviewed by subject matter experts and senior leaders, as well as other front-line employee stakeholders across the system to assess feasibility for wide application. The selection process leveraged both technology and effective governance: evaluations occurred at every level of the organization, but in a structured manner.

A Diffusion Council of mid-level managers and subject matter experts; a Governance Board of senior leaders; and most importantly, a community of practice of front-line providers all had an equal stake in identifying the 13 Under Secretary for Health Gold Status Best Practices (fully described below) to be disseminated across the system, assuring both value assessment at the point of care and alignment with leadership priorities. We used the same technology platform for swift data collection from hundreds of employee evaluators. By the end of 2016, every regional service network will use similar criteria to identify promising practices in their own forums.

*Pronovost PJ, Armstrong CM, Demski R, et al. Creating a high-reliability health care system: improving performance on core processes of care at Johns Hopkins Medicine. Acad Med. 2015 Feb;90(2):165–72.

Step 2: Find the Champions

Local champions, or “early adopters,” are crucial for front line implementation of best practices. VHA held a competition to identify locations where Under Secretary for Health Gold Status Best Practices would be replicated initially. Nineteen innovators pitched best practices to 28 VA Medical Center directors, and directors had to bid resources, including employee time, space, and funding needed to enable implementation. Most importantly, they had to identify a champion to own the initial phase of implementation at their facility. This format solidified leadership commitment at field sites, ensuring alignment to local priorities and the resources necessary to inculcate the practice. Because participating facilities spanned the entire Nation, the competition was held virtually, enabling efficient information transfer and communication, without any cost. As noted previously, 13 of 19 finalists were ultimately chosen as Under Secretary for Health Gold Status Best Practices, based on bids from the VA Medical Center directors and national leadership endorsement.

Step 3: Adapt and Replicate

Before national deployment, the Diffusion model calls for “phase 1” implementation of each practice in at least one other location to learn about implementation challenges in different contexts. To achieve this, we brought local implementing champions together with innovators (who initially developed the practices) in person for a planning summit to engage in intensive project planning. The two-day intensive session allowed for rapid-fire planning, minimizing time away from clinics and overall cost. Along with a lean-trained project manager, these individuals constituted Action Teams, which conference regularly and track implementation. Four Action Teams, defined by strategic priority (access, care coordination, quality and safety, and employee engagement), report to an operational body called the Diffusion Council.

The Diffusion Council is a governance body composed of different operating units that span from central program offices to local leadership. Its purpose is to recommend policy changes or resource allocation decisions to a Governance Board composed of senior VHA leadership, specifically to enable Under Secretary for Health Gold Status Best Practice implementation. This structure provides ongoing operational support to Action Teams, but also accountability for progress at each level. An online tool called the Integrated Operations Platform (IOP) allowed both innovators and local implementing champions to conduct lean implementation against milestones, useful for local project execution. The IOP also serves as a knowledge hub that is searchable by any employee in the system. This allows champions to find projects that have worked at other sites of care for similar challenges. In addition, registration of milestones generates structured data, allowing the Diffusion Council and Governance Board transparency into progress (or lack thereof) when data is aggregated for national view. Systemic barriers are therefore identified and addressed proactively with resources or policy changes.

Step 4: Establish Consistency and Standardize

After initial replication efforts, certain Under Secretary for Health Gold Status Best Practices are chosen for national standardization based on two parameters: 1) relative success with initial implementation, and 2) similar outcomes achieved when replicated, in a reasonable timeframe. Within just five months, 12 of 13 practices have been replicated at more than 14 sites (and the 13th is in the process). With this success, Action Teams have begun developing national roll-out plans for several of the practices that leverage shared resources (e.g., central information technology servers for applications) and system-wide channels of communication (e.g., national communities of practice for clinicians or social workers). Because the Diffusion Council is composed of representatives from many program offices, national roll-out can be supported for most practices. To enable consistent execution operationally, champions must be identified in both regional service networks and individual facilities, which use a road-map generated by the Action Teams during the first phase of implementation to ensure consistency. Standardization is defined by the equivalence of Veteran or employee outcomes, rather than strict adherence to a defined process, allowing for facility and network champions to use human-centered design and adapt practices to their local environments. Finally, because the IOP cumulatively records every facility’s experience with implementation and barriers, data about system-wide resource needs allow the Governance Board to make targeted investments accordingly.

Step 5: Sustain and Improve

Even before a best practice is scaled nationally, Diffusion of Excellence engages staff, resources, and technology to ensure sustainment once it is scaled. “Practice-

based service lines" will combine the original innovators with an appropriate, national level executive partner for ongoing validation and monitoring. This combines content knowledge of the practices with the operational expertise required to monitor for variation or changes in performance. VISN and facility champions in every site of care will continue to monitor the sustainment of practices that achieve implementation and adapt to changing needs as necessary. To ensure sustainment, lagging indicators (outcome data) must be tied and correlated with already-established implementation metrics in the IOP, combining self-reporting with objective analytics. This allows for proactive assessments of performance shortfalls, now incorporated into a centralized operations center that will be replicated at every level of the organization.

In addition to a diffusion process based on implementation and dissemination science best practices, a fail-safe governance process and a technology platform that promoted information sharing were key to success.

Figure 3: Integrated Operations Platform: VA Diffusion of Excellence Hub

GOLD STATUS PRACTICE SUMMARIES

Brief descriptions of each practice are provided below, including information about the fellow(s) that designed it and their facility, and the facilities that are replicating this practice.

Improving Same-Day Access Using Registered Nurse (RN) Care Manager Chair Visits. At the Boise VA Medical Center (VAMC), the primary care team created a process where same-day appointment requests are triaged and scribed by RN Care Managers, saving primary care providers' time when they see patients between appointments to assess and confirm the care plan. The originators, a primary care physician and nurse duo, Dr. Henry Elzinga and Debra Hendricks Lee, took this practice on the road, providing real-time coaching to their peers to support implementation, including the Albany Community-Based Outpatient Clinic (CBOC). Together, these facilities serve many rural Veteran patients.

- Gold Status Fellows: Dr. Henry Elzinga and Debra Hendricks Lee, Boise VAMC
- Implementing Facilities: Central Alabama Veterans Health Care System (Montgomery, Alabama),Carl Vinson VAMC (Dublin, Georgia), Albany CBOC (Albany, Georgia)

Access Data Dashboard to Improve Clinic Management. As VA staff continues its dedication to the core ICARE values, transparency, and a "we can fix that" attitude, the data analysis team at Harry S. Truman Memorial Veterans' Hospital (Columbia, Missouri) implemented a dashboard for clinic access metrics (no shows, completed appointment wait times, clinic utilization, etc.). These metrics are posted monthly on an accessible dashboard that can be used by staff to solve problems and make key decisions that help Veterans get timely access to care. This dashboard encourages thoughtful discussion on ways to improve measures and mutual accountability for results. For example, clinic teams use the no-show data to actively engage in preventing future no-show appointments. Use of the dashboard has shown positive

results include improved no-show rates and improved wait times. This team helped to design a similar dashboard for the Kansas City VAMC, and has been working closely with VHA's clinical analytics and reporting team to integrate this model into the national Health Care Operations Dashboard.

- Gold Status Fellow: Michelle Pruitt, Harry S. Truman Memorial Veterans' Hospital (Columbia, Missouri)
- Implementing Facility: Kansas City VAMC

Planning for Future Medical Decision via Group Visits. When a patient is critically ill or mentally incapacitated, family members or even staff may be forced to make difficult, life-altering decisions. This interactive and patient-centered group visit approach to engaging Veterans in planning for future medical decisions allows patients' wishes to be honored while reducing unwanted treatments. Now, thanks to Dr. Garner and a social worker-led team at the Bedford VAMC, more Veterans are having those important discussions early, bringing peace of mind to themselves, their families, and those who care for them. This team has also been working tirelessly with VHA's Social Work Office and the National Center for Ethics to develop a toolkit for implementing this practice throughout the VA.

- Gold Status Fellow: Dr. Kimberly Garner, Central Arkansas Veterans Healthcare System (Little Rock, Arkansas)
- Implementing Facility: Edith Nourse Rogers Memorial Veterans' Hospital (Bedford, Massachusetts)

Increasing Access to Primary Care with Pharmacists. At the William S. Middleton Memorial Veterans' Hospital (Madison, Wisconsin), Dr. Ellina Seckel, a CPS, and her colleagues knew that VA's CPS, when authorized by their scope of practice, may prescribe medications and monitor patients with diabetes and other chronic diseases. They are also key members of the Patient Aligned Care Team (PACT). The facility matched CPS with multiple PACTs to conduct New Patient Intake calls one week before a new patient has his or her first appointment with a provider, collecting medications, noting any formulary conversions, and orienting the patient to VA. This effort has saved the provider an average of 20 minutes during the initial appointment. The team was also able to convert 27 percent of appointments from the primary care provider to the CPS, opening up hours of access for acute care patients. By practicing true team-based care, the facility has shifted the chronic disease workload off the primary care providers. The CPS are able to work to the top of their scope of practice as pharmacist providers. Primary care providers have more time to spend with patients and Veterans can get the care they need more quickly. With the support of the innovating team, the El Paso VA Health Care System has begun integrating CPS into PACTs to practice true team-based care. In just 4 months of implementation with one CPS paired with three PACTs, El Paso VA Health Care System has already seen improved access to care for Veterans, and is expanding the practice to include all PACTs. This practice has also achieved significant recognition in the private sector, with health systems in the U.S. and United Kingdom requesting to shadow and learn from the William S. Middleton Memorial Veterans' Hospital team.

- Gold Status Fellow: Dr. Ellina Seckel, William S. Middleton Memorial Veterans' Hospital (Madison, Wisconsin)
- Implementing Facility: El Paso VA Health Care System (El Paso, Texas)

Unit Tracking Board. Michael Finch, a clinical nurse leader at the C.W. Bill Young VAMC saw that key clinical unit data were not being presented and shared effectively with nursing staff. He developed a simple and accessible Unit Tracking Board to post on floor units. Now, all staff involved in care can quickly see important data about their patients. They are empowered to use that information to make the best decisions that help improve the care experiences of Veterans. This practice also supports VA's mission to foster a culture of transparency since the board is posted publicly. Michael helped a nurse-led team at the White River Junction VAMC develop a similar board for the Intensive Care Unit, and similar boards will soon be placed in all inpatient units at White River Junction. This team is also working with the national nursing leadership at VHA to standardize a model for all medical centers.

- Gold Status Fellow: Michael Finch, C.W. Bill Young VAMC (Bay Pines, Florida)
- Implementing Facility: White River Junction VAMC (White River Junction, Vermont)

Journey to Open Access in Primary Care. Using system redesign principles and VA's PACT model, this practice focuses on implementing new protocols that increase same-day access opportunities for Veterans. Dr. Michael Tom, Chief of Primary Care Services at the VA Central California Health Care System (Fresno, California), has

worked hand-in-hand with the team at Gulf Coast Veterans Health Care System (Biloxi, Mississippi), a facility with significant access to care challenges, to mentor and help with this significant transformation.

- Gold Status Fellow: Dr. Michael Tom, VA Central California Health Care System (Fresno, California)
- Implementing Facility: Gulf Coast Veterans Health Care System (Biloxi, Mississippi)

eScreening. The eScreening Program was developed to facilitate the screening process and improve care coordination and measurement-based care for Veterans. eScreening is a mobile technology that can significantly improve care coordination and business processes. It offers Veteran-directed screening, real-time scoring, individualized patient feedback, instantaneous medical record clinical documentation, immediate alerts to clinicians for evaluation and triage, and monitoring of treatment outcomes. Put simply, the Veteran is handed an iPad when he or she checks in for an appointment, and can complete any required screening on the iPad. The information is then transferred directly from the waiting room to the patient's medical record. The tool can be used in any clinical setting from primary care to urgent care to mental health. This best practice has already spread to three facilities organically and to three other facilities through Diffusion of Excellence. There are 40 more facilities "on deck" and ready to implement.

- Gold Status Fellows: Dr. Niloofar Afari, and Liz Floto VA San Diego Healthcare System
- Implementing Facilities: Lebanon VAMC, Ann Arbor VAMC, Edith Nourse Rogers Memorial Veterans' Hospital (Bedford, Massachusetts)

Code Tray Redesign. Certified Pharmacy Technician Kristine Gherardi at VA Boston Healthcare System noticed that the current code tray was not set up in a way that made it easy to find life-saving drugs in an emergency. She created a simple and compelling solution to reduce the time it takes to find a certain drug during a code. This easy-to-implement, low-cost strategy reduces medication distribution errors, improving outcomes for Veterans. The Loma Linda VAMC is already implementing this code tray and more are quickly following.

- Gold Status Fellow: Kristine Gherardi, VA Boston Healthcare System
- Implementing Facility: VA Loma Linda Healthcare System

Regional Liver Tumor Board. The hepatology team at the Philadelphia VAMC combined a regional telehealth-supported Liver Cancer Tumor Board model, a web-based submission process, and a consolidated database to manage and track communications for patients with liver cancer. This practice has shortened the time for Veterans with liver cancer to receive their evaluation and first treatment, as well as reduced unnecessary biopsies—easing the minds and experiences of patients and their families in an incredibly stressful time. Jackson VAMC, a facility without a dedicated hepatologist, is now implementing this practice in partnership with the Central Arkansas VA Healthcare System, giving Veterans faster access to top-notch clinical care.

- Gold Status Fellow: Dr. David Kaplan, Corporal Michael J. Crescenz VAMC (Philadelphia, Pennsylvania)
- Implementing Facility: G.V. (Sonny) Montgomery VAMC (Jackson, Mississippi)

Using External (Non-VA) Comparative Data to Achieve Excellence and Engage Employees. To do a better job of comparing outcomes, not only against the VA average, but also against "the best," the Mountain Home VAMC expanded non-VA benchmark data to provide indicators of how Veteran and caregiver stakeholders view VA care and services in relation to other health care choices in their region. This results in higher performance and employee engagement, so staff can seize opportunities to improve, while also instilling pride in the fact that VA truly provides world-class care for our Nation's Veterans. Using this model, the San Francisco VA Health Care System is replicating the practice for its Engineering service, ensuring that top notch support services are provided at the facility.

- Gold Status Fellow: Jill Stephens, James H. Quillen VAMC (Mountain Home, Tennessee)
- Implementing Facility: San Francisco VA Health Care System

WAKE Score® for Recovery from Anesthesia/Sedation. The WAKE Score® replaces a previous anesthesia recovery scoring system, which would often leave patients with nausea and vomiting, lightheadedness, and pain. The WAKE Score® takes a "zero tolerance" approach to anesthesia side effects, improving patient experience and outcomes. Developed by anesthesiologist Dr. Brian Williams, the WAKE Score® has been evaluated and the results have been published in several peer-re-

viewed academic journals. To improve post-surgery outcomes at Martinsburg, the anesthesia team adapted this model. VHA surgery senior leadership are currently assessing the options based on this replication and other models to determine the best standardized model that will improve optimize Veteran outcomes post-surgery.

- Gold Status Fellow: Brian Williams, VA Pittsburgh Healthcare System
- Implementing Facility: Martinsburg VA Medical Center

Direct Scheduling for Audiology and Optometry Services. Previously, Veterans had to see their primary care provider to receive a referral for simple audiology and optometry services, such as new eyeglasses. This new model, piloted first at Bay Pines VA Healthcare System (Bay Pines, Florida), allows direct scheduling for certain appointment types. This direct scheduling process eliminates redundant consultations, consolidates clinic profiles, and standardizes communications, leading to greatly reduced overall wait times for Audiology and Optometry. It has been rolled out to several VA facilities, and will be in all VA facilities by the end of this year. Next, VA is looking to implement a similar policy and process for other services—for example, podiatry services.

- Gold Status Fellow: Michelle Menendez, Bay Pines VA Healthcare System
- Implementing Facility: Multiple Sites

Flu Self-Reporting Desktop Icon to Capture Employee Vaccinations Received Outside the VA. The Flu Self-Reporting Desktop Icon was created by the occupational health team at the VA Boston Healthcare System. This icon allows staff to quickly report with the click of a button on their computer's desktop when they've received the flu vaccine outside VA. Capturing an average of 500 vaccinations annually, not only does this tool help encourage staff to take care of themselves, but it also protects the health of patients and their families. The Boston team worked closely with the Mountain Home and VISN 12 teams to replicate this practice, and to develop a national model for rolling this out at every medical center as a standard. Seeing the potential, more than 40 leaders at other facilities took the initiative to roll this out in their facilities over the last several months.

- Gold Status Fellow: Vanessa Coronel, VA Boston Healthcare System
- Implementing Facility: VA Great Lakes Health Care System (VISN 12), Mountain Home VA Medical Center

CONCLUSION

While VA historically operated as a siloed system, we are transforming that legacy through the Diffusion of Excellence Initiative and the broader innovation ecosystem. This lack of strict standardization has, in part, created fertile ground for innovation, prompting VA's recent listing as a top organization for innovation. The Diffusion of Excellence Initiative has added a critical capability to VA's Innovation Ecosystem and will play a vital role ensuring that Veterans get the best care that the Nation has to offer.

Giving front-line employees the opportunity, resources, guidance, leadership support, and where needed, some bureaucratic relief to re-apply best practices is crucial for standardizing top quality health care. Success requires striking a balance that creates a path to standardization, but also rewards and elevates innovation at the point of care. Dr. Garner and Mr. Bryant exemplify the innovation ecosystem that exists in our system that we are finally able to leverage. While many large systems face similar challenges, especially as they acquire smaller hospitals and sites of care, to our knowledge, no operational system has been able to achieve diffusion or consistency of best practices to this scale. In addition, it is impossible to overstate the excitement and energy of employees serving Veterans every day seeing their great ideas translated into better access and outcomes for all Veterans.

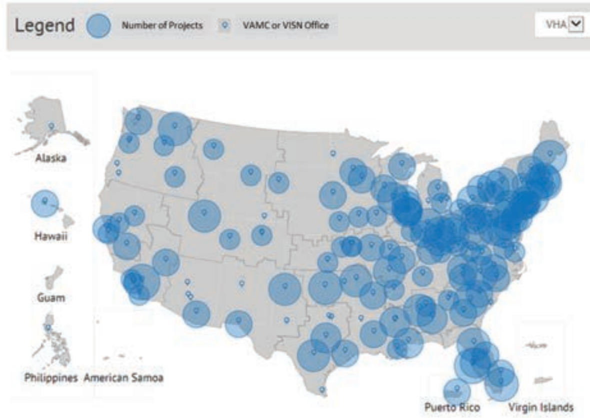
Moving forward, VHA will continue to refine the model to meet VHA needs, while encouraging continued innovation and best practice development to meet the needs of Veterans across the Nation.

We, therefore, believe that this is not only an initiative that can benefit millions of Veterans across the Nation, but a model that can be used by any health system facing similar challenges in providing consistent care. In the meantime, we will continue to empower front-line employees like Dr. Garner and Mr. Bryant, both of whom have contributed to an effort that allows them to impact countless more Veterans than they otherwise could have themselves.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to testify before the Committee today. We appreciate your support and are pleased to take questions that you or the other Members of the Committee may have.

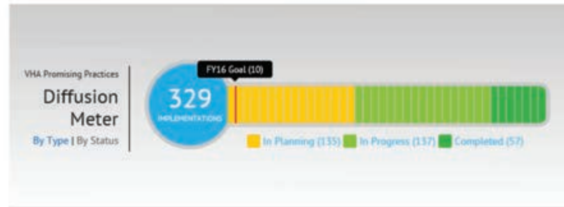
DIFFUSION OF EXCELLENCE POSTERS (5 SLIDES)

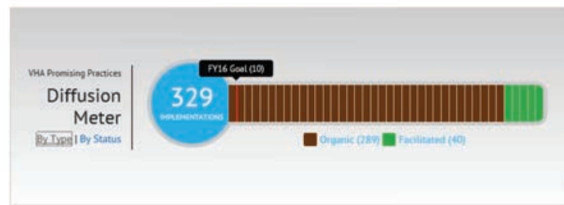
VHA is implementing **300** ongoing replications at over **70** facilities.



As of August 29, 2016

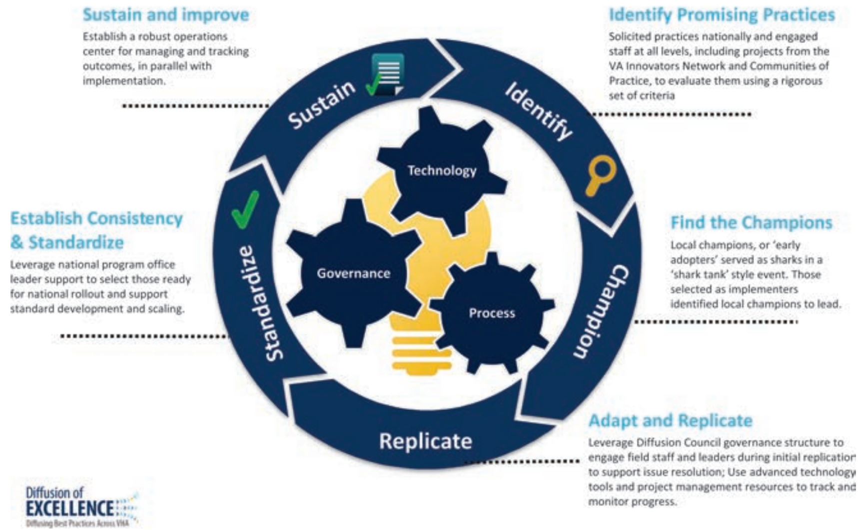
Diffusion Meter





As of August 29, 2016

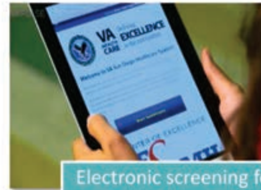
Diffusion Methodology



Diffusion in Action

Pharmacists increasing access to Primary Care

Preventing Falls with Unit Tracking Boards



Electronic screening for mental health conditions

Redesigning Code Trays for Patient Safety

Diffusion of EXCELLENCE
Diffusing Best Practices Across VHA

Innovation at VA

Diffusion of EXCELLENCE

Chairman ISAKSON. Well, thank you, Dr. Clancy.

I think what I want to do is focus on Dr. Garner and Mr. Bryant for a second because you are the two all-stars that brought us to this hearing. I did not now where Chillicothe, OH, was until I met Sherrod Brown. I did not know who you were until I met Senator Brown. So, I am glad you are here in person. Glad to have you.

Dr. Garner, my aunt was in Little Rock, where I went for many a summer back in the 1950s. It is a great town. I appreciate what both of you have done.

To start with, Dr. Garner—you are probably aware of this, though you may not be—but one of my passions since being in Congress is advance care planning for end-of-life as a standard practice that everybody ought to do—something you do not want to do, but it is so much better for the quality-of-life that you have or the quality-of-life that your families have. I commend you for doing this—because that is your program, if I am not mistaken, is it not?

Dr. GARNER. Yes, sir.

Chairman ISAKSON. Would you like to expand a little bit on how you got into it and what the results of it are?

Dr. GARNER. Yes, sir.

We were aware that a lot of the veterans and adults in general are not aware what an advance directive is and how it may help them and their families. So, we were brainstorming about how we might be able to better efficiently get that message out and we came up with the idea of doing it in groups. Since then, we have been able to develop it with veteran feedback, veteran focus groups, asking veterans to help us: What is the best way to interact with you about this topic?

We have been able to come up with a program that is very satisfactory to veterans and that allows a discussion to occur to talk about: Have you ever thought about this? Have you ever had an experience of making a decision for someone else?

Through that process, they are able to actually engage and think about what it might be like for them if they were ever in a situa-

tion where they could not speak for themselves. Who would they trust to make decisions for them? What would they want that person to know and be prepared to do if they were ever in that situation?

Another thing that we emphasize is it is not just about end of life. This durable power of attorney for health care, which is part of an advance directive, allows someone—if it is a surgery or even if a veteran is just very sick because—and are expected to recover but for a period of time cannot make decisions for themselves.

As a health care provider, I want to know who this veteran trusts, and I want to provide the care that is consistent with who they are as a person. This allows us to engage veterans in this discussion, because doing it as a group we have more time, we are able to get into a pretty detailed discussion about how this might benefit them and their families.

Chairman ISAKSON. Well, it is ironic that you have ended up with a program that is based in doing it in a group rather than doing it individually, but it must be easier for the veterans to talk early on in a group than it would be if there were just one individual veteran and a nurse or a practitioner. Is that right?

Dr. GARNER. Yes, sir. What we hear from the veterans is that having—discussing this as a group is a little bit less intimidating. A one-on-one discussion, you pretty much have to say something, but veterans feel that they can come to the group and they do not have to say something if they do not want to.

The other thing that we hear time and time again is: I heard something from another veteran that I do not think I would have thought of myself. That is very beneficial to them to hear what their peers have to say and what their peers think about this process. We have also been told multiple times: You need to be doing this with every veteran. You should not have such a small program. We want you doing this with everyone.

Chairman ISAKSON. What is so ironic about your best practice is it is exactly the opposite of what Mr. Bryant is doing. If I am not mistaken, your e-evaluation is a one-on-one, with the veteran answering questions on a computer, is that correct—or a laptop or an iPad?

Mr. BRYANT. Yes, that is correct.

Chairman ISAKSON. The military learned with the Warrior Transition Units from Afghanistan and Iraq that a lot of times soldiers will not tell you they are having bad dreams, they will not tell you they are having flashbacks, they will not tell you they are having symptoms of post-traumatic stress disorder (PTSD) or traumatic brain injury in a group meeting or group session like that. But, you put them in a room with a computer where they are answering questions on the touch pad, they will tell you those things.

In your case, Dr. Garner, the group therapy actually helped to bring out people's discussion on the subject, which is a difficult subject. In your case, Mr. Bryant, you did exactly the opposite but found a way to give them privacy, which makes it easier for them to talk about very difficult subjects. Would you address that for 1 second, Mr. Bryant?

Mr. BRYANT. Sure.

Actually, the veteran will be able to use the iPad. When they use the iPad, they answer simple yes/no questions. When they answer a yes question, that automatically alerts the provider to focus their appointment on those yeses.

The appointment time that you spend is very valuable to the veteran. That is why they are there. They want to see the physician. So, by doing this, it allows it to be more focused on what they are there for rather than all those other questions.

Chairman ISAKSON. Well, thanks to both of you for being great leaders.

Ranking Member Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Let me ask you, Dr. Clancy, what is the innovation or a few innovations that you would recommend most widely and most highly to health care facilities?

West Haven has adopted the hepatitis C infection detection—hepatitis C carcinoma tracking system that, I am told, has been replicated across the country. That is the kind of innovation that the VA has brought to that particular illness. Are there others that you would recommend?

Dr. CLANCY. Yes. There are a number that I am very excited about and probably more I do not know about yet, which is really the whole point of this initiative.

Given the imperative of addressing our access problems, it is very, very hard not to be incredibly excited about any initiative, whether it is group visits for advance care planning or for some other topic—we do a fair amount of that—or in the case of what Mr. Bryant has, a way to make sure that we are rapidly identifying those at increased risk of suicide, but there is a number of other best practices related to access.

I might just ask Dr. Elnahal to amplify.

Dr. ELNAHAL. Thank you, Dr. Clancy and Ranking Member Blumenthal.

Personally, I am proud of all 13 of our Gold Status practices and all of the fellows, the implementing fellows, that are getting them done.

You see, Dr. Garner and Mr. Bryant sitting to my left, they are too humble to tell you that they are extremely invested in the practices that they have espoused. For example, Dr. Garner offered to pay her own way to DC to come teach the entire country how to do the practice. We found funding for her, but she offered that. Mr. Bryant has been late to some of our sessions to prepare for this hearing because he was finding his way to help veterans find their way to get in the Chillicothe campus. So, these people are very focused, and that is what everyone is doing with our practices.

Two examples that I will just highlight for your benefit that could really help the health care system generally: clinical pharmacy specialists. Our best practice improved access to primary care by 28 percent by allowing clinical pharmacists to have their own clinics, their own consult service to manage medication issues.

I am a diabetic, so I was actually taught how to use my insulin from a clinical pharmacist when I was first diagnosed. If we have expanded practice authority for these professionals, that could real-

ly improve access not just within the VA, which we are doing now, but throughout the American health care system.

We also have a Virtual Tumor Board that is currently being held in Little Rock, AK, serving patients in Jackson, MI. That is a model that will allow all of the experts for a particular disease to evaluate your case and discuss the case that you have together in the same room, allowing you to get your treatment plan much sooner and to start treatment within 30 days, which is the evidence-based guideline for treatment.

These are just two examples of practices that can really help, and are targeting rural veterans as well.

Senator BLUMENTHAL. Let me ask you about some of the drugs that are used in VA facilities—insulin, Narcan, my guess is EpiPens. Are you finding—I know that the VA can negotiate prices, but are you affected by practices in the private sector and by shortages in those drugs which exist in the private sector? Hospitals tell us about shortages in those drugs and many others. How does that affect health care in our VA system?

Dr. CLANCY. I will say that, given the recent publicity about EpiPens in particular, I asked our lead chief pharmacist about this the other day and, in fact, it has not affected the price that we get at all. Whether it will I think is an unknown question, but because we have the capacity to negotiate, we have—we clearly get the best deal for hepatitis C in the country. That is an ongoing practice. Narcan, I think that we are doing OK right now, but that is obviously another example of one that is going up quite a bit.

Shortages where you simply do not have supplies available, yes, we are going to get impacted by that, but again, because we are a predictable customer and have negotiated arrangements long in advance, in general we are going to avoid the worst of all of this.

Senator BLUMENTHAL. The fact that the VA can negotiate, unlike Medicare, for example——

Dr. CLANCY. Yes.

Senator BLUMENTHAL [continuing]. Unlike our hospitals, keeps down the cost of health care——

Dr. CLANCY. Yes.

Senator BLUMENTHAL [continuing]. And has spared you, at least until now, the effects of those astronomically-rising prices for EpiPens and a number of other pharmaceutical drugs.

Dr. CLANCY. Yes.

Now, I will also say that when the market gives us an advantage—for example, once there was more than one highly-effective, very-few-side-effects treatment for hepatitis C. That brought prices down for everyone and we were able to further negotiate an even much better deal.

Senator BLUMENTHAL. So, it is all relative?

Dr. CLANCY. Yes.

Senator BLUMENTHAL. You may not be paying 600 to 700 percent higher——

Dr. CLANCY. Yes.

Senator BLUMENTHAL [continuing]. But your prices may be higher——

Dr. CLANCY. Yes.

Senator BLUMENTHAL [continuing]. Simply because negotiations are not a one-way street. You have to give and take, so your prices will rise but just not the same as in the private market.

Dr. CLANCY. Correct, greatly muted.

Senator BLUMENTHAL. Thank you.

Chairman ISAKSON. Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Senator Isakson and Senator Blumenthal, for holding this really important hearing.

As was mentioned, you will hear a lot of problems at the VA, and this and that, but it is good to sit back and, you know, talk about some of the successes. The good news is that there really are many of them. We certainly appreciate you being here, Dr. Garner and Mr. Bryant—the entire panel, but especially you all—telling us about some of these things.

Dr. Garner, your reputation in Little Rock is excellent. We just appreciate, besides your innovation ability, your ability also to take care of people in a very, very caring, very excellent way. You have described what you have done and your idea. Tell us if you see any problems with the national rollout of that.

Dr. GARNER. I think it will be fairly easy, as I have made—I hope that I adequately stated that most of these groups are held by not-physicians. Because we want physicians taking care of veterans and access issues, these were not designed to be led by physicians. Social workers, nurses, chaplains, psychologists, many different health professionals run these groups after their training with us.

We know that different VAs are variable, and so we are going to have to be flexible as how we roll this out, so that we get the personnel and the staff and have the staff to be able to do this. That is one of the things that we will be working diligently with, with multiple different service lines around the country, to do.

I think as far as just—the veterans really love it. They tell us all the time that they want this information. They like being proactive and having people come tell them what their rights are and what are the opportunities for them to make sure that they take care of themselves and their families.

The biggest issue is that many VAs are different, so we are going to have to be flexible in how we roll this out.

Senator BOOZMAN. With the veterans communicating that they like the group setting, have you thought about any other areas that the group setting would be helpful in regard to——

Dr. GARNER. Well, I think there are a lot of complex topics where a veteran could benefit from having a longer discussion that sometimes can occur in a short period of time. We do see a lot of groups in the VA—like there are some diabetes groups, there are PTSD groups, there are other groups, and we think that those could be expanded with some of the other topics that are kind of complex, that need a little bit more time than you can get in a traditional appointment.

Senator BOOZMAN. Right.

Dr. Clancy, you looked like you wanted to jump in on that. Have you got any other thoughts on that?

Dr. CLANCY. No, I think I was just very positive about her response. [Laughter.]

Senator BOOZMAN. Oh.

Dr. CLANCY. Many, many of our facilities have group visits for PTSD, mental health, and so forth.

Senator BOOZMAN. Right.

Tell me, in the sense of being a winner in the innovation efforts, is there the mechanism for you to stay involved? Will you stay involved as—are we going to do something with winners in the future?

Go ahead.

Dr. ELNAHAL. Senator Boozman, yes, absolutely. We really see our fellows in this program as being permanently involved in the improvement of the VA health care system, and Dr. Garner is really no exception.

We are partnering her with an accountable executive in our Central Office in DC to come up with a comprehensive national-scale plan for the advance care planning best practice. We have already started that process. In fact, we had our first meeting several weeks ago.

By pairing the subject matter expert, Dr. Garner, with somebody with resources and accountability over professionals in social work across the entire country, we are going to start our national implementation very soon, where everybody at every facility who is owning the project is going to design the implementation as it best fits them.

Dr. Garner is very flexible in saying it may be a social worker doing these classes, may be a physician, may be a nurse, but the whole point is that the outcome is achieved for the veteran.

Senator BOOZMAN. That is great.

So, in regard to that, the metrics in place then—can you talk a little bit about, specifically, how are you going to judge the outcome of these things as time goes by?

Dr. ELNAHAL. Certainly.

First and foremost—I will let Dr. Garner supplement this answer, but—really we want to increase the rate of filed advance directives, just getting the service to as many people as possible, expanding that access, and really just to start the conversation. So, the more classes the better. That means the more veterans are being exposed to it.

Dr. Garner, I do not know if you had more comments.

Dr. GARNER. We actually have been working on a method of doing that where—in the VA there are certain titles that you use that can—we can be tracked to say that a certain discussion was had, an example being advance directive. It is used when an advance directive is actually filled out, or if you just had a discussion, you say advance directive discussion. Pairing that with the actual group clinic visits, we will be able to see how many people had that group visit discussion about advance directives.

We are actually working diligently right now to make sure that that is something that we can track and make sure we are getting the outcomes that really benefit the veterans.

Senator BOOZMAN. Good. Very good.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.
Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. You should know that Chillicothe was Ohio's first capital in 1803. [Laughter.]

You should know that if you see the Great Seal of the State of Ohio, it is a picture of the hill in Chillicothe with the sun rising over it, correct?

Mr. BRYANT. Yes.

Senator BROWN. So, as a 500-acre tree farmer—Mr. Bryant's other job—he knows that. [Laughter.]

Thank you. Chairman Isakson and Ranking Member Blumenthal thanks for this hearing very much and for, more than any Committee I have ever served on in the Senate—six or seven—although when I was on the Ethics Committee and Senator Isakson was co-chair it was different kinds of subjects but good cooperation. I so appreciate how you run things.

I appreciate the VA. Late last week I spoke to Keith Sullivan, who is the director of the Chillicothe VA, who so applauds your work, Mr. Bryant. Chillicothe has a particularly good, strong image serving homeless veterans in a very remote, Appalachian part of Ohio. People come from a long ways away and it makes a difference in their lives.

You are about halfway—my understanding—through the planning and the preparation stage to enable veterans to do the medical questionnaire on an iPad. This whole eScreening process obviously seems to be something that is going to work well. If you would, so we really understand sort of from start to finish, walk through additional steps needed before the eScreening practice is fully operational.

If you would, at the same time, explain how you ensure that veterans understand the technology. Do you have sort of the—how employees work with them—how VA employees work with them. And what are barriers you see as you study this to implementation so that this can serve every veteran that comes in and can be adapted to VA centers around the country?

Mr. BRYANT. Thank you, Senator Brown.

Well, on the eScreening, a few things that we need to do yet before implementation are a training program with our staff—in other words, let them go in, let them actually do eScreening themselves and get an idea for what it is asking, how it is going to print out, the types of things the veterans will see.

As far as the veterans go, we are planning on having people at the front desk when they walk in to help them through the process. We will have some veterans that will not want to do it. It is high-tech. They will not want to have anything to do with that process, and that is fine. We will revert to what we currently do. But for the ones that do want to do that, we are going to have people stationed there to walk them through it, show them——

Senator BROWN. Do you——

Mr. BRYANT. Sure.

Senator BROWN. Do you have any indication on how many veterans will not choose to do this, that you will continue the present practices with? Do you have any way of knowing that?

Mr. BRYANT. We really do not, in the fact that many of our veterans, they range different age groups. So, ones that you might think would not want to be part of that are the ones that will. And they are very much into Facebook and different things, so they are going to be onboard with high-tech kind of things.

The other piece that we need to work on is our communication plan in letting our veterans know it is coming, letting our staff know it is coming. We are going to spread it out to 21 clinics starting in our primary care and our community-based outpatient clinics (CBOCs), where our rural veterans can get to the——

Senator BROWN. Those are the CBOCs initially in southern Ohio or throughout the State, throughout the——

Mr. BRYANT. Initially in southern Ohio——

Senator BROWN. OK.

Mr. BRYANT [continuing]. Chillicothe community-based outpatient clinics.

Senator BROWN. OK.

Are you seeing any resistance from employees to this idea? I mean resistance—you know, it is kind of human nature that some people are resistant to change. Are you happy with the cooperation you have seen in that way?

Mr. BRYANT. We are. The one thing that is very clear at Chillicothe VA Medical Center is we all are behind the mission and we all believe in the mission very strongly. We have had many outside people come in and say that is the one thing they really see there. So, if it is better for our veterans, our staff get on board and they want to make that change.

Senator BROWN. OK.

If I could, in the last few seconds, Mr. Chairman, shift to the bike share program, which I know you have been part of in Chillicothe. Talk to me about the transition from a bike repair shop idea to a vocational rehabilitation sort of writ large, or a vocational rehabilitation and entrepreneurial training program. Explain sort of how that happened, and walk through what it is exactly.

Mr. BRYANT. OK.

The bike share program was actually initially a byproduct of, let's have a bike shop; let our veterans run the bike shop in our voc rehab areas. The concern that I had initially was, how many bike shops can you have in Chillicothe, OH? [Laughter.]

We worked on that a little bit and started to think, what if I want to run a flower shop or a motorcycle shop or any other kind of business? That is where we need to go with this.

So, we then contacted the Small Business Administration and we have been working with them. They offer all the entrepreneurial training for free to our veterans. They come to our site, and they are able to not only teach the veteran that, but then we use the bike share as a practicum for the veterans so they can not only take what they learn but actually put it into play.

Senator BROWN. Good.

Thank you, Mr. Chairman. Thank you again for holding this hearing.

Chairman ISAKSON. Thank you, Senator Brown.
Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman. First of all, let me add my congratulations for putting this together today with Ranking Member Blumenthal, but also for the work that both of you did in getting the Veterans First Initiative moving forward and getting the legislation out of here and moving down. I just think that is very, very important and I appreciate all the work that you have done so far, sir. Hopefully we will have a very fruitful end of the year and we will be able to get some more stuff done as well and actually have results.

Dr. Clancy, I will address my questions to you, and you can redirect if you feel appropriate.

One of your Gold Status best practices is increasing access to primary care with pharmacists. Now, that leads me to suspect that the Veterans Health Administration (VHA) staffing and management is included in the Diffusion of Excellence Initiative.

If that is so, one of the most controversial issues with the VHA staffing right now is the practice of authority granted to advanced practical registered nurses. I know that currently VHA grants these authorities very differently depending on a number of different factors, including local State laws.

Has there been any discussion about the differing levels of access, quality of care, and staffing efficiency between hospitals that treat advance practice registered nurses (APRNs) differently? And, would a high-performing hospital that grants full practice authority to APRNs be able to submit their best practices to the Diffusion of Excellence Initiative in order to produce a more effective workforce across the VHA?

Dr. CLANCY. I think that we will be learning a great deal as this authority is implemented. It actually exists right now in some parts of our system. As you know, State laws in terms of scope of practice vary a bit across the country.

Frankly, as I think you also know but I think it bears restating, this is all about improving access to care. That is why we are excited about the best practice related to clinical pharmacy specialists, because a huge proportion of primary care visits are about medication management. Pharmacists are often better at it, as Dr. Elnahal noted a little bit earlier in citing his own care as an example. I think we have all been in pharmacies where we watch people actually go up to ask the pharmacist: Yeah, the doctor told me this, but give me the real story here. [Laughter.]

I have every expectation that advanced practice nurses will do a terrific job. It will be something that we will continue to be looking for best practices in that area as in others. We are probably going to continue to do research in that area as well to make sure that veterans get great care and timely access to that great care wherever we take care of them.

Senator ROUNDS. Well, I know in rural areas it is critical that we have that available, simply because we do not have the numbers without them. I appreciate your thoughts on that and I am happy to hear that.

If I can just change subjects just a little bit. The VA Office of Suicide Prevention has worked very hard over the past few years to capture accurate, comprehensive data on the number of veterans committing suicide. Recently the VA released the most comprehensive report that we have seen in years on veteran suicide.

I am told in the upcoming weeks and months this data will be broken down by region and State, at which time we will be able to compare VISNs and facilities on their suicide prevention efforts. As that data continues to be made public, can we expect to see results-driven best practices from high-performing mental health facilities in the Diffusion of Excellence Initiative?

Dr. CLANCY. Absolutely. One initiative that we are going to launch very soon—and, again, this comes from our own researchers—is actually testing the reliability and utility of using a suicide risk stratification—in other words, identifying veterans who we have reason to believe are at the highest risk of suicide—with the idea that if clinicians know about those veterans ahead of time, they will be able to actually provide extra efforts and make sure that they get the help that they need as rapidly as possible.

That is going to launch either this month or next month. I think that is going to be a very, very exciting—we are going to be careful about it, in other words evaluating as we go, but this for us is a very, very high imperative. Frankly, I am looking forward to seeing some of the results broken out by State and region, some of which will give us good information about what is going on at our facilities and what kinds of interventions and services we are providing, some of which may give us other clues as to what is behind the increased suicide risk for veterans and, frankly, the rest of the country, because there is a lot we have to learn.

Senator ROUNDS. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Rounds, and thank you for your comment. Ranking Member Blumenthal and I appreciate the fact that this Committee passed out, unanimously, the Veterans First bill. We hit a few roadblocks leading up to the election in November, but I am hoping that when November 8th is over we get that put to bed. I appreciate very much the Committee's full support and everything everybody did to make that happen.

Senator Manchin.

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. I want to thank you, Mr. Chairman, also for the fine job you do and allowing all of us to participate. It comes out with unanimous—usually unanimous cooperation.

Dr. Clancy, all over our State we have an epidemic of opiate addiction, and it is not immune to the veterans community. With that being said, the amount of our veterans that are coming in with chronic pain that have been addicted or are committed—you know, are committed to pain management, what are you—what are your efforts to incorporate the pharmacy specialist in to the Patient Aligned Care Team (PACT) for veterans who suffer from that?

Also, what we are doing—I was told that—by one of—in one of our veteran hospitals in West Virginia, the lady who was in charge, she says, if you just would not let the patients call you politicians

all the time and raise Cain about it when we will not give them something, they would be a lot better off. If you let us do our job—and she was just—I loved her for it—very frank. She said: Let me deny the person who I know is addicted. Let me try to help that person. But, if they know they can call a politician and raise Cain about not getting quality of service because they did not get the prescription they wanted, how much of a problem is that?

Dr. CLANCY. That is a problem. Obviously it is a problem that I think gets to a lot of people. We are here to serve veterans, so if someone calls one of you or calls one of us——

Senator MANCHIN. Sure.

Dr. CLANCY [continuing]. And says, I am in extreme pain and you are denying me——

Senator MANCHIN. It gets to our level. Basically, they think they can——

Dr. CLANCY. Yeah. We take that seriously, but we also get that it is very, very difficult to stop taking these medications.

Senator MANCHIN. We are trying to pass legislation not only in the VA but across the board that basically they cannot do that, to rate hospitals or rate the quality——

Dr. CLANCY. Yes.

Senator MANCHIN [continuing]. If opiates are being given out, prescribed. Would that be helpful?

Dr. CLANCY. I know that many, many physicians believe that incorporating questions about pain management has been part of the problem fueling this epidemic.

Senator MANCHIN. How many would you say, a percentage—maybe any of you all doctors—how many of the patients that you have coming in, you all see in your practices, are because of addiction? How much is opiate addiction in your patient load?

Dr. ELNAHAL. I can start to answer that.

I am an oncologist, so a lot of the patients that I have seen in my career are on pain medications because of cancer pain, which is significant pain. There is dependency in that setting, so it is difficult——

Senator MANCHIN. PTSD.

Dr. ELNAHAL. I have not seen many PTSD patients but, you know, the whole point is——

Senator MANCHIN. Maybe Dr. Garner has. She is on the front lines, right?

Dr. ELNAHAL. Yes, absolutely.

Dr. GARNER. I will say that I take care of the older veteran, the 80s and 90-year-olds, and we——

Senator MANCHIN. Hopefully, they are out of that league.

Dr. GARNER. We just do not see that much in them.

Senator MANCHIN. Right.

Dr. GARNER. I do have some primary care colleagues where pain management is a significant issue for them.

Senator MANCHIN. Are you all using other methods rather than prescribing? We have alternative methods as far as pain management, right?

Dr. GARNER. Yes, we have the clinics where they go to where they learn touchy—massage, acupuncture——

Senator MANCHIN. Everything else.

Dr. GARNER [continuing]. Everything else that we can give them. But I do know that my—just from hearsay that my colleagues say that that is a significant issue.

Senator MANCHIN. Well, we want to work with you any way we can, Doctor—all of you all—to solve that.

Dr. CLANCY. Just to mention, we also have a new National Director for Complementary and Integrative Health Options, which I think will help a lot. In addition to that, we are sponsoring a state-of-the-art scientific conference on non-pharmacologic approaches to pain management a little later this fall.

Senator MANCHIN. Good.

Dr. CLANCY. We will certainly make you all aware of that.

Senator MANCHIN. It is my understanding that both Martinsburg and Clarksburg, in my State of West Virginia, our VA medical centers, will be sites where the Journey to Open Access in Primary Care Practice will be implemented in the future.

Dr. CLANCY. Yes.

Senator MANCHIN. You and I both know how critical access to primary care is in the preventing long-term and more serious illnesses and conditions from developing from that.

Both Martinsburg and Clarksburg both serve rural areas. And I think my question would be, are there differences in implementing this Gold Star practice in rural and urban settings? Do you need any new authority from us in Congress to allow you to be able to cover both the rural and urban settings?

Dr. ELNAHAL. Thanks for that question, Senator Manchin. I think it is a really important topic.

I do want to say that this initiative could not have been possible without collaboration with the Office of Rural Health and the statutory authority you have given that office to be able to provide great care for veterans.

One thing that could really help a lot of these practices—the Liver Cancer Tumor Board, the primary care access practices you were talking about—is legislation around telehealth and expanding the access that rural veterans can have to that service from their own home across State lines.

An example that I can give you is that the Tumor Board that we are actually running out of Little Rock is serving patients in Jackson, Mississippi, and so those patients actually have to go to that Jackson facility right now in order to receive that service. If we were able to receive legislation that expanded that scope of practice, that access from the patients' home, the veterans' home, we would be able to expand the access to it to many more veterans, and so that would be very helpful.

I do want to also thank you for hosting a facility that has been an incredible participant in this initiative. Martinsburg has already implemented the WAKE score, which has expanded access to OR services because patients are able to be discharged more quickly and safely. Also, they have already implemented the flu icon, which allows patients—sorry, employees to register that they have gotten the flu vaccine, which is an important public health initiative. Thank you for that.

Senator MANCHIN. Thank you all. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Manchin.

Senator Heller.

HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Mr. Chairman, thank you. I want to thank you and the Ranking Member for your work and efforts on behalf of this Committee. If I could echo what has been said and how pleasant it is to work on a Committee like this when everybody is working together.

I also want to thank our panel. I came onto this Committee four or 5 years ago and I had a very different attitude than I have today. I say that because I see a couple of hospital directors in Nevada, both in the north and in the south—and they have changed recently—and seen the improvements of some of these changes.

Mr. Chairman, I know that through hearings that we have had here, the need for that has been emphasized. Fortunately, the VHA has helped us over this time in getting this work done. It is not just the fact that they communicate better with my office, which they do, and I certainly do appreciate that they are available to us, but more important, they are available to the veterans and their families in their time of need. I certainly do appreciate that also.

Now I want to go to this Diffusion of Excellence. Because of the improvement that I see in leadership in our hospitals, I am wondering if, during this Diffusion of Excellence, if leadership development is part of this process. Dr. Clancy?

Dr. CLANCY. We do not have a specific practice around that, but it has been a very, very high priority for the Secretary. In fact, we will be having some 600 senior leaders from across the system convene together next week, because he believes, as does Dr. Shulkin, that this is our number-one priority in terms of restoring trust and, as Senator Isakson said earlier, brand.

Leadership stability and getting the best people and the right people in leadership positions is absolutely essential. So, I was thrilled when you said a moment ago that Veterans First passed unanimously out of this Committee, because that is going to give us a lot more flexibility.

We have also changed how we are approaching hiring medical center directors. It used to be if one facility in Nevada needed a new director, they would start their process, and then if the other one did, they would do their process. Now we are saying, look, we have a lot of vacancies.

We have actually put out announcements where people can apply to one of a number of opportunities. They are then interviewed consistently by leaders from Central Office, from networks, and from other facility directors. We just had a big round of this last week. I led a team and we interviewed about ten people, but there were about six other teams doing the same thing. This is the initial screening phase.

We have been encouraged by the interest. Frankly, we will not stop or rest until we have good people in all the right leadership positions.

Senator HELLER. Thank you.

Dr. Clancy, as part of your initiative that—I am looking over there on that board—did you reach out to the VA hospitals to find

out what they are doing right, specifically the Nevada hospitals, to see—as part of this initiative effort?

Dr. CLANCY. Yes. I am going to turn that to Dr. Elnahal. Thanks.

Senator HELLER. If you would, please. Thank you.

Dr. ELNAHAL. Senator Heller, thanks for that question.

We actually did a broad solicitation from every facility throughout the country to see what was done right—what was being done right in all of the important areas that the Under Secretary and the Secretary have found in terms of priorities.

I will tell you that in Nevada we have eScreening already implemented, which is a practice that Mr. Bryant is owning in Ohio, and it is achieving great results there. In fact, it has been shown that so far, on the site that it has been reapplied, that it is increasing mental health referrals from primary care for really concerning findings around PTSD and suicide by 20 percent. Those results are being reflected every single day in southern Nevada. The flu icon is also operating in Reno right now. Your facilities in Nevada have been great participants.

To answer a little bit about your first question in terms of leadership, we just described that Dr. Garner is leading now a national implementation of a practice that she is an expert in. What our goal was, was to set up a system where the best practice fellows got an incredible leadership experience just by virtue of participating and allowing their practices to be elevated throughout the country.

Senator HELLER. The question I guess—and I will stay with you for just a minute—is what could I go back—I look at the board there, implementing 300 ongoing—sorry, I have to use my glasses here—replications at over 70 facilities. What is going on in the Nevada facilities right now? What can I tell the families—veterans and their families of how this initiative is actually helping them?

Dr. ELNAHAL. The two facilities that I mentioned in terms of the facilities that have implemented eScreening and the flu icon, you can say that if you are a veteran who is having concerns about their mental health or thinks that they are not well, they will be found much more often now in these facilities than many others who do not have it, and we are trying to expand that service, as we speak. Southern Nevada has been a major example of success in that area.

In terms of just simply public health and proper occupational health practices, Reno now has an easy way for employees to report that they have gotten the flu vaccine. You can just rest assured that if you are a patient in that facility, you are probably less likely to get the flu.

Senator HELLER. Thank you.

If the Chairman will indulge just for one more minute, one more question, which has to do with doctor shortages. This Diffusion of Excellence, how does it address this particular issue that probably is at the forefront in Nevada, trying to get the doctors necessary in these hospitals?

Dr. ELNAHAL. I think a lot of that relates to overall access. You know, if you have a shortage of physicians, obviously you will be waiting longer to see them. Five of our 13 best practices are access-related for that reason.

In many places throughout the country, it has been brought up that a lot of providers need to be practicing at the top of their license. We are trying to spread those practices through clinical pharmacy specialists by way of a Patient Aligned Care Team, which originated in Fresno, and through nurse Case Manager Chair visits, which are available at many of the States of the Senators sitting on this Committee now. That is why we have taken a particular focus on access as a priority for both the Secretary and the Under Secretary.

Senator HELLER. Doctor, thank you, and to the panel, thank you very much for being here.

Mr. Chairman, thanks for holding this hearing.

Chairman ISAKSON. Thank you, Senator.

Senator Hirono.

STATEMENT OF HON. MAZIE K. HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman.

Dr. Clancy, the regional Liver Tumor Board is one of the best practices highlighted in your testimony today. And in the past 10 years, the number of liver cancer patients among the veteran population has increased tenfold, and at some point I would like to understand better why that is happening. Maybe we have an aging veteran population. I am not sure.

In any event, I am pleased to see VA taking aggressive steps to treat liver cancer. I am also pleased to see the creative use of telemedicine, as I have supported legislation to expand VA's utilization of telemedicine. I know that the VA has requested legislative action when it comes to increasing the use of telemedicine. Can you speak on the importance of telemedicine and VA's efforts to improve access to high-quality health care for the veterans?

Dr. CLANCY. I am going to refer to this Dr. Elnahal, who just gave a brilliant summation of this, particularly as it relates to the Tumor Board.

Some piece of the increase in liver cancer, by the way, is almost certainly due to the increased prevalence of hepatitis C. I cannot tell you how excited all our folks are about being able to provide these effective treatments and to thank all of you for your support to be able to do that.

Dr. ELNAHAL. Senator Hirono, thanks so much for that question.

When we did our solicitation of best practices, we got many of them around telehealth, and some networks in our system provide pretty robust telehealth services and wanted to spread that to other places.

We found that, unfortunately, in our effort to find facilities that were willing to reapply them, that a major limitation was certain restrictions on the use of telehealth, and namely the following: If I am a physician at one facility in the VA and I want to provide care for a patient who is at home and they are not in my State, I cannot do that. That prevents adequate load-balancing in terms of me being able to see a patient across the country in a situation where that is convenient for them, especially for rural veterans who may live very far away from our nearest site of care.

There are efforts to pass legislation on this that would be helpful. For example, Senator Ernst had a bill last year called the Veterans E-Health——

Senator HIRONO. Which I cosponsored, by the way.

Dr. ELNAHAL [continuing]. And you as well, Senator Hirono—that really put this effort at the forefront to allow physicians within the VA to see patients in their homes across State lines. That would help with the Liver Cancer Tumor Board; it would help us to adopt more of our best practices in telehealth, which would be extremely helpful for this effort.

Senator HIRONO. I would anticipate that the VA would continue to push for this because I think that, at this point, especially those of us who represent rural areas—and basically all of the neighbor islands, apart from Oahu, are rural areas. I think that our veterans there could very much benefit. So, please continue to push for the kind of legislation that you must mentioned.

Dr. Clancy, for the eScreening best practice, you describe that the veteran is handed an iPad when he or she checks in for an appointment, and can complete any required screening on the iPad. Do you have any idea about the extent to which different generations of veterans are comfortable using the iPad? What sorts of safeguards are in place to ensure the protection of sensitive information that will be obtained through this eScreening process?

Dr. CLANCY. I am going to refer this to Mr. Bryant, who is right up to his eyeballs in making sure that this all works well.

I would just make one comment before having him jump in, which is, in general—and Senator Isakson hit this point in his opening comments, or questions—many people find telling an iPad or a computer about their symptoms far less intimidating than they do telling a person. That is one more reason behind it.

Do you want to talk about generational difficulties and the others?

Mr. BRYANT. Sure. Thank you for the question.

One of the things we have decided to do as we break this out is to offer staff and volunteers in the waiting room, so when the veteran comes in, someone is there to walk them through the process. We did the same kind of thing with kiosk when they first came to the VA system and it worked very well. Veterans felt at ease. The questions that they are asked are yes/no questions, so they are not very difficult.

In the eScreening, the iPad itself is a dummy box, basically, so it is not going to go across the network. Basically it goes right into our Computerized Patient Record System (CPRS). The veteran will get a printout at the desk. They take that back with them. The provider is given an alert. So, when the veteran says “yes” to one of the questions, it alerts the provider to kind of tailor that appointment to their needs.

Senator HIRONO. Thank you.

I see, Mr. Chairman, I am out of time, yet I want to commend the VA for doing everything they can to make their process much more accessible, efficient, and effective to our veterans. Thank you.

Chairman ISAKSON. Thank you.

Senator Sullivan.

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for holding the hearing, and the panelists for the hard work they have been doing on this initiative. I think it is a great undertaking and I want to commend you for it.

I want to talk about the consistency of accessibility in rural communities. I know, like a lot of my colleagues here in the Senate when we were home over the summer, I spent a lot of time out in the rural communities in Alaska. And, for those of you who have been—you know, we hear the talk of "rural" but, as you know, there is rural America and then there is Alaska. [Laughter.]

It is very, very extreme rural—no roads to hundreds of places, limited telecoms, challenging terrain, small communities—but we have a huge veteran population, which we are very proud of, more vets per capita than any State.

When I travel to even the smallest communities in Alaska, I always meet with our veterans, no matter where—try to. It is very humbling because you will go to a small rural village in Alaska and you ask for a town hall with veterans, and there will be, you know, 10 or 15 Vietnam vets, combat vets, who come out to these meetings—great Americans.

One of the things I asked during this recent recess is, let's say you are a Vietnam vet, you live in a very extreme rural community in Alaska, so you are 100 miles away from anywhere—you are maybe a thousand miles away from Anchorage—in the same State—and you have a problem, a health problem. My question was, well, what do you do? Literally, you could be sitting with five veterans in the same community and their answers were different.

Some said, well, they had the opportunity to just go to a local Native Alaskan health clinic, if you were a Native Alaskan. Some said, no, I can go to the Native Alaskan health clinic myself even though I am non-Native. Others said they could go to the local clinic. A lot of our clinics in rural Alaska do not have any doctors, even the clinics. So, responses were all over the place, literally in the same community.

Others said, well, the VA told me I can go to Anchorage to get, you know, my health. That is maybe, you know, 500, 600, 700 miles; easily $1,500 round trip, maybe $2,000 and if you are staying at a hotel, maybe $3,000. Sometimes those veterans were told the VA will pay for that whole trip and the hotel and the airfare. Other times—literally the same community—the VA would say, you are going to Anchorage, you have an appointment, but good luck; get there yourself.

So, here is my question—and I have already blown 3 minutes of my time so I know you cannot answer it in the remaining 2 minutes. What I would really like is a written answer. If you can help me and my veterans and maybe this Committee understand, what is the right answer?

Maybe it depends on your veteran status—if you are a combat veteran, if you are retired—but if you live in an extreme rural community in Alaska or Hawaii, you know, extreme, like, no roads—you guys know what I am talking about—what is the answer, because right now the answer is literally all over the place. I asked probably dozens of veterans this question just in the last 6 weeks

and everybody had different answers, including people sitting next to each other who lived in the same small community.

I did not have an answer for them, which, you know, I did not think was appropriate, but I need help from you on what that answer is for the veteran who lives in the extreme rural community and maybe does not have a doctor in that community, maybe one Native health clinic. You know, Dr. Clancy, can you just give me a sense of what that answer is?

Again, I would really like it in a detailed written-out response from you guys, but, maybe just real quick, what is the answer?

[Responses were not received within the Committee's timeframe for publication.]

Dr. CLANCY. Senator, it is an incredibly important question. About one-third of the veterans we serve are in rural areas, most not quite as rural as what you are describing.

Senator SULLIVAN. Remember, most rural places in America you can get in a car and you can drive to.

Dr. CLANCY. Yes.

Senator SULLIVAN. In my State——

Dr. CLANCY. You need a road, yes.

Senator SULLIVAN [continuing]. We do not have roads, unfortunately.

Dr. CLANCY. Yes.

Senator SULLIVAN. That is a whole other issue, but——

Dr. CLANCY. Yes.

The good news is that we have a growing number of options to help those veterans. We have a terrific Office of Rural Health. We would be delighted to follow up with you with a more detailed answer, because what I am worried about, from what you are telling me, some of what you are hearing I think does track back to some eligibility rules.

Senator SULLIVAN. Yeah.

Dr. CLANCY. I am thrilled that we are working with you, frankly, at much of your enthusiasm on making Choice as effective as possible——

Senator SULLIVAN. Yeah.

Dr. CLANCY [continuing]. For the constituents you represent, but I also am wondering how effectively we are communicating or not, possibly, to the veterans you are hearing from when you are having these town halls.

Senator SULLIVAN. OK, thank you.

Just one final thing. I commend you again on your map. It is a little weighted heavily on the Northeast, I would say. I am not sure why. I do have a suggestion: I strongly encourage you to set up a project of excellence in the great State of Alaska.

There is no big dot over Alaska here, which is a little disappointing. But if you guys are looking at extreme rural issues to deal with in terms of a project of excellence, there is literally no better place in the country to undertake such a project. I would love, you know, next time you guys come here, to make sure there is a big blue dot over Alaska.

Dr. ELNAHAL. Senator Sullivan, we will be heavily weighting all submissions from Alaska in this. [Laughter.]

Senator SULLIVAN. That is a good answer. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. I assume you will not forget Kansas either, Doctor. [Laughter.]

Mr. Chairman, thank you very much. Thank you to you and the Ranking Member for having this hearing. It is always pleasing to know that the VA is working hard to find better ways of doing more things to care for those who served our country.

I want to raise a circumstance we find ourselves in, in Kansas. And this is a topic that I have raised with Mr. Missal as well as a letter to the Secretary, but a tragedy has occurred in our State that involves the Leavenworth VA. That tragedy is that a physician assistant is accused of sexually harassing and molesting veterans, particularly those with PTSD, and has been discharged from—has terminated his employment with the VA.

The facts now indicate that the knowledge of this person's history could have—or perhaps it was known. He indicated in his application for licensure in our State that he had past circumstances involving sexual crimes, yet this individual still gets hired by the Department of Veterans Affairs. The reports continue to come in. Criminal prosecution is ongoing.

Again, those are the circumstances we find ourselves in. As we look at best practices, obviously having the best personnel in place is a requirement for us to implement best practices. I want to ask a set of questions that are related to the circumstance that we now have in our State.

Again, it is outrageous that someone with a criminal record would be hired and put in a position to care for veterans. We are uncertain as to how long this circumstance was known before the termination occurred. There were several investigations that apparently resulted in no termination.

While you are here to talk about improvements in best practices at the VA health care system, we obviously have some immediate circumstances that we need to take care of. My question—there are a couple. My questions are these: What best practices to improve the vetting and hiring process, and what are the best practices that come in regard to background checks? Are there things afoot at the VA that would improve the circumstances that these kind of circumstances, this circumstance in particular, cannot or would not happen again?

Dr. CLANCY. Senator, first, we share your sense of outrage on behalf of the veterans you serve and, frankly, all veterans. It is our responsibility to learn from this so that we can prevent anything that we could have done differently from happening in the future. That is a big priority for the group that I am leading at VA. I appreciate your comments very much.

I think that you have stated very eloquently why credentialing of the providers that we hire is such an important function for us and for any health care system. We are striving for ways to improve that at all times, including working with the Federation of State Medical Boards and so forth.

It used to be because State licensing is a State authority, right, that you—someone might leave one State and it would be hard to get information. Well, this federated group makes information about prior incidents and reports much more easily available, and the people who do credentialing at VA are taking advantage of that opportunity. We will certainly be most attentive to these specific responses you need around this incident, while it is something that we are always looking to improve.

Senator MORAN. What about best practices when it comes to a complaint being alleged, a concern raised? What about best practices in how you then treat that employee and his or her potential termination or—I guess I will leave it at that—in this circumstance the termination and ultimate prosecution, best practices in place once we know something has happened to terminate that person?

Dr. CLANCY. Certainly we are going to do everything in our power to try to learn, again, if there is something that we could have and should have done differently in the past with respect to this individual employee.

The phenomenal part of an integrated health system is that we have the potential and, in fact, do share information about this system-wide, so that where we do make decisions that might have been done differently we can share that system-wide, and you have my commitment that we will do that.

Senator MORAN. Dr. Clancy, I appreciate what you just said. I would tell you that I have had the sense over a period of time that, seemingly too often, when there is a problem with an employee, a health care provider within the VA, my impression—and you can convince me that I am wrong—is the most likely outcome is that that professional is transferred to some other facility within the Department of Veterans Affairs. It seems to me that the likelihood of termination is minimized and often an individual is transferred.

Dr. CLANCY. Having been personally involved with a couple of fairly senior clinicians in this circumstance, I can tell you that it was my highest priority to make sure that that did not happen. I cannot speak to what has happened in the past, but that is not fair to veterans or to anyone else.

Frankly, it is our responsibility to report to State licensing authorities. In cases I have been involved with directly, we have made sure that we have done that. It is a lengthy process, both because of due process and also making sure that we have enough evidence to uphold everything that goes forward; but that is what we need to do, period.

Senator MORAN. Doctor, I use this hearing as an opportunity to raise this issue——

Dr. CLANCY. Yes.

Senator MORAN [continuing]. For its importance. In this particular circumstance, justice needs to be had.

Dr. CLANCY. Absolutely.

Senator MORAN. Individual veterans need to be cared for as a result of this individual's actions, but also that this needs to come to an end. This should never be the circumstance we find ourselves in, in any VA facility across the country. I would ask your commitment that we achieve that goal.

Dr. CLANCY. You have my full commitment to that.

Senator MORAN. Thank you, Doctor.

Chairman ISAKSON. I want to thank Senator Moran for bringing up the subject, and I want to make a comment, if I can.

What you have just said is exactly the evidence that testifies to the fact that we have got to pass Veterans First. You have got to be able to fire employees and make it stick. There are certain crimes or certain practices or certain illegal activities for which there should be zero tolerance, period. Sexual predators is one of them.

There is a recent series in the *Atlanta Journal-Constitution* that has run for about 16 weeks on the number of physicians who have abused the doctor-patient relationship and have been sexual predators, and even the boards of medical examiners in the States have returned their licenses to them rather than disciplining them.

I would just add this comment: We need to give the VA the ability to fire and make it stick, and that is why Veterans First is so important, number 1, first at 434-level employees and then all the way down.

Second, there ought to be a complete attitude of zero tolerance for certain things, and sexual abuse or sexual predators is one of them. You should not move them around somewhere else in the agency to get rid of them. You should get rid of them entirely so they cannot ever come back in the agency again. That is something I hope the VA will work on.

I am going to work on seeing that Veterans First gets done so you can fire and make it stick. I want you to work on policies and practices that have a zero tolerance for those types of activities.

Thank you for bringing that up.

Senator MORAN. Thank you, Mr. Chairman.

Chairman ISAKSON. I thank our guests for being here today.

Senator BLUMENTHAL. Can I——

Chairman ISAKSON. Sure.

Senator BLUMENTHAL. Mr. Chairman, with your permission, may I ask another couple of questions?

Chairman ISAKSON. I will give you 4 minutes because I have got to go to another meeting.

Senator BLUMENTHAL. Four minutes or I will be fired? Is that——

[Laughter.]

Chairman ISAKSON. No, no, no, no. No, I am leaving. You can stay. [Laughter.]

No, you go right ahead.

Senator BLUMENTHAL. I can do it in 4 minutes.

Chairman ISAKSON. You go right ahead.

Senator BLUMENTHAL. First of all, I want to join the Chairman's comments about zero tolerance; and the record should note that Dr. Clancy was nodding, so I assume that means agreement.

I want to come back—not to exhaust but to suggest the need for more information—to the topic of drug pricing and the VA's negotiation practices, and how maybe those practices can help our hospitals and other providers do better. They will not have the same kind of organized weight or market power that the VA has, but maybe some of your, for lack of a better word, tactics and practices can be modeled by other private buyers.

I also would like to know whether those prices have changed, how you track those prices, and whether they can—that data can be made available to us. In other words, we were talking earlier about how the impact of drug shortages can affect even your prices. You can negotiate but you still have to reach an agreement. You cannot dictate the results. You have to have bargaining.

So, I would like to explore whatever information you have about those price trends on some of those medicines that we mentioned, and others, that have been raised with me from my constituents and others around the country in response to the EpiPen controversy. They affect not only EpiPens and insulin and Narcan but certain kinds of inhalers and other everyday kinds of medicine, where the cost of health care could be dramatically affected by the prices that we pay, and the VA's success relative to others in the market may provide some guidance for us.

I want to join the Chairman in thanking you today, and look forward to continuing this conversation.

Dr. CLANCY. We would be delighted to follow up on that. And just to make sure it is captured for the record, you have my full commitment that we will pursue it on the policy front, the issue of zero tolerance.

[This information was provided by VA by way of a phone call.]

Senator BLUMENTHAL. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Ranking Member Blumenthal.

Thank you, Dr. Clancy, Mr. Bryant, Dr. Garner, Dr. Elnahal. Thank you very much for being here today. I thought it was a great hearing.

I want to thank Senator Boozman and Senator Brown for raising this issue to our attention and for forcing us to call this hearing today.

With no further business, we stand adjourned.

[Whereupon, at 3:43 p.m., the Committee was adjourned.]

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