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THE STATE OF THE VA: A 60-DAY REPORT

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
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SEPTEMBER 26, 2018

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THE STATE OF THE VA: A 60-DAY REPORT

WEDNESDAY, SEPTEMBER 26, 2018

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

The Committee met, pursuant to notice, at 3 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

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

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

Chairman ISAKSON. I call the Veterans' Affairs Committee of the U.S. Senate to order and thank everybody for being here today, particularly Secretary Wilkie, who hit the ground running a few weeks ago and has not stopped. We slowed him down enough to come in today to testify.

We really appreciate your being here today——

Secretary WILKIE. Thank you, sir.

Chairman ISAKSON [continuing]. And the other Members of the VA staff that are here and our friends in the VSOs and everyone else that is here. We are going to have good attendance from our Members. Do not let the poor numbers right now throw you because there are a lot of them working on stuff they are going to come in and ask the Secretary about because they have been asking me about it.

But, I do want to set the table for 1 second. I want everybody to listen very closely so you can tell the other Members who are not here yet that I covered this already.

The biggest issue for 3 or 4 years has been can we get the VA functional. We have put up with front-page stories where they lost stuff, veterans could not get services, everything known to man.

We have done a great job and the VA has done a great job of addressing that. When you hear the Secretary talk today, he will talk about his four key priorities for the VA. Customer service is number 1.

I have gotten letters from my district, unsolicited, veterans who used to write me about why we were not worth anything because we could not get anything done to thanking me for the efficient way the operation works now.

We are not perfect, and I do not want the Secretary to rest on his laurels and think the hard part is over. The hard part has just

started, but no journey starts without the first steps. That is an old Chinese proverb. We took the first step with Secretary Wilkie, and he has taken the step of making customer care and veterans care and the importance to the veteran the number 1 priority of his administration at the VA.

So, we have got a long way to go on that. We have got Cerner software to get installed. We have got lots of changes to make. We have got lots of things to come to reality, and we are working on them.

But, if you ask anybody that is sitting here in this room in this audience if there is another problem that needs to be addressed, they would tell you it is Blue Water Navy.

I spend a lot of my time sitting with a lot of you, some of you in the VSOs and some of the other activist organizations and some of the loved ones' parents and the like that are veterans. They said, "You guys need to fix that."

Well, I have been working on it, and I want to commend the Committee, every Member, Republican and Democrat, because at one time or another I have talked to each one of them about this, and I think I know where every one of them stands. Every one of them has been supportive to find a way to do it. Also, I have tried to talk to, beginning with the Secretary whom I started talking to a month ago; I have started bouncing various ideas off of him to see where we could come to some kind of solution.

The Secretary is right—and the reasons he has been opposed—to just doing Blue Water Navy, period, but he is not wrong about how we get to it. We need to get to it with you, together as a Committee, and the VA Secretary is a principal member of the VA.

The veterans who think they deserve that benefit ought to get it. We ought to realize that we do not need to run a Veterans Administration that does not have standards in terms of new benefits that come along. This is not a new benefit. It is a new benefit to some because they never heard of it before, but this is a benefit that existed until 1999. Then with an administrative change, the eligibility was taken away for certain veterans.

So, you have got the situation if you are on the ground, you are inone category; if you are on the water, you are in another category. If you are this, you are one category; if you are that, you are another category.

We do not have scientific conclusive proof, which you seldom do in a scientific discussion, as to exactly what the solution is or what the problem is, but we do know there is a problem. We know that non-Hodgkin's lymphoma and certain other diseases with presumptive eligibility in other cases is something we have to address.

We need to look at the facts and let us see where they lead us, and we need to look at being right and fair to the veterans. We should not have two classes of veterans who fought, just because one of them was on water and one of them was on land, if it was the same conflict, the same exposures, then the same difficulties.

But, we should not also hand out benefits just because we think we ought to. We ought to hand them out because it is the right thing to do for the veterans; we do it in the right way. We set a template for what is going to happen in the future. If another situation comes up, we have to evaluate it.

That is not just me talking; that is all the Members of the Committee I have talked to. They feel the same way. They want to get this problem solved, but they also do not want to create a problem. That is why working with the Secretary to find a solution, rather than the Secretary just saying no or me just saying no or me saying, "Yes, we are going to do it." We are not going to act that way.

We are going to work together as a team. We are going to decide what we need to do. We are going to decide where we need to go, and we are going to get this problem solved. I have told you all in every beginning year or ending of the 2-year cycles that we have gone through that we had goals to accomplish, and my goals were Caregivers. My goals were getting the MISSION Act done. My goals were doing a lot of things. I know what Jerry's goals have been. I know what Jon's goals have been. I do not think anybody has been excluded. Everybody on the Committee has gotten ideas into the law, but we have now got to deal with this problem.

I do not need to try to cajole you or put it off and not deal with it. I need to do everything I can to see that it gets done.

So, I want to just set the table at this hearing with the Secretary present to thank him for giving me the time he has given me in the last month to talk about this. I appreciate what his attitude is about customer service being the principal foundation of his administration in VA.

And, for all of you in the VSOs and all of you of various interests—Blue Water Navy or any other benefit anywhere—know this is a Committee and a VA that will tackle your problems and try to do it as fairly and equitably and as right for everybody as we can. However, we are not going to get bulldozed into a corner, and we are not going to bulldoze somebody into the corner either. I want to bring that up because that is going to take care of a lot of questions. I hope it does.

Again, I want to thank the Secretary for the time he has given me and the time we are going to be sharing together in the weeks ahead. I now turn it over to the Ranking Member for any comments he might have.

OPENING STATEMENT OF HON. JON TESTER,
RANKING MEMBER, U.S. SENATOR FROM MONTANA

Senator TESTER. Well, thank you, Mr. Chairman. Thank you for your comments, and I want to thank Secretary Wilkie for being here today. Welcome.

I have intentionally stayed away from your office as much as possible to be able to give you time to get oriented and get your team together and move the VA in a direction I think we all want to see it go.

In your written testimony, you shared five real-life stories of individuals in the VA who are really making a difference. We do not hear enough about the good things the agency does day in and day out, so thank you. There is a reason why an overwhelming number of veterans prefer the health care that the VA delivers, and there is a reason why thousands of men and women across this country work tirelessly every single day to provide veterans with the care and benefits that they have earned.

I am talking about the physician assistant in Montana, the claims processor in Georgia, the cemetery taker in North Carolina, and countless others.

The VA means a great deal to these folks, and it means a great deal to this country. So, today, I am hopeful we can talk about what is right with the VA, while I am also hopeful that we can address the challenges that the VA has and what needs to be done to improve it.

Mr. Chairman, in terms of numbers and scopes of bills we signed into law, this Committee has been under your leadership, historicly, but there is much more to do.

We do need to pass a Blue Water Navy Veterans Act. We need to move on a number of other critical bills, and I know you addressed that in your opening statement.

I will tell you that I remember having the conversation with you when Patty Murray brought in the caregivers bill, and you said, "I made a promise to get this done, and I am going to get it done," which you did.

The challenge we have here is the House is leaving town tomorrow, and the Blue Water Navy folks are out there. I trust you unequivocally to get this done, but we do need to get it done. We have been talking about it for far too long.

Just as important, we need to ensure that the reforms of the previous 2 years are implemented appropriately by the VA as Congress intended, as the veterans deserve.

Mr. Secretary, as you highlighted in your testimony, this is not business as usual. This is a fundamental transformation not seen in the VA since just after World War II.

Because the stakes are so high, collaboration and partnerships are more critical than ever. Collaboration and partnerships are more critical than ever. Whether it is the VA and the VSOs working together, whether it is Congress and the VA and the VSOs working together, or whether it is Congress and the VA working together. That triangle needs to have good, solid communication.

Unfortunately, in my opinion, it looks as if the VA may be headed in the opposite direction—disengaging with veteran stakeholder groups when it should be more engaged than ever with this transformation and becoming less transparent when it needs to be more transparent. I hope that I am wrong.

Let me tell you why I believe what I just said. When the negotiation process for the MISSION Act started nearly 2 years ago, this Committee worked in good faith with the VA to develop legislation that made the most sense for the veterans, community providers, and the taxpayers—veterans, community providers, and the taxpayers.

I cannot overstate the amount of collaboration that went on between Congress and the VA to get that bill across the finish line.

Now 3 months have passed since that bill has become law, and the most that we have received is a 40,000-foot view of the offices responsible for implementing the program, really nothing of substance.

It took a letter signed by the leadership of the Senate and House Veterans' Affairs Committees after a planned briefing was unilaterally canceled by the VA to start getting some answers. In my opin-

ion, that is a problem. It is not the way we have done business in the past, and it should not be the way we do business in the future.

With that in mind, Mr. Secretary, there were a couple of lines toward the conclusion of your written statement that gave me some serious pause. You state that the VA cannot stop everything that it is doing to provide updates or respond to inquiries if we are serious about getting to our destination. Providing updates and responding to inquiries about implementation of the laws that we fought hard as hell to pass may not always be convenient, and it may not always be pleasant, but it is really how the democracy works.

As a longtime congressional staffer, you have been on this side of the dais. You know that the only way we get information is we have to do our job; we have to get information. That job is to provide oversight of the second largest agency in the Federal Government, an agency that will spend more than $200 billion next year during what we both agreed are transformational times.

I strongly believe in your nomination. I continue to believe that you are the right person for this job. Our Nation's veterans are counting on you. I sincerely—and I mean this—I want you to succeed, man. I really want you to succeed.

After your confirmation, you deserve some space to get your bearings, and you need to get your team in place. You need to bring some stability to the agency. It has been 60 days, and I think we can all acknowledge that the honeymoon is over.

Moving forward, I am hopeful that the VA can be more transparent, engage more constructively with the stakeholders, and work more collaboratively on critical issues for veterans. For me, medical workforce vacancies, workforce vacancies are at the top of the list.

I know the shortage of medical personnel is a national problem, and it is just not a VA problem. It is truly a national problem, but I also know that the Secretary before you and the one before him and the one before him all sat in that chair and asked this Committee for new authorities and additional resources to better recruit and retain folks needed by the VA to serve our veterans. You know what? Congress delivered every single time, including the additional funding in next year's appropriations bill and the newest authorities that you now have in the VA MISSION Act.

Mr. Secretary, today you will be receiving a letter from me that requests more information about how the VA is utilizing those additional authorities. It is not an exercise to create additional paperwork. It is so that this Committee, both sides of the aisle, can have a better idea of what is working and what is not so that we can focus our efforts. It is critically important.

Since vacancies continue to be the biggest barrier to primary, specialty, and mental health care for veterans across this country, I think it is a very reasonable request. I hope that we can work closely together moving forward on this issue.

We have got a lot of ground to cover. I look forward to getting started.

Mr. Secretary, I want to thank you for being here today. I have been looking forward to this hearing, I am going to tell you, for a long time.

Mr. Chairman, I would like to include a written statement for the Partnership for Public Service in the record today, with your permission.

Chairman ISAKSON. Without objection.

[The statement can be found in the Appendix.]

Senator TESTER. Their statement underscores the need for the VA to maintain a collaborative relationship with Congress, this Committee, and highlight the importance of employee engagement within the VA.

With that, Mr. Chairman, I appreciate your leadership and look forward to this hearing.

Chairman ISAKSON. Thank you, Senator Tester. I appreciate your comments. I have two things to say before we turn it over to the Secretary.

One is I would like Mr. Brett Reistad to stand up. He is the new American Legion National Commander.

Brett, will you stand up, please? Give him a round of applause. [Applause.]

What is your State, sir?

Mr. REISTAD. Virginia, sir.

Chairman ISAKSON. Virginia. Well, you are close to home, so that is good. We are glad to have you and appreciate The American Legion and all they do.

Mr. REISTAD. Thank you for having us, sir.

Chairman ISAKSON. Who in my Committee is in charge of the air conditioning? [Laughter.]

Anybody in this room who is going to admit to that?

OK. You go find them and tell them it is hot in here.

We want to cool this place off a little bit. We want to make it right and comfortable.

Senator MORAN. It is Tester's fault.

Chairman ISAKSON. Tester's fault. That is right.

Senator TESTER. We do not want this to be a heated hearing. [Laughter.]

Chairman ISAKSON. Secretary Wilkie, we appreciate you being here today. We appreciate the access you have given us in the past and look forward to working together and appreciate you being here today.

STATEMENT OF HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary WILKIE. Well, thank you very much, Mr. Chairman and Senator Tester and distinguished Members of the Committee. I want to thank you for this first opportunity to discuss the state of the Department of Veterans Affairs and for the many courtesies that you have shown me in the last few months, my first iteration as the Acting Secretary and now 7 weeks into the term as the confirmed Secretary.

I am happy to tell you that the state of the VA is better, and it is better, as Senator Tester said, because of the work of this Committee and the attention paid to our Department by the administration.

It is also better because, a Senator Tester pointed out in conversations with me, we now have a fully-experienced leadership

team in place at all levels. It is better because we have a workforce dedicated to the care of veterans, their families, caregivers, and survivors. I will say better because the turmoil of the first half of 2018 is now in the rearview mirror.

What this means in terms of leadership is that our new team is on the same page, speaking with one unified voice on behalf of veterans, moving out and delivering the mandate of this Committee.

I also want to thank the Veterans' Affairs Committee for its quick movement on our nominees for leadership in the Office of Accountability and Whistleblower Protection as well as the CIO.

Mr. Chairman, you and I have discussed that there are two Departments in the Federal Government that must always be above partisan politics. I have been fortunate to serve in both—the Department of Defense and the Department of Veterans Affairs—and this Committee proves that postulate.

Now more than ever, we are seeing the need for DOD and VA to work together to provide quality care for our Nation's servicemembers and veterans, and now more than ever, we are seeing the benefit of strong bipartisan support for our DOD/VA partnership in the many major acts of Congress passed in the last few years.

Mr. Chairman, you and the ranking member have equipped the Department with a $200 billion budget. You have passed the Accountability Act to shake up complacency, and you have passed the MISSION Act to strengthen our ability to ensure that veterans have access to the best care available when and where they need it.

As Secretary Mattis said when the Congress passed his budget, there are no more excuses. The future now is up to the Department. I look forward to working with the Committee and the Congress to carry forward the work of that transformation, and I pledge to you to make efforts as transparent as possible to give you and the veterans of our Nation the best service possible.

In the past 6 weeks, I have met personally with the leaders of nine veterans service organizations, attended several conventions, and visited 12 VA hospitals from Boston to Las Vegas plus two claims processing centers, two national cemeteries, and a veterans treatment court in Maryland. From what I have seen and heard, it is clear to me that the veterans population and their needs are changing faster than we even realize.

For the first time in 40 years, half of our veterans are now under the age of 65. Of our 20 million veterans, 10 percent are now women, and the number of women veterans receiving VA care has tripled since 2000.

The new generation of veterans is computer-savvy and demands 21st century service, service that is easy to access, efficiently delivered, and available where needed. For the VA to thrive as an integrated benefits and health care delivery system, it must be agile and adaptive.

I have also seen the wonderful examples of VA accomplishments that Senator Tester pointed out. They deserve more attention than they have received. We are on the cutting edge of medical care and rehabilitative services, prosthetics, Traumatic Brain Injury, spinal cord treatment, opioid and mental health, telehealth, and community care, where one-third of our appointments reside.

The VA health care system continues to outperform the private sector in the quality of care and patient safety for our veterans.

Our National Cemetery Administration has dedicated its 136th cemetery in Colorado Springs.

Fifty-two State veterans' homes received construction and renovation funds this year, and for the first time in many years, our overall VA customer satisfaction rate is steadily on the rise.

Thanks to the unprecedented series of legislative actions aimed at reforming the Department and improving care and benefits for our heroes, we are now tackling issues that have vexed VA for decades: giving veterans more choice in their health care decisions with the passage of MISSION; increasing accountability for misbehaving employees and protecting whistleblowers with our Office of Accountability and Whistleblower Production; improving transparency by becoming the first hospital system in the Nation to post online wait times, opioid prescription rates, accountability, settlement information, and chief executive travel.

We are adopting the same electronic health record at DOD, so there is a seamless transfer of medical information for veterans leaving the service and are implementing the Appeals Modernization Act while reducing wait times for those with appeals already pending.

As the Ranking Member said, we are on the cusp of the most important era in the history of the Department. This is not business as usual. This is fundamental transformation not seen since World War II when Omar Bradley headed the Veterans Administration.

As you said, Mr. Chairman, my number 1 priority is customer service. When an American veteran comes to VA, it is not up to the veteran to employ a team of lawyers to get VA to say yes. It is up to VA to train and equip its employees to get that veteran to yes, and that is customer service.

Second, we will implement the MISSION Act, a landmark achievement of this Congress that will fundamentally transform health care by consolidating all of VA's community care efforts into a single program that is much easier to navigate for veterans, families, VA employees, and community providers. As Senator Murray worked so hard for, this Act also expands VA's family giver programs, caregiver programs, to provide much needed assistance to the people who care for our most needy veterans day in and day out.

Third, we will replace our aging electronic health record system with the system in use by the Department of Defense to modernize our appointment system, automate our disability claims and payment claims systems, and connect VA to DOD, private health care providers, and private pharmacies, finally creating a continuum of care organized around the veterans' needs.

What I see in the future is that we will never have a veteran, as my father was, carrying around an 800-page paper record. The new system will allow for best practices to be shared and implemented across the network and empowering us to turn the corner, hopefully, on opioid abuse and suicide prevention. Implementation of this system will be ongoing and iterative, and I look forward to working with the Members of this Committee throughout the process.

Fourth, we must transform our business systems processes to modernize our management of human resources, finance, and just as important, our supply chain. This means giving people more leeway to manage their budgets and recruit, retain, and relocate the staff they need to serve veterans in their areas. It also means entering into more robust partnerships with our State and local communities to address veterans' homelessness and suicide prevention.

At the same time, we will continue our recent progress on many other important issues. For example, to accommodate the rapid growth in America's women in the service, VA has expanded services and sites of care across the country. We now have at least one women's health primary care provider at all of VA's health care systems.

In addition, 90 percent of the community-based outpatient clinics have a women's health primary care provider in place. Gynecologists are on-site at 133 facilities, and mammography is on-site at 60. VHA is in the process of training additional providers so every woman veteran has an opportunity to receive her primary care at VA.

We are also working to fill the gaps in our ranks. VA has had a net gain of 7,423 employees in fiscal year 2017, and so far in fiscal year 2018, we have seen a net increase of more than 9,500, including 3,600 in the mission-critical position Senator Tester mentioned. Our average annual turnover rate is 9.2 percent, which beats the 11 percent average of Cabinet-level agencies in the last 2 years as well as the 20 to 30 percent turnover rate in the health care industry in America.

We are providing more health care appointments than ever before, having authorized 32.7 million appointments in 2017, which was nearly 2 million more than in the previous year.

All VA health care facilities now provide same-day primary and mental health care services for veterans in urgent need.

Finally, Mr. Chairman, I want to bring to your attention something that was very important to me, and I think I am speaking for my former boss, Senator Tillis. I want to thank the Department of Veterans Affairs for the round-the-clock efforts that they provided to serve and protect our veterans across the Carolinas. Without a hitch, we were able to evacuate patients in the danger zone and provide fuel, food, and oxygen to hospitals we had to keep open, in spite of deteriorating conditions and the communities they served being cut off from the rest of the country.

What is not known to many of our fellow citizens and some in our own Department, we were the foundational emergency responders for our foundational emergency Federal response. We were the part of the Government providing incident command centers, sending doctors, nurses, and engineers plus mobile pharmacies, clinics, and nutrition centers into the hardest-hit areas. America should be proud of their citizens at VA.

So, as I said, we are embarking on the most comprehensive improvements to veterans' care and benefits since World War II. We have more work to do, and thanks to you and the Members of this Committee, we now have the resources to complete the work.

Mr. Chairman, again, I thank you for your many courtesies to me and I look forward to working with this Committee as we work

for the betterment of veterans across the country. I thank you for your courtesy.

[The prepared statement of Secretary Wilkie follows:]

PREPARED STATEMENT OF HON. ROBERT WILKIE, SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

CHAIRMAN ISAKSON, SENATOR TESTER, DISTINGUISHED MEMBERS OF THE COMMITTEE: Thank you for my first opportunity to discuss the current state of the Department of Veterans Affairs (VA) and my vision for the future of America's Veterans.

I am happy to say that the state of the VA is better—better because of the work of this Committee; better because of the attention paid to Veterans Affairs by the President; better because we have a functioning, experienced leadership team in place at all levels; better because we have a workforce dedicated to the care of warriors; and better because the turmoil of the first seven months of 2018 is in the rear-view mirror.

Mr. Chairman, while all executive branch departments and agencies must carry out their missions without consideration or influence of partisan politics, I have said in my visits across the department—visits that in the last five weeks cover ten VA hospitals from Boston to Las Vegas—that there are two departments of the Federal Government that must be especially careful to rise above partisan politics: the Department of Defense (DOD) and the Department of Veterans Affairs—this Committee is proof of that postulate.

Now more than ever we are seeing the need for DOD and VA to work together to provide quality care for the Nation's Servicemembers and Veterans. And now more than ever we also are seeing the benefit of strong bipartisan support for our DOD/VA partnership in the many major acts of Congress passed in the recent years. Mr. Chairman, Congress has infused VA with a $200 billion budget. You have passed the Accountability Act to shake up complacency, and you have passed the MISSION Act to strengthen VA's ability to ensure Veterans have access to the best care available when and where they need it. As Secretary Mattis said when this Congress passed a $700 billion defense budget, there are no more excuses. The future now is up to the department. I look forward to working with the Committee and Congress to carry forward that work of transformation, and I pledge to make our efforts as transparent as possible to you, to Veterans, and to the American people.

Mr. Chairman, I would also be remiss if I did not mention the round the clock efforts of our VA employees to serve and protect our veterans during this great time of need across the Carolinas. Without a hitch, we were able to evacuate patients in the danger zone; provide fuel, food and oxygen to hospitals we had to keep open in spite of deteriorating conditions in the communities they serve; and what is not known to many of our fellow citizens and some in this Congress—we were the foundational emergency responders for our government providing incident command centers and sending doctors, nurses and engineers plus mobile pharmacies, clinics and nutrition centers into the hardest hit areas. America should be proud of their fellow citizens.

INITIAL ASSESSMENT

As Acting Secretary and Secretary of Veterans Affairs, I met personally with the leaders of nine Veterans Service Organizations (VSOs), spoke at four VSO events, hosted two VSO breakfasts, and attended one White House VSO meeting. I have met with the combined leadership of VA's three administrations—Benefits, Health, and Memorial Affairs—and I have visited 14 VA medical facilities, two claims processing centers, and two national cemeteries, as well as a Maryland Veterans Treatment Court. From what I have seen and from what I have been told by Veterans' advocates, it is clear to me that the Veteran population is changing faster than we realize. For the first time in over 40 years, half of our Veterans are now under the age of 65. Of America's 20 million Veterans, 10 percent are now women. We face some persistent problems: increasing demand for care, vacancies in critical specialties, aging facilities, antiquated management systems, and a new generation of computer-savvy Veterans who expect and deserve 21st-century service—service that is quick, diverse, and close to home.

I have also seen wonderful examples of VA accomplishments that deserve more attention than they get. Many of them are the result of collaborations with our public and private sector partners, such as our consultation with the National Football League on Traumatic Brain Injury. And I've seen VA making groundbreaking

progress, particularly in the areas of accountability, transparency, and efficiency, thanks to an unprecedented series of legislative actions aimed at reforming the department and improving care and benefits for our Nation's heroes.

Most inspiring to me have been the many exceptionally competent and caring VA employees I have met who truly live by VA's core "I CARE" values: Integrity, Commitment, Advocacy, Respect, and Excellence:

- Not long after I rejoined VA, The Washington Post ran a story about the people who answer phones for the White House VA Hotline. I was touched by the patience and compassion of one of the call takers—an Army widow named Mary Hendricks—that I called to thank her and her co-workers for the work they do.
- Then there were the four employees of the Phoenix VA medical center who talked a homeless man out of committing suicide. They were on their way to work when they saw him about to jump from an I–10 overpass. One VA employee did not see the homeless man at first, but he did see his co-workers trying to help the man, so he stopped to help them, and together they saved a life that day.
- Last month, Alethea Varra, a regional director of VA's National Tele-mental Health network, met with Ajit Pai, Chairman of the Federal Communications Commission (FCC), to impress upon him the importance of extending high-speed Internet access to rural Veterans. Varra introduced Pai to a Veteran who lives two hours from the nearest VA clinic but is able to keep weekly appointments with mental health counselors over the Internet. Advocacy is one of our core I-CARE values; Alethea Varra lived up to that value by connecting Pai with Veterans in need.
- There's Dr. Joseph Potkay, a researcher at the University of Michigan who is also a biomedical engineer at the VA in Ann Arbor, and who is working to create a microfluidic artificial lung using a high-resolution 3D printer. If it works, it could revolutionize the treatment of Veterans with lung disease.
- Finally, for the past two years, VA health professionals in West Palm Beach and Miami, Florida, have been treating an Army Veteran with melanoma named John Johnson. This summer—after radiation, surgery, and immunotherapy—Johnson was able to realize his dream of bicycling the mountainous route followed by the Tour de France. He later told us, "I owe the West Palm Beach VA a huge debt of gratitude for making [this ride] possible. . . . There are great people who work here, and they deserve thanks and attention. They're fantastic, and they should all be told, 'You're fantastic.'"

These are just a few examples of the people who make me truly thrilled to be part of VA at just this time in its history. They are exceptionally competent and dedicated people, and with the support of the President, the Congress, and our many partners, they are now tackling head-on issues that have lingered for years, including:

- Giving Veterans more choice in their healthcare decisions with passage of the historic MISSION Act,
- Increasing accountability for misbehaving employees and protecting whistleblowers with the establishment of the Office of Accountability and Whistleblower Protection,
- Improving transparency by becoming the first hospital system in the Nation to post online our wait times, opioid prescription rates, accountability, settlement information, and chief executive travel,
- Adopting the same electronic health record as DOD so there is a seamless transfer of medical information for Veterans leaving the service, and
- Overhauling our claims and appeals processes to create a simplified system for filing to provide Veterans with clear choices and timely decisions.

This is not business as usual. This is fundamental transformation, not seen at VA since just after World War II, when General Omar Bradley headed the VA.

MY VISION FOR VA

Many of the issues I encountered as Acting Secretary and more recently as Secretary were not with the quality of medical care but with getting our Veterans through the door to reach that care. Those problems are both administrative and bureaucratic. Alexander Hamilton said that the true test of a good government is its aptitude and tendency to produce a good administration. That is where VA must go.

Our first challenge is to improve the culture to focus our attention and efforts on offering world-class customer service through all our operations. Our second chal-

lenge is increasing access to care and benefits through MISSION Act implementation and business transformation, which includes adopting a new electronic health records system, implementing a new claims appeals process, and modernizing our human resources, financial management, construction program, and supply systems.

Priority 1: Customer Service (CX)

My prime directive is customer service. When a Veteran comes to VA, it is not up to him to employ a team of lawyers to get VA to say yes. It is up to VA to get the Veteran to yes, and that is customer service.

VA receives 140 million phone calls a year. Ten million people contact VA online each month. We have 348 contact centers, hundreds of websites, and dozens of databases. Veterans think of VA as a single entity, but we deliver services in silos, forcing the Veteran to figure out which VA phone number to call, website to search, or office to visit. For many, finding the right office to access the right benefit or service is a fractured, frustrating experience.

Driven by customer feedback, we are integrating VA's digital portals, contact centers, and databases so that Veterans easily find what they need no matter which channel they choose. We have planned a re-launch of our VA.gov website on Veterans Day, and we are unifying Veteran data, adding customer preferences for electronic correspondence to our new Vet360 database and integrating the Vet360 profile service with mobile apps. We are also establishing a governance structure to involve senior VA leadership in the customer-service effort.

Our goal is to make accessing VA services seamless, effective, efficient, and emotionally resonant. The delivery of excellent CX is my responsibility and the responsibility of all VA employees. When the interactions between VA employees and our Veteran customers in these areas are positive, our Veterans will trust and Choose VA, for their care, benefits, and memorial services across their lifetime.

Customer service must start with VA employees not talking at each other but with each other across all office barriers and across all compartments. If we don't listen to each other, we won't be able to listen to our Veterans and their families and we won't be able to provide the world-class customer service they deserve. We must be a bottom-up organization, with energy flowing upward from those who are closest to those we are sworn to serve. It is from our dedicated employees that the ideas we carry to the Congress, to the Veterans Service Organizations, and to America's Veterans will come. Anyone who sits in this chair and tells you he or she has the answers is in the wrong business.

To help us become the best customer-service team in Government, and earn the trust of our Veterans and their families, caregivers, and survivors, I have issued a policy statement outlining how VA will achieve this goal along three key pillars: CX Core Capabilities and Framework; CX Governance; and CX Accountability. I am holding all VA executives, managers, supervisors, and employees accountable to foster this climate of excellence in customer service. I have also pledged the shared services and support of VA's Veterans Experience Office as a key enabler to help us all achieve this climate of customer service for both those we serve, and to those we serve alongside.

Priority 2: MISSION Act Implementation

The MISSION Act is landmark legislation that will fundamentally transform VA health care and improve Veterans benefits and services. To ensure VA meets all of the provisions within the MISSION Act, we have established an enterprise program management office, with integrated project teams to implement each specific MISSION Act provisions, led by Acting Deputy Secretary Jim Byrne.

Community Care

The MISSION Act consolidates all of VA's community care efforts into a single program that is much easier to navigate for Veterans, families, VA employees and community providers. This will ensure our Veterans receive the best healthcare possible, whether delivered in VA facilities or in the community. To implement requirements under the MISSION Act for the consolidated VA community care program, VA began drafting the required regulations immediately. Several significant regulations are targeted for publication in the summer of 2019. In the meantime, the MISSION Act includes an additional $5.2 billion in funding for the Veterans Choice program to continue until June 6, 2019, while VA develops the regulations to implement the new consolidated community care program.

Caregivers Expansion

The MISSION Act also expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) beyond post-9/11 Veterans to include eligi-

ble Veterans from all eras of service. VA's Caregiver Support Program (CSP) will oversee the expansion, which will occur in two phases:

- Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975, will begin integrating into the program first.
- Veterans who incurred or aggravated a serious injury in the line of duty between May 7, 1975 and September 11, 2001, will begin integrating into the program two years later.

The timeline for incorporating all eligible Veterans is still under development. To meet the needs of incoming Veterans, CSP must develop and implement a new information technology system to support administrative and recordkeeping needs. CSP will soon submit a report to Congress with a timeline for implementation.

VA supports this expansion and recognizes the sacrifice and value of Veterans' family caregivers not only through this program but through its first Federal Advisory Committee for Veterans Families, Caregiver and Survivors and its new Center of Excellence for Veteran Caregiver Research. Caregivers and Veterans can learn about the full range of available support and programs by visiting www.caregiver.va.gov or by contacting the Caregiver the Caregiver Support Line toll-free at 1–855–260–3274.

Priority 3: Business Transformation

Business transformation is essential if we are to move past compartmentalization of the past and empower our employees serving Veterans in the field to provide world-class customer service. This means reforming the systems responsible for claims appeals, GI Bill benefits, human resources, financial and acquisition management, supply chain management, and construction. Office of Enterprise Integration (OEI) is charged with coordination and oversight for these efforts.

Appeals Modernization

The Veterans Appeals Improvement and Modernization Act of 2017 was signed into law on August 23, 2017, and takes full effect in February 2019. VA is on track to implement the law by that timeframe. The Appeals Modernization Act transforms VA's complex and lengthy appeals process into one that is simple, timely and fair to Veterans. The new appeals process will feature three decision-review lanes:

- *Higher-Level Review Lane:* A senior-level claims processor at a VA regional office will conduct a new look at a previous decision based on the evidence of record. Reviewers can overturn previous decisions based on a difference of opinion, or return a decision for correction.
- *Supplemental Claim Lane:* Veterans can submit new, relevant evidence to support their claim and a claims processor at a VA regional office will assist in developing evidence.
- *Appeal Lane:* Veterans will have the option to appeal a decision directly to the Board of Veterans' Appeals (Board).

The law created the Rapid Appeals Modernization Program (RAMP), which allows Veterans with a pending disability compensation appeal to participate immediately in the new appeals process. About 48,000 Veterans with more than 57,000 appeals have opted into RAMP so far, and VA has paid over $66 million in retroactive benefits as of August 2018. While focusing on the timely implementation of the Appeals Modernization Act, the Board has also completed a record number of more than 81,000 decisions to Veterans for Fiscal Year 2018. The Board is focused on developing and updating information technology systems for the new claims and appeals process, developing and refining meaningful metrics, providing training across VA for employees, adding appropriate resources for deployment and collaborating with stakeholders throughout the implementation process.

Forever GI Bill

Since the law was signed last August, VA has implemented 28 of the law's 34 provisions. Twenty-two of the law's 34 provisions require significant changes to VA information technology systems, and VA has 200 temporary employees in the field to support this additional workload. Sections 107 and 501 of the bill change the way VA pays monthly housing stipends for GI Bill recipients and VA is committed to providing a solution that is reliable, efficient and effective. Further system changes and modifications are being made and testing is ongoing on the IT solution for Sections 107 and 501. VA will announce a deployment date upon completion of testing. Pending the deployment of a solution, Veterans and schools will continue to receive GI Bill benefit payments as normal.

Financial Management Systems

VA's financial management system is 30 years old and continued reliance on it presents an enormous risk to VA operations. The technical and functional ability to support these legacy applications gets more difficult with each passing year. Our Financial Management Business Transformation (FMBT) program will replace VA's financial management and acquisition system with new systems that will increase transparency, accuracy, timeliness, and reliability of financial information across VA, improving fiscal accountability to taxpayers and enabling VA employees to better care for and serve Veterans. FMBT will provide a modern, Integrated Financial and Acquisition Management System (iFAMS), an acquisition solution with transformative business processes and capabilities that enable VA to meet its goals and objectives in compliance with financial management legislation and directives.

Supply Chain Transformation

Effective management of the supply chain is a major differentiate between high- and low-quality healthcare systems, yet the 2016 Commission on Care concluded that the Veterans Health Administration (VHA) could not modernize its supply chain to overcome cost inefficiencies because it is burdened with confusing organizational structures, lack of expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management. In response, VHA has embarked on a supply chain transformation program designed to build a lean, efficient supply chain that provides timely access to meaningful data focused on patient and financial outcomes. To date, VHA has established a standardized supply chain organizational structure, a robust supply-chain training and development program, an integrated data analysis capability, and a comprehensive equipment lifecycle management program. VHA is continuing to work on data standardization and governance, supply chain innovation center, and a clinically driven strategic sourcing program.

Priority 4: VA/DOD Collaboration

Electronic Health Record Modernization (EHRM)

VA has made a historic decision to modernize its electronic health record (EHR) system to provide our Nation's Veterans with seamless care as they transition from military service to Veteran status and whether they choose to use VA care or community care. To that end, VA has established the Office of Electronic Health Record Modernization (OEHRM) to ensure VA successfully prepares for, deploys and maintains the new EHR solution and the health IT tools dependent upon it. The OEHRM Executive Director is Mr. John Windom, who has been with the effort since its inception and has the necessary expertise and institutional knowledge to effectively lead this initiative. Prior to joining VA, Mr. Windom was a Program Manager for the Program Executive Office of the Defense Healthcare Management Systems (DHMS). He led his team to acquire, test, integrate and deploy a new EHR system to replace DOD's legacy EHR system in support of over 9.6 million military servicemembers and other beneficiaries.

OEHRM is working closely with DOD to ensure we are deploying an EHR that is fully interoperable. Veterans Integrated Service Network (VISN) 20 in the Pacific Northwest has been selected as the first Initial Operating Capability (IOC) site to deploy and test VA's new EHR solution. Engaging front-line staff and clinicians is a fundamental aspect in ensuring we meet the program's goals and we have begun work with the leadership teams in place in the Pacific Northwest. OEHRM has established clinical councils from the field that will develop national workflows and serve as change agents at the local level. The work at the IOC sites will help VA identify efficiencies to optimize the schedule, hone governance, refine configurations and standardize processes for future locations. We are committed to a timeline that makes sense and are also working with DOD to understand the challenges and obstacles they are encountering, adapt our approach to mitigate those issues, and identify efficiencies.

Suicide Prevention

Suicide prevention is a top priority for VA. Of the twenty (20) Veterans, active-duty Servicemembers and non-activated Guard or Reserve members who died by suicide, fourteen (14) have not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support. In June, VA published a comprehensive national Veteran suicide prevention strategy that encompasses a broad range of bundled prevention activities to support the Veterans who receive care in the VA healthcare system as well as those who do not come to us for care.

Preventing suicide also requires closer collaboration between VA and DOD. To that end, President Trump issued an executive order January 9, 2018, to assist Servicemembers and Veterans during their transition from uniformed service to civilian life, focusing on the first 12 months after separation from service, a critical period marked by a high risk for suicide, during which—

- Servicemembers will learn about VA benefits and start enrollment before becoming Veterans.
- Any newly transitioned Veteran can go to a VA medical center or Vet Center and start receiving mental health care right away.
- Former Servicemembers with other than honorable discharges can receive mental health care from VAMCs in the first 12 months after separation.
- Transitioning Servicemembers and Veterans will be able quickly to find information online about their eligibility for VA care.

Every day, more than 400 Suicide Prevention Coordinators (SPC) and their teams—located at every VA medical center—connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.

VHA has also expanded its Veterans Crisis Line to three call centers and increased the number of Veterans served by the Readjustment Counseling Service (RCS), which provides services through the 300 Vet Centers, 80 Mobile Vet Centers (MVC), 18 Vet Center Out-Stations, over 990 Community Access Points and the Vet Center Call Center (877–WAR–VETS). In the last two fiscal years, Veterans benefiting from RCS services increased by 31 percent, and Vet Center visits for Veterans, Servicemembers, and families increased by 18 percent.

We are committed to advancing our outreach, prevention, and treatment efforts to further restore the trust of our Veterans and continue to improve access to care and support inside and outside VA.

Additional Priorities

Accountability

Everyone recognizes that VA has struggled in the past to hold employees accountable when they violated the public trust and to protect whistleblowers from retaliation. That is why last year President Trump signed an executive order establishing VA's Office of Accountability and Whistleblower Protection (OAWP). The first office of its kind in the Federal Government, OAWP has changed dramatically the way VA handles accountability and whistleblower issues, ensuring adequate investigation and correction of wrongdoing throughout VA while also protecting employees who lawfully disclose wrongdoing from retaliation.

OAWP is dedicated and empowered to provide transparency and build public trust and confidence in VA. The office improves the performance and accountability of VA senior executives and employees through thorough, timely, and unbiased investigation of all allegations and concerns. When allegations are substantiated, OAWP recommends actions to be taken, which can include removal, demotion, or suspension based on poor performance or misconduct.

OAWP has worked a full range of case since its inception, receiving 2,000 disclosures in its first year. In that year, the average investigation cycle time declined from 163 days to 100 days. From June 23, 2017, through June 1, 2018, OAWP completed 128 senior-leader investigations involving 236 persons; discipline was recommended in 54 cases involving 58 persons.

Women's Health

VA has made significant progress in serving women Veterans in recent years and now provides full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. For severely injured Veterans, we also now offer in vitro fertilization services through care in the community and adoption services.

The number of women Veterans using VHA services has tripled since 2000, growing from 159,810 to 484,317. To accommodate the rapid growth, VHA has expanded services and sites of care across the country. VA now has at least one Women's Heath Primary Care Provider (WH-PCP) at all of VA's healthcare systems. In addition, 90 percent of community-based outpatient clinics (CBOCs) have a WH-PCP in place. VHA now has gynecologists on site at 133 sites and mammography on site at 60 locations.

VHA is in the process of training additional providers so that every woman Veteran has an opportunity to receive her primary care from a WH-PCP. Since 2008, 5,800 providers have been trained in women's health. This fiscal year, 756 Primary Care and Emergency Care Providers were trained in local and national trainings. VA has also developed a mobile women's health training for rural VA sites to better serve rural women Veterans, who make up 26 percent of women Veterans.

VA is at the forefront of information technology for women's health and is redesigning its electronic medical record to track breast and reproductive health care. Quality measures show that women Veterans who receive care from VA are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike some other healthcare systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management. We are also factoring care for women Veterans into the design of new VA facilities and using new technologies, including social media, to reach women Veterans and their families. We are proud of our care for women Veterans and are working to increase the trust and knowledge of VA services of women Veterans so they choose VA for benefits and services.

Community Living Centers (CLC)

This is the first year VA has compiled ratings for our nursing homes using the Center for Medicare and Medicaid Services rating system. We are now able to present an apples-to-apples comparison of VA homes with private facilities. The data show that, overall, VA's nursing home system compares closely with the private sector, even though VA cares for sicker patients—with conditions such as prostate obstruction, spinal cord injury, mental illness, homelessness, PTSD, combat injury, terminal illness—in its homes than do private facilities. Private-sector nursing homes also admit patients selectively, whereas VA cannot refuse service to any eligible Veteran, to the extent resources are available. These factors make achieving quality ratings comparable to the private sector more challenging.

Hiring and Vacancies

VHA's workforce challenges mirror those of the health care industry as a whole. There is a national shortage of healthcare professionals, especially for physicians and nurses. VA remains fully engaged in a fiercely competitive clinical recruitment market and has increased its number of clinical providers including hard-to-recruit-and-retain physicians such as psychiatrists. Additionally, VHA is taking a number of key steps to attract qualified candidates, including:

- Mental Health and other targeted hiring initiatives
- Leveraging flexible pay ranges resulting in competitive physician salaries
- Utilization of recruitment/relocation and retention (3Rs) incentives and the Education Debt Reduction Program (EDRP)
- Targeted nationwide recruitment advertising and marketing
- The "Take A Closer Look at VA" trainee outreach recruitment program
- Expanding opportunities for telemedicine providers
- DOD/VA effort to recruit transitioning servicemembers
- Exhibiting regularly at key health care conferences and job fairs
- Critical Position Hiring and Vacancies

VA had a net gain of 7,423 employees in FY 2017. So far in FY 2018 (October 1, 2017 to July 31, 2018), VA has seen a net increase of more than 9,500 employees, including 3,600 in mission-critical occupations. As of June 30, VA had 45,239 overall vacancies, out of a total of 419,353 full-time authorized and budgeted positions. From the start of fiscal year 2014 to the end of FY 2017, VA achieved a growth rate of 12.5 percent and an average annual turnover rate of 9.2 percent. VA turnover rates compare favorably with other large cabinet-level agencies, which averaged 11 percent in FY 2017.

Wait Times

VA is providing more healthcare appointments than ever before, authorizing 32.7 million appointments in FY 2017, nearly two million more than in the previous year. All VA health care facilities now provide same-day urgent primary and mental health care services for Veterans who need them. In June 2018, VA completed 95.18 percent of appointments within 30 days of the clinically indicated or Veteran's preferred date; 83.46 percent within 7 days; and 20.29 percent the same day. The average time it took to complete an urgent referral to a specialist has decreased from 19.3 days in FY 2014 to 3.2 days in FY 2017 and 2.0 days in FY 2018—this number continues to improve and is now down to 1.3 days during July 2018.

Blue Water Navy

VA's view is that the commitment to science and an evidence-based approach to creating or expanding presumptions should be maintained. Presumptions of exposure and/or medical causation should always be supported by historical, scientific, and/or medical evidence about the specific population of Veterans affected. While VA continues to study the science of exposure, we do not believe the available scientific evidence currently supports a presumption of service connection in this case.

We are also concerned that congressionally mandated presumptions not supported adequately by evidence would erode confidence in the soundness and fairness of the Veterans' disability benefits system, creating the impression that the system can be gamed by political activism. Such statutory presumptions will lead to increased pressure on VA to create or expand additional presumptions administratively, under a similarly liberal approach favoring less deserving but politically demanding Veterans over more deserving Veterans who trust VA to do the right thing for all Veterans.

VA estimates a total cost of $6.7 billion over ten years associated with such a presumption, including $5.7 billion for mandatory benefit payments, $625 million for health care costs, and $357 million for discretionary costs to administer benefit payments. Such a presumption would also impact VA's ongoing efforts to reduce the appeals and claims processing backlogs. The accomplishments VA has made with Congressional assistance will be stymied by VA's requirement to verify and study in great detail over 30,000 previously-denied claims in the first year alone and adjudicate more than 230,000 claims over 10 years, adding time to our 125-day claims processing goal.

CONCLUSION

Mr. Chairman, I would like to again thank Congress for passing VA's FY 2019 funding bill. Starting the fiscal year with our full year's appropriations in place is extremely important as we implement the laws Congress has passed.

As I mentioned, we have instituted new management processes that will facilitate successful implementation of these laws. This will be a long journey that will not be accomplished overnight. I am committed to providing you with regular updates on our progress and the challenges that arise. However, I respectfully ask for time to implement and evaluate the programs. We cannot keep changing course, or stop everything we are doing to provide updates or respond to inquiries if we are serious about getting to our destination. I need your help on this.

As we look to the next few years and full implementation of the new Veterans Community Care Program and an expanded Caregivers Program, VA will need to resolve the necessary funding requirements to meet Congress's intent. We are embarking on the most comprehensive improvements to Veterans care and benefits since World War II. We will need the resources to complete this work and I look forward to working with you on that.

Mr. Chairman, I look forward to working with you and this Committee and appreciate your many courtesies to me. I am also eager to continue building on the reform agenda I was privileged to work along with Senator Tester and Senator Tillis. The mission of this Committee is clear—you help remind all Americans why they sleep soundly at night because of those who sacrificed in uniform. There is no more noble mission in all of government.

Thank you.

Chairman ISAKSON. Thank you very much, Mr. Secretary.

What I am going to do on the questions, I am going to reserve mine until the end. We have got Members coming, so I am going to try to get everybody in. We will take you while you are here. If you have got another meeting to go to, we will let you go.

I will start out on our side, and I am going to waive my time. I will go to Senator Moran.

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

Senator MORAN. Mr. Chairman, thank you very much for that courtesy. Thank you for you and Senator Tester having this hearing.

Mr. Secretary, welcome. Let me also join what the Chairman did in welcoming the new American Legion National Commander. Let me take that a step further. Thank you for your visit to Kansas last week. A significant number of posts across our State where you visited I know were well received. I appreciate the message you brought to veterans in our State.

Mr. Secretary, thank you for joining us today. I think you would know that one of my biggest priorities of this Congress was the MISSION Act and making certain that we achieved legislation that was more than just a reauthorization of the Choice Program.

In my view, the MISSION Act or that reauthorization was a choice and an opportunity for real reform at the VA, one that we could not waste and that we ought to use as a chance to fix the very real problems that existed with Choice and reform the entire VA health care system to better serve our veterans really for decades to come.

I think that, largely, we were successful in that effort, and a number of the reforms that I fought to have included in this legislation were put in place. You are now preparing to implement them.

My focus is on implementation, how you are going to do that. One of the provisions we fought to have included requires the VA to regularly consult with Congress during the development of rules and regulations that govern the program, particularly with the development of access standards, which will largely be used to determine when a veteran is eligible to receive community care.

I am out across my State. We are about to complete our 105th town hall meeting at the 105 counties in our State. I raise this topic, and I want my veterans to know that there was a Choice Program that is becoming something different. I need to make certain that it does become something different than what many of them experienced that did not work for them.

Next week, October 4, marks the first time the VA is required to consult with us, Congress, in developing those standards, and I want to make certain that it is a veteran-centric approach. I want the standards to be easy to understand and utilized for all parties involved—the VA, the veterans, the community providers—and I am anxious to see what is presented next week to see that the VA is on the right track.

One area that I want to highlight for you, bring to your attention, is this definition of "episode of care." It is my hope that once a veteran is sent to community care for conditions, they are able to see their community provider through the entirety of their care for that condition.

For example, a veteran needs eye surgery. It does not mean that you get the eye surgery under the MISSION Act and then you are required to come back to the VA for follow-up care and treatment.

Mr. Secretary, my question is, how do you expect that complex care that requires numerous appointments for a certain condition will be structured?

Let me highlight this because one of the problems we had with Choice is a veteran was referred to community care by the VA and then was told once that provider needed a lab test, an x-ray, back to the VA for additional authorization. That is a component of this,

but also the continuum of care that is needed for a particular condition.

Thank you.

Secretary WILKIE. Well, thank you, sir. I also want to thank you for making your staff available, as I have gotten into my job for discussions with them.

My view of Congress' thrust in MISSION is to do exactly what you said. It is to give that veteran choice and allow that veteran to continue with the choice that he or she is most comfortable with.

I think we have a continuum of issues that will come together to provide that—electronic health record, getting our access standards, as you said, understandable and available to everyone. Particularly, as I have said before, we still do not understand the scale of the American West, west of the Mississippi. I think our changes when they come for access standards will revolutionize veterans care.

It is my goal to make sure that that veteran will experience the continuum of service where he or she desires, and I think that is one of the more revolutionary changes that comes out of MISSION.

I will also say in response to your last comment about briefing, we will have that 120-day briefing for you tomorrow. I think we are a little ahead of schedule. I will take responsibility for not coming the last day of August when I think the first 60-day period came because I did not get—know what was in it, but I can assure you that we will get a very comprehensive briefing up here tomorrow. We will meet the first hurdle that I am fully responsible for, in response to Senator Tester's comments, tomorrow.

Senator MORAN. Mr. Secretary, I thank you, and I look forward to further conversations with you. We will talk about budgeting and the ability for the VA to predict the costs and levels of care required.

Secretary WILKIE. Thanks.

Senator MORAN. Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

I want to thank you once again for being here, Secretary Wilkie.

Is that your wife behind you?

Secretary WILKIE. Yes.

Senator TESTER. Welcome, Julia. I do not know that we have ever had the Secretary of the VA come with his wife. That is pretty sweet. Appreciate you being——

Secretary WILKIE. We came to see you and not Tillis.

Senator TESTER. Oh, yeah. Right. That is it. [Laughter.]

So, look, I visit with veterans groups all the time, and yesterday was no exception. I visited with a number of them to hear their concerns, one of the things they said was VA's communication on EHR has gotten better, so thank you. Thank you for that.

I am not going to overstate this because if this changes we will not bring this up again. But, overall, they expressed alarm with what they perceived as increasing disengagement with VSOs in several areas.

I have said in this Committee meeting many, many times, we take our cues from the VSOs and from the veterans. So, as we implement the MISSION Act and as these men and women as vet-

erans are going to utilize it and they are represented by VSOs back here, who need to be a part of the equation, in my opinion.

So, talk to me about the Department's engagement for those who really helped frame the community health care bill, the VSOs, and tell me what you are doing, what you have done, what you intend to do. I know there are a number of them, but I think they are critically important to your success.

Secretary WILKIE. Well, absolutely, which goes back to what the Chairman said about customer service. My view of Government is that the only way Government can be efficient is if it is closer—closest to the people it serves.

I will take a step back and give you my agenda in the last 6 weeks. I have gone to the Paralyzed Veterans Health Summit. I have addressed The American Legion, AMVETS, Jewish War Veterans, other groups. I have been making the rounds, as I promised you, to walk the post.

Friday, we will have our first comprehensive all-day briefing for VSO leaderships under my tenure. It will be a regular feature of——

Senator TESTER. How regular, if I might ask?

Secretary WILKIE. I believe it is going to be every 2 months, but that can be augmented as needed.

Senator TESTER. OK.

Secretary WILKIE. I will get back on the schedule, a series of regular breakfasts that the VSOs were used to two Secretaries ago, and I continue to go out and talk to as many veterans organizations as I can. That is the promise, and I will make sure I inform the Committee that I am keeping that promise.

Senator TESTER. OK. I am going to use the next question as a recommendation, not a question, because you are a smart man. Your confirmation hearing was one of the most impressive things I have seen with anybody that we have confirmed in any Committee.

I would hope that your conversations with the VSOs is not one way. I hope it is not an information dump. I hope it is a consultation, an opportunity to tell them what you are doing and hear from them how they see it working.

Secretary WILKIE. I agree with that completely, and I will say that in my presentations across the country, I have pointed out that my own military service has been modest.

I would have been very comfortable sitting in front of Senator Tillis' subcommittee on SAS without any notes because that was my world. I will be honest and say I am still in the process of learning, and part of that education, a large part of it, comes from talking to veterans across the country, including many that I have grown up around.

Also, I will just mention this. We may talk about the subject of burn pits. I had a conversation with someone I have known since I was a child about that, General Petraeus.

So, I am looking to talk to veterans in the VSOs and veterans who just want to offer an opinion.

Senator TESTER. That is good, and I would tell you that the burn pit discussion may not be a lot different than the Blue Water discussion, so we need to get our arms around that, too.

I am just going to ask you real quick because I have only got 30 seconds left. You come out of the DOD. The EHR is a shared effort between the DOD and the VA. Have you or somebody within your organization had fairly high-level conversations with Secretary Mattis to make sure that DOD is paying attention, or would you recommend that we have a joint hearing with SAS on this issue?

Secretary WILKIE. Well, I think that would be valuable in the future and hopefully in the near future.

I am in discussions, the Department is in discussions with the Department of Defense. I am waiting for information to come back from the latest series of engagements, and then I will engage Secretary Mattis.

At my confirmation hearing, you asked me about that symbiotic relationship, and I will say on the electronic health record—and there was a lot of criticism in the press about being too closely tied to the Department. If we do not get the front end of a servicemember's service right with the electronic health record, it really does not help us when that veteran comes into our system.

One of my goals is to make sure that the DOD end works. I know that is something that Secretary Mattis believes in. I have the advantage of having been responsible for that, that program, when I was Under Secretary as well.

Senator TESTER. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. I understand Senator Boozman wants to switch places with Senator Heller.

Senator Heller, you are recognized.

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

Senator HELLER. Thank you, Mr. Chairman. I appreciate that, and I appreciate my colleague for accommodating.

Secretary Wilkie, thank you for being here today, and I also especially want to thank you for coming out to Las Vegas last week.

Secretary WILKIE. Thanks.

Senator HELLER. I thought that was a great experience, and in conversations through your nomination process, I asked you to try to get out to Las Vegas, spend some time before the end of the year. Just to have you there, it meant a lot to me.

Secretary WILKIE. Thanks.

Senator HELLER. It meant a lot to our veterans in the State.

Mr. Chairman, the President and Secretary Wilkie came out to Las Vegas and signed the appropriations for the VA and the military construction. I think it is the first time in history that a President has gone to a facility, a VA facility, to actually sign the appropriations bill for veterans, and it was done with great fanfare and interest. Our veterans very much were supportive, and I want to thank you——

Secretary WILKIE. Thanks.

Senator HELLER [continuing]. For taking that time. It was wonderful.

Like most of us here on this panel, I do a roundtable, and I had a veterans roundtable in Reno. Obviously, a lot of important issues are raised. We talked about mental health, homeless veterans, vet-

erans employment opportunities, and the gamut of issues that are important to our men and women.

But, most of all, I heard about our Blue Water Navy Vietnam veterans. There is a gentleman in Nevada from Elko. His name is Joe, and he is a Blue Water Navy veteran, who has been diagnosed with terminal prostate cancer. It is a disease that is associated with Agent Orange, but he is not eligible for compensation because he is a Blue Water Navy veteran.

My concern is I think we are turning our back on Joe, and before I go much further, I would like to have you clarify your position on compensation for our Blue Water Navy Vietnam veterans.

Secretary WILKIE. Thank you, Senator.

Let me start from an emotional position. I probably have experienced the effects of Vietnam in a way that few people my age could. I certainly did not fight there, but I saw my father and his comrades fight there. My father was gravely wounded in Southeast Asia, and some of my classmates' parents did not return. So, I have an emotional attachment to the cause of Vietnam veterans that I think is unique at this time.

I have also said that I do not like the term "greatest generation." I think that could have only been said by someone who has never put on a uniform because soldiers all have the same hopes, dreams, and fears. It does not matter what era they fight in. So, that is the emotional premise.

I agree with Chairman Isakson. I want to make sure that we get it right, that we get it right for all of our veterans. I pledge to work with the Chairman. We have had many discussions.

I will say I do want to make clear what is happening in VA. There are about 40,000 Vietnam veterans across the country who served in the Navy who are eligible for VA benefits. It is not as if—Agent Orange-type conditions, I should say—it is not as if the VA is turning people around—turning people out. We are going to continue to do that.

My pledge to the Chairman is to work with the Committee to ensure that we are just, we are equitable, equitable on both ends.

I think the Committee received a letter from four of the largest VSOs supporting the legislation but also saying, "We have a question about the funding mechanism," a funding mechanism that puts a burden on young active-duty servicemembers who are getting their first home. It also puts a burden on disabled American veterans who live in higher-cost areas like Charlotte or Atlanta. So, we want to look at that, too.

My pledge is to work to make sure that we get it right, and that is something I believe in sincerely and emotionally.

Senator HELLER. Let me just ask a quick follow-up because my time is almost out, but to get it right, in your opinion, if you get it right, will Joe from Elko be compensated?

Secretary WILKIE. Well, yes. I mean, if we get it right, anyone who fought, anyone who was exposed and deserves attention from us will get it. That is my pledge to work as hard as I can to see that nobody slips through the cracks.

I will say if your staff wants to get me any information——

Senator HELLER. OK.

Secretary WILKIE [continuing]. On Joe, I will see to it. He may even qualify and not know it.

Senator HELLER. Mr. Secretary, thank you, and again, thanks for coming to Las Vegas.

Secretary WILKIE. Thank you. Appreciate it.

Chairman ISAKSON. Two things, Senator Heller. First of all, do what he just said about giving him a call. There may be a way they can help.

Senator HELLER. Good, good.

Chairman ISAKSON. You missed my opening statement.

Senator HELLER. I did. I apologize.

Chairman ISAKSON. But, you did not miss—no, you do not need to apologize. [Laughter.]

You did not miss the conversation you and I had on the floor 2 days ago because you were right there.

I told this—everybody that is here, all the Members that were here, the people in the audience here, the VSOs here—the issue of dealing with Blue Water Navy is no longer going to be a question. How we do it is the only question.

I told the Secretary and worked with him in various meetings to get us to a position we can do a vehicle of some description that is unanimously approved by everybody, to be sure the veterans who deserve a benefit, that have been denied or could not get it, that we do not open the door or set a precedent down the road for something else that would run away.

I know Sherrod Brown has had conversations with some of the Members. I have. Senator Tillis has worked with me on a lot of stuff we have done talking about this. Senator Boozman. I have talked to Patty Murray about it. Jon and I have talked a lot about it. So, it is not a subject we are not dealing with.

I know other people in the audience that have a very vested interest, including yourself and including your veterans.

So, we set the table this morning in my opening remarks, and he just confirmed what I said without me coaching him because he is down there and I am up here. He has agreed to work with us to make that happen. So, we are going to do it.

Senator HELLER. Thank you. I appreciate that. The veterans appreciate that.

Chairman ISAKSON. You betcha.

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

Senator BROWN. Thank you, Mr. Chairman.

I thank you, Secretary Wilkie.

Chairman ISAKSON. Indians finally won a game.

Senator BROWN. They did. They did. Won one. Thank you for pointing that out. [Laughter.]

When the Indians beat the Braves in the World Series, you will think a little differently. Thank you. Being a Cleveland sports fan is tough business.

Thank you, Mr. Secretary, and thank you for not starting the clock yet either, Mr. Chairman.

I want to follow Senator Heller's remarks and the Chairman's and the Secretary's. I do not blame anybody personally. I do not

take any of this personally, but I want to keep the pressure on the Blue Water Navy issue because I know that—I think I mentioned to the Secretary in my office that I knew a gentleman early as a lawyer that fought Agent Orange cases one by one by one, and veterans from Vietnam died while they were being litigated. Then, the bitterness grew, which Congress understood that later, rather than sooner, but admirably, it was a victory for Government doing the right thing with the VA and on behalf of these veterans. You can always do it faster.

Veterans are dying, as Senator Heller said, while we—we are not fiddling while Rome burns. Again, I know that the Secretary wants to do the right thing. I know the Chairman and I have had a number of conversations on the floor and in this Committee, formally and informally about this. I just want to keep the pressure on.

To a lot of Blue Water Navy veterans, it sounds like the VA is standing in the way of our efforts to pass this legislation. I do not think you see it that way. I am not sure I see it that way, but I want to again emphasize the importance of this.

The Blue Water Navy veterans in my State—I have, like so many of you, done a number of roundtables, and my staff has done a number. We have done close to a dozen in the last several months. Blue Water Navy veterans comes up in every single one of these in every part of my State.

They have read the Institute of Medicine reports. They know the science inside and out. They see the VA, in their minds, turning their back on them. Again, I know that is not your intent, yet, I think to them, it looks that way.

I wonder, Mr. Chairman, if I can enter the IOM reports into the record?

Chairman ISAKSON. Without objection.

[The submitted reports, due to their volume, are not being reproduced here, but can be accessed at http://nap.edu/13026 and http://nap.edu/12662.]

Senator BROWN. Thank you.

I know the letter, the September letter that you sent to the Chairman, there is inconsistent evidence that Blue Water Navy veterans were at higher or lower risk than shore-based veterans. Mention the presumption of exposure of military personnel serving in those vessels is not unreasonable. I know about the 12-mile limit. I know that is an issue here.

I also know the battles that on presumptive eligibility, not just the beginning, but every time with Secretary Shulkin and his predecessors, your predecessors, we added to the presumption eligibility list.

I know that most of us around this diaz will not let this drop; we will keep the pressure on you. It is part of your job as a public official. You used to keep the pressure on the VA when you sat here with Senator Tillis and prior to that in your job. I think that there are a few things this Committee can do that are more important than that.

I appreciate Senator Tester's guidance on this and his relentlessness also, so thank you for that.

In the last couple of minutes, I want to—on a different topic, Mr. Chairman—raise my concern about—and I mentioned this in my

office too—how the VA has implemented the Accountability and Whistleblower Act. We moved this legislation last year. We intended for VA to use the authority to discipline employees who had egregious offenses, as VA should.

I have some concerns that VA has used this new authority to fire low-level employees with marginal offenses, not the senior managers who have had egregious offenses. 2,700 employees have been fired since last July. I am not arguing that most of them did not deserve it. I am arguing, though, that the focus needs to be on the most responsible, committing the most egregious offenses, that had the most impact, and that is almost by definition, in many cases, the senior members.

I have heard facilities are no longer using performance improvement plans or progressive disciplines. I ask if you would commit the VA will once again use these tools to address employee performance instead of firing for a single offense.

Secretary WILKIE. We are going to hold our employees to the highest professional standards. I am looking at new ways to evaluate performance.

I do want to say that we are unique—and I apologize for taking more time. We are a unique Federal Department. We have three offices that are symbiotic, but they all are focused on the same thing. We have a general counsel. We have an Inspector General, and we have the Office of Accountability and Whistleblower Protection that was set up by this administration.

They are all designed to address employee misconduct. They are also designed to protect employees from retaliation who legitimately blow the whistle on bad acts.

Let me talk quickly about the Office of Accountability and Whistleblower Protection. That is designed to deal with employees at the GS–15 level and above.

Right now, I believe there are about 280 investigations of GS–15-level employees and above. I am proud of that because I think that also meets the intent of the Congress.

Last year, about 2,500, as Senator Brown said, 2,500 employees were dismissed. I will also note that we do have different conditions here, and I do not mean to cast aspersions on my friends who work at the Department of Labor, the Department of Commerce.

When a junior employee who is responsible for sweeping the floors does not sweep the floors or does not sterilize an instrument, that is all right at the Department of Labor because nobody will notice. If they do not do that in our hospitals, the consequences could be catastrophic. So, we have to hold employees at that level to the highest professional standards.

That said, I am going to ensure that our Office of Accountability and Whistleblower Protection continues to evaluate and reevaluate those employees at GS–15 and above. That has the double advantage of keeping their feet to the fire, but also sending a message down the ranks that there are—as we say in the military, "There are not different spanks for different ranks."

Senator BROWN. Thank you.

Mr. Chairman, if I could have 20 seconds just to sum up. Thank you.

You know what—it is because you know so much about the VA even before you took this job. You know the importance of whistleblowers in Cincinnati and Dayton; and those were terrible situations. Because the whistleblowers came in and the meetings that my office had and those I personally had in hotel rooms and in all kinds of places to talk about the problems with safety and to talk about the problems of accountability made a huge difference.

The VA was helpful in it, but it was the whistleblowers that drove it. They were of all ranks, and protecting them is essential. Many of them were veterans, as you know. It really did make the VA hospitals in those two cities operate more smoothly and more efficiently and more humanely for veterans, so thank you.

Secretary WILKIE. Yes, sir, I agree.

Chairman ISAKSON. Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair.

And, Secretary Wilkie—I will refer to Robert Wilkie real quick. The fact that your wife is here does not mean this is a date. [Laughter.]

I am sorry I was not here for your opening testimony. I am cochairing a committee hearing on cyber and personnel.

The one thing I want to say about the discussion on blue water, I fully expect the past is prologue, and when you were in my office, you were very much a part of the effort to get us to the right place on the Camp Lejeune toxic substances. That is an area where we were at odds with the VA. That is an area where we looked to outside expertise to come up with a rational basis for a presumption, and we made progress there. I hope it is in that same spirit that you are able to make progress and also address the legitimate concerns of some of the VSOs with respect to once we identify what the need is and once we start expanding presumptions, that we also fund it in a way that is not at odds with other promises that we have made that we need to fulfill for our veterans.

Secretary WILKIE. First of all, Senator Tillis, thank you.

I will add that there was an addendum to that agenda that you had. You and Senator Klobuchar were responsible for creating the registry for those who were exposed to burn pits in Iraq and Afghanistan. We worked across the aisle to set the stage for science and funding for those who were exposed to that.

I mentioned, I think before you came in, to Senator Tester that I have spoken to General Petraeus about the burn pit legislation.

So, the same standards that you apply, the same standards that you had me apply in development of the Camp Lejeune situation and the burn pit legislation apply here.

Senator TILLIS. I also want to thank you about Hurricane Florence. We received a call, and we were concerned with the storm headed toward Wilmington and other areas, like your hometown of Fayetteville, with very high veteran populations. We were concerned with whether or not those receiving care there—dialysis and a number of other things—if we were going to have continuity of care, and the Department was well ahead of it. I commend you for doing that. That has not always been the case in every disaster response.

One question I would have for you is that after action, if you take a look at the areas that are most prone to these sorts of storms, they happen to be the States with some of the highest concentrations of veterans.

So, what did you learn from that? Maybe what other things should we look at in terms of authorities or things that we can do to be as prepared for the next storm as you all were for Florence?

Secretary WILKIE. Well, I do want to say that I was amazed, being a North Carolinian, of the response, by the Federal Government and the State government. I told Governor Cooper that as well.

I am actually going down to Wilmington on Monday to take a look at our clinic. It was under water, and I am going to evaluate what the future is there. The same applies to Morehead City.

I think we need to do a close look at where some of our facilities are located. We have the benefit in Fayetteville when the Cape Fear crested at 63 feet above flood stage, the VA hospital was at 142 feet above the river. That does not always happen.

But, I want to take a look at the way we position our clinics. That might involve looking more closely at the opportunity to lease facilities away from the danger zone, and I also want our people to take a close look at our facilities and their ability to withstand storms.

The good news in North Carolina is that other than Wilmington, two clinics in Jacksonville, and then one in Morehead City, everybody else is up and running.

We did send three mobile medical units to Wilmington, so they are addressing the needs of the veterans there. I am very proud of the response VA gave.

Senator TILLIS. Well, thank you for that.

I also wanted to briefly touch on the electronic health record. The governance structure you have here is something that I am familiar with. I am glad to see that.

I think that I would also probably just submit a question for the record, or perhaps you and I can just talk. I am also interested in the MISSION Act and some of the change management initiatives that you have going, separate from the electronic health record, but I know you are taking a look at what I think are some fundamental changes in organizational structure that is going to be helpful for the whole of VA.

So, tell me a little bit now about the DOD/VA relationship; how well that is going. We have got a learning over in DOD from the electronic health record. We are going to have an opportunity to see a life-cycle view of a soldier to a veteran after this gets implemented. Can you give me a little idea of how that collaboration is working and how we are for the Pacific Northwest VISN 20 implementation?

Secretary WILKIE. Well, you see, I think this was a chart that Senator Cassidy has. You do see that there is now cross-pollination. We are in the process of formalizing a structure, and before we finish formalizing that, I will make sure the Committee has insight into that and will be able to review it.

I said during my confirmation hearing, my instructions from—and I will call him General Mattis now—when I left the Depart-

ment was that we needed to be joined at the hip on this. General Mattis uses the VA in Washington State, and he has a personal commitment to making sure that this works. I do envision us being joined together because it will not work if one of the two halves inchoate.

So, I will get back to the Committee. Our two staffs are working on this. I will sit down with Secretary Mattis and begin the formalization of the structure fairly soon.

Senator TILLIS. Thank you.

Chairman ISAKSON. Mrs. Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman.

Thank you, Mr. Secretary. Thank you for being here.

Let me just start with a huge frustration of mine, and that is with ongoing delays in the construction of new clinics in Washington State. It has taken almost 9 years—9 years to get a new CBOC opened on the Kitsap Peninsula.

The needs of community have changed, and the VA now expects this facility to be at complete capacity on the day it opens. Our veterans have been waiting for years to get this open, and they have heard promise after promise after promise from the VA over these years.

Can you personally make sure that this and other facilities are completed right away and review the Department's performance on this as well? Because we have got to hold people accountable for this.

Secretary WILKIE. Yes, Senator. I am actually headed to Washington State in a couple of weeks to look.

Senator MURRAY. At the Kitsap Peninsula CBOC in particular?

Secretary WILKIE. I did not hear the last part.

Senator MURRAY. Kitsap Peninsula CBOC in particular?

Secretary WILKIE. I will be discussing that with the VISN leadership.

Senator MURRAY. OK.

Secretary WILKIE. I think that is important because people think of the Southeast as the growth sector for VA, but Washington State in the Pacific Northwest has a very important—and I think unmet—need.

Walla Walla is a continuing issue. Actually, Walla Walla was the reason I said at one of the VA conventions that we have to give our directors in the regions more authority to relocate and evaluate and then change——

Senator MURRAY. OK. Well, on this one in particular, if you are going to be out there——

Secretary WILKIE. Yeah.

Senator MURRAY [continuing]. I want to find out what you said to them.

Secretary WILKIE. Yeah, absolutely.

Senator MURRAY. I need to get this done.

OK. Let me ask you about a completely different direction. Six weeks ago, I sent you a letter about my concerns over the reports of private well-connected individuals known as the "Mar-a-Lago

crowd," who are exercising wildly inappropriate influence over the VA.

It is entirely unacceptable for the VA to put those people's interests before what is in the best interest of our veterans. I believe that is something you agree with. So, we need to see steps taken to correct that right away.

Plus, the Department has to be transparent about this. So, I wanted to ask when I would get a response to my letter.

Secretary WILKIE. Well, I did not know it was in the works, but I will give you my response right now.

I agree with you about outside influences. I also listen to a lot of people with opinions. A lot of those stories took place before I became the Secretary.

Senator MURRAY. Right. I know.

Secretary WILKIE. I am also committed to making sure that I am the sole person responsible to you.

Senator MURRAY. OK. Are there any VA officials consulting with the Mar-a-Lago crowd now?

Secretary WILKIE. Not that——

Senator MURRAY. Have you met with them?

Secretary WILKIE. Not that I know of.

I have met—I met with them once for an hour when I was at Palm Beach, the first week I was Acting. I have had no connection with them since then.

Senator MURRAY. OK. So, the question is, can you assure this Committee that there will be no inappropriate interference?

Secretary WILKIE. Absolutely.

Senator MURRAY. OK. That is important to all of us.

And, if you can respond to my letter——

Secretary WILKIE. Yes.

Senator MURRAY [continuing]. I am looking to the data and records on that as well.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Secretary Wilkie's September 14, 2018, response to Senator Murray indicated: "This is in response to your August 17, 2018, letter to the Department of Veterans Affairs (VA). I want to assure you that VA takes very seriously its responsibilities to comply with the law and its obligation to respond appropriately to Congressional requests for information. The matters about which you inquired in your letter are the subject of ongoing litigation alleging violations of the Federal Advisory Committee Act and, therefore, not appropriate for release at this time."

Senator MURRAY. Let me ask you about homelessness, which I know is something you care deeply about, and is a priority for you to end veteran homelessness, but I am really concerned about the VA's focus on this issue because it has fallen off in recent years.

We have seen the VA now try to divert funding away from homeless programs. Program providers actually in my homestate are losing funding, and despite some of the VA's promises to help target Seattle by surging resources to the area, we are not seeing that come through on the ground.

I was really troubled to learn at many of the facilities in Washington are failing to actually use the HUD-VASH vouchers often, and they tell me it is because they do not have enough case managers.

So, this has got to change, and I wanted to know when we are going to see the plan and resources in particular to address Seattle's serious needs and how you are going to make sure there are enough case managers.

Secretary WILKIE. The case managers are part of a larger issue that we have in retaining those people particularly in the social work field, and that is a target for us when it comes to hiring.

I will tell you that we are going to put the word out that we need to make maximum use of those HUD vouchers.

I have a meeting coming up with Secretary Carson, I believe, in the next week or so to discuss that.

Senator MURRAY. OK. Can you get back to me on that?

Secretary WILKIE. Yeah.

Senator MURRAY. Because that is critically important, and I am deeply concerned that they are not being used. Then, the report back is that they do not need them. That is not the case. So, we need that rectified.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Please see the answers to Question 1 above, which addresses the plan for Seattle as well as for addressing hiring and voucher use in HUD-VASH.

[Specific voucher use figures are in the posthearing responses.]

Senator MURRAY. I will also add my concerns about the electronic health records. As you know, my State was one of the first locations to deploy that with the Department of Defense, which was a $4 billion investment. I heard about misdirected referrals, long waits, staffs that could not open the programs in a timely manner. There was inadequate training. There was consideration of taking money out of local budgets to supply the implementation training, which was really not done well and lives were really put at risk.

I just want to make sure that the problems at DOD are not repeated as you move forward. We are going to be following this really closely and expect to be kept up to date on any challenges that you have to assist this implement.

Thank you.

Secretary WILKIE. Thank you.

Chairman ISAKSON. Senator Boozman.

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

Senator BOOZMAN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here. We appreciate your continued commitment to serving. I know that you are working very, very hard in that direction.

We have seen reports detailing challenges veterans face when using the GI Bill. In some instances, the VA underpaid some 340,000 GI Bill beneficiaries for their housing allowance.

In your testimony, you mentioned that IT challenges contributed to the situation, and that there is an ongoing task to find a suitable solution. When can we anticipate the conclusion of the testing, and how quickly will a solution be implemented?

Also, in the meantime, what is the plan and subsequent timeline for compensating those students who are underpaid, and will any student who received an overpayment through no fault of their

own—are we going to go back and are they going to face a debt owed to the VA?

Secretary WILKIE. Senator, the GI Bill issue is an important one.

In the issue of full disclosure, my son uses the post-9/11 GI Bill.

Let me tell you what has happened in terms of benefits flowing to beneficiaries. The housing payments are still going out. What is not going out is the increase, the cost-of-living increase, which comes out at about a half of 1 percent. So, the GI Bill beneficiaries are being paid their housing allowance, but it is on 2017 levels.

When we get the computer system right, we will repay those GI Bill beneficiaries. I think it will come out to about $69 a month because it is, as I said, it is zero—it is half of 1 percent.

This points to a problem that Senator Tester mentioned at the beginning of the hearing. We received the instructions from Congress on the Colmery Act, and those instructions were—they attempted to implement them on a 50-year-old computer system. Even something as simple as changing the percentages broke the system. It is part of a larger issue that we have to get right.

I will also say that one of the benefits of the GI Bill that this Committee worked on—and it is a good news story—is those veterans, both active and veteran, who are part of a college program or a pay-for-fee program that fails, we will not penalize them. We will make them whole. They will not lose those months. We will make sure that they can get the best education that they can, and that is the other part of the story that we are working on.

Senator BOOZMAN. Very good.

Senator Heller mentioned that the President signed the VA MilCon bill. In it was included $1.25 billion more than the VA requested for medical services and medical community care.

The new legislation requires the Department to provide monthly reports to the Committees, identifying obligations for the medical community care program against available appropriations, as well as anticipated funding needs based on the developing program structure.

As you noted, the MISSION Act provided $5.2 billion to continue the Choice Program through June 6, 2019. Based on the VA's current estimates, is this funding, combined with the recent appropriation, sufficient to support medical community care through the fiscal year? If not, how does the VA intend to address any possible shortfall?

Secretary WILKIE. Yes, sir. I will tell you I believe it is sufficient for this fiscal year.

When we begin the series of briefings, I believe we will begin to talk about all the changes that will come that will affect fiscal year 2020 and beyond, but, no, I believe it is sufficient right now.

We have to get a handle on, as Senator Tester sent to me in a letter I believe last week, overpayments and underpayments which affect community care. That is something I am working on now.

Senator BOOZMAN. Very good.

Thank you very much. We do appreciate your service.

Secretary WILKIE. Thank you, sir.

Chairman ISAKSON. Senator Hirono.

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

Senator HIRONO. Thank you, Mr. Chairman.

I realize that the VA continues to be against the Blue Water vets being included in the presumptive eligibility list, but when Congress enacts such legislation, can we get your commitment that you will do everything possible to enable and facilitate these veterans to get the care that they need?

Secretary WILKIE. Well, Senator, I grew up in this institution, and you reminded me of that at my confirmation hearing. Article I is gospel. What the Congress says, I will carry out.

Senator HIRONO. OK, good. A strong yes.

You were asked by Senator Murray about this, but some of us also wrote a letter to the Chairman that we would like to have a hearing, an oversight hearing regarding reports of ongoing—what we would consider inappropriate influence of your Department with the few people from Mar-a-Lago.

So, I am going to take this opportunity to ask you some questions about the interactions with Ike Perlmutter, Marc Sherman, Bruce Moskowitz.

You noted that you met with them for 1 hour, but when you were confirmed as Secretary, Mr. Sherman was—on the first day of your being Acting Secretary, Mr. Sherman was waiting for you in your office. Can you tell us what was discussed at that meeting with Mr. Sherman?

Secretary WILKIE. What was discussed was somebody I had never met before who was standing there and told me for whom he worked, and I listened. I said, "Thank you." I am always happy to listen to anyone who wants to talk about veterans.

I was not familiar with what was going on. Again, it was my first day, and in terms of a formal meeting, I believe I spent an hour when I was down at the Palm Beach VA at my first week.

Senator HIRONO. So, what was that 1-hour meeting about?

Secretary WILKIE. That was actually about the electronic health records, and if I am going to believe the media stories that the folks I talked to were against it, then I went against their wishes because I approved it 2 weeks later.

Senator HIRONO. So, was Dr. Moskowitz at that meeting? Because he had some interest in the electronic health records. That subject must have come up.

Secretary WILKIE. Yes. There were several—I think there was a Marine general and a couple of other veterans there.

Senator HIRONO. So, you are going ahead, obviously, with an electronic health records program that is long in coming.

You just testified right now that you had no further interactions with these three people; by the way, when you met with any of them, did the subject of privatizing VA come up?

Secretary WILKIE. No.

Senator HIRONO. Since you yourself have not had any further interactions with them, though, have any of your other high-level decisionmakers at the VA been having meetings with these three people?

Secretary WILKIE. Not that I know of.

As I mentioned at the beginning, we have a completely new leadership team in place; everyone from the chief of staff to the Under Secretaries, so a completely new—completely new leadership team.

Senator HIRONO. So, as far as you know, none of your high-level leadership people have been meeting with these folks.

So, does the type of interactions with members of Mar-a-Lago reported by *ProPublica* violate appropriate standards of transparency? Because you have testified that transparency is very important and accountability at the VA is very important to you.

Secretary WILKIE. Well, that is right, and I believe I have laid out everything that went on as a result of my meeting and went against what they were advocating.

Senator HIRONO. Well, I hope that is made clear to them because it certainly seems as though they just weighed in as though they ran the place.

As Secretary, you are responsible for managing over $1 billion in funding to assist homeless veterans and their families, and we have made progress. But, we are not there yet.

You did not mention homelessness in your testimony. Could you provide to the Committee where this issue of veterans homelessness falls on your list of priorities and what your plan is to end veteran homelessness and also improve the transition process to prevent homelessness of veterans?

Secretary WILKIE. Well, it is very important, and I mentioned earlier that on the issue of Blue Water Navy, our veterans homelessness problem impacts a community that I am very familiar with and very close to, more than any other, and that is Vietnam era.

We are working with HUD. We are also working with State and local communities on the issue of homelessness. We are funding homes and projects across the country to get homeless veterans off the street.

In North Carolina Senator Tillis and I worked on the creation of a program that gets them off the street and gets them sober and with a job.

Senator HIRONO. Can you tell me right now how many homeless veterans there are?

Secretary WILKIE. I cannot tell you that number because it changes every day.

Senator HIRONO. I do realize that, but give and take, the number?

Secretary WILKIE. No, I cannot because we do not know. We just do not know.

We have the same problem with homelessness that we have with suicide. The tragedy in our Department is that every day 22 veterans commit suicide, yet 14 of those veterans are outside of our purview.

Senator HIRONO. I think that, Mr. Chairman, if you do not mind, because this is an area that we really need to provide, as far as I am concerned, more focus. Whatever efforts you are making to reach out to the veterans, I think that is important. I would like to know what you are doing along those lines——

Secretary WILKIE. Yes.

Senator HIRONO [continuing]. And some numbers——

Secretary WILKIE. Right.

Senator HIRONO [continuing]. As to how many veterans——

Secretary WILKIE. I will get you——

Senator HIRONO [continuing]. Are being helped.

While I am at it, I just would like to have you continue to make sure that you implement the VA telehealth bill that Senator Joni Ernst and I were really pushing for.

Secretary WILKIE. Very important for mental health.

Senator HIRONO. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you very much.

I want to introduce Colonel Sullivan of the U.S. Marine Corps who was yesterday promoted in the Mansfield Room. I happened to be there, and he looked great in his uniform, with all his family. We are proud of you.

Before you start, I want to get up for a second because I have got to make a phone call. So, in case I am not back when you finish, Senator Boozman is going to conduct the rest of the meeting.

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

Senator SULLIVAN. Well, thank you, Mr. Chairman. I appreciate you being there and so many of my other colleagues.

Mr. Secretary, welcome back. I am glad you are on the job. I know it is not an easy job and probably one of the hardest jobs in Washington, if not the hardest job in Washington, but probably one of the most important jobs. I personally am glad you are there.

I want to talk to you about a couple of specific Alaska issues. One of the things that you committed to me on is getting up to the State, my State, soon in your tenure. I know your staff and my staff have been looking at possibly confirming dates for the third week of October, and as luck would have it, that is when the Alaska Federation of Natives is going to be meeting in Anchorage. So, that is the large—AFN is an annual meeting. It has all of our—thousands and thousands of Alaska Natives, who constitute almost 20 percent of the population in my State, meet together.

Very importantly from the VA perspective, these are some of the most patriotic Americans in the country. They serve at higher rates in the military than any other ethnic group, such as Native Hawaiians and American Indians. Decade after decade, even though, let us face it, after World War II or Korea or Vietnam, they came home to a country that did not always treat them so well.

So, I would welcome your commitment to participate in this conference, whether by giving a speech, or convening in that Native Alaskan veterans roundtable with me, or both. Of course, we will coordinate with the executive director of that organization, but I think they would be excited, particularly given how many veterans you will see. You will have an opportunity to meet literally with thousands of Alaska's finest, most patriotic citizens.

Secretary WILKIE. Senator, I am planning to be in Alaska for several days, including that conference. I will actually be in Anchorage the day before the conference convenes, and I am looking forward to that. So, I will be there for a while.

Senator SULLIVAN. OK. Well, let us try to work together and get—it is a great opportunity, and it is fortuitous timing.

Let me talk about another issue, both kind of at the national level, but again, also an Alaska issue. One of the important issue that we addressed in the MISSION Act was prompt payment for providers, which has been an issue that has bedeviled the VA. As you know, it has a real negative domino effect because you have these providers who want to serve veterans, and then they are not getting paid on time. They have problems meeting their own payrolls, and the next thing you know, they are turning away veterans, even though they do not want to turn away veterans.

So, the MISSION Act establishes a prompt payment standard. I want to get your views on how you think that is going. Granted, we just passed the bill. The President signed it just a couple months ago.

More specifically, I have a constituent, Joyce Abangan, and her husband, who is a 21-year veteran, lieutenant colonel, U.S. Army, two combat tours. They are small business owners in Alaska. They have an operating home health agency that has a backlog of pay of over $100,000 with the VA, and they are getting ready to do what other providers have to do, which is turn away veterans because they are almost—you know, they are having a hard time.

I would like to get your commitment to work with me and my staff on that specific one, but more broadly for this hearing and the other Senators here, how is that going? It is such an important issue. I know you cannot turn on a dime on it, but, boy, it is really important. Now, it is in law. I mean, you have to do it, so I would like an update on that.

Secretary WILKIE. Senator, now we are turning. MISSION does not work unless we have that relationship with particularly small-town providers, small-town community hospitals.

Senator Tester sent me a letter about Health Net, and I think this change answers in part his concerns, which is a concern particularly for the West.

That provider is on the way out. They stopped getting new authorizations 2 months ago. VA has had to pick up the slack. A few months ago, VA was adjudicating 100,000 of these small provider claims. We are now up to 700,000 a month. We are working as quickly as we can to do that, and that will hopefully accelerate when we get a new vendor on board. But, it is a terrible problem, and if it does not work, MISSION does not work.

Senator SULLIVAN. Well, let me just real quick on that—we have TriWest. I do not know if it has the same issues as HealthNet, but it is part of the network. If I can get your commitment, your staff's commitment to help my staff and I work with this one group, it is exactly the kind of people we want to keep in the system, not have them walk away. They are veterans themselves, and 100 grand for a small business is——

Secretary WILKIE. It is devastating.

Senator SULLIVAN. Yeah, devastating.

Let me ask just one final question. How is morale overall? The one thing I always liked—you come in here a lot of times and get the crap kicked out of you and everything, as do the other employees. But, the vast majority of the VA, the vast majority of the employees who care are focused on vets. I know that is the case in Alaska.

A big part of leadership is morale, so how is it with regard to your employees? Because we need to know that, too.

Secretary WILKIE. I will let others make a more definitive statement.

I will say that VA is calm. A lot of my first objectives was to do what Marines do—Air Force guys do not do it as much—that is, walk the post. That is why I have been across the country, to be seen and to talk to the people who work in VA.

They have gone through a lot. I am going to refer back to something Senator Tester said in the debate on my confirmation on the floor. Their lives have been upset by an agency that has been run by—I think you said anecdote—and the individual story that sometimes does not apply across the Department.

I will continue to walk the post, and when the opportunity presents itself, I will tell the good news stories. I will also tell the truth. As I said at the beginning, the state of VA is better. I did not say good or excellent. It is better, and I do think we are headed in the right direction.

Senator SULLIVAN. Great. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you.

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

Senator MANCHIN. Thank you, Mr. Chairman.

Secretary Wilkie, it is good to have you. I wanted to say that my reports have been excellent, the job you are doing, the changes you have made, and basically the care that you have shown for the Vietnam veterans.

With that, I just wanted to discuss—a couple of subjects, basically. We are all concerned about the Blue Water Navy. We all have Vietnam veterans. West Virginia has more, unfortunately, veterans on the Vietnam Wall than any State per capita. So, we have all given.

Anyway, I want to talk to you about the number of electronic health records, things that we have done over the years that have not seemed to work that well. I think you know that. They include the joint program of DOD called—the new one now called the Integrated EHR to replace the separate EHR system with a single shared system.

On that, the integrated system was abandoned in 2013, and the Secretaries of VA and DOD announced that they would not continue or develop this joint system.

Once again, VA has announced its intentions to establish an electronic health record system that is interoperable with DOD, and that is through a $16 billion contract, as you know, with Cerner Corporation. However, the DOD's initial rollout of Cerner's system in four medical facilities was plagued with significant problems.

So, with the way that this is rolling out—VA is starting with the rollout on the West Coast and moving East. By the time it gets to West Virginia, that will be 2023.

So, we have to work with the system at hand, which is the VistA system, and I need to know how are you all working with that. Are you able to maintain and keep that system up until you integrate the other system?

Secretary WILKIE. EHRM is an iterative process, and it is going to take time to get it online. We will have the other systems in place to mitigate.

Senator MANCHIN. VistA will stay in place?

Secretary WILKIE. I believe. I will have to get——

Senator MANCHIN. You can get back with me. I know, yeah.

Secretary WILKIE. Yeah, I will have to get back with you on that as to what exactly will happen.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOE MANCHIN III TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Yes, VistA will stay in place until the Cerner rollout is completed.

Secretary WILKIE. I will say something about the failures of the testing in the Pacific Northwest. My last job at DOD was—I was the head of Secretary Mattis' close combat task force, and we were evaluating weapon systems and computer systems that we would deploy with Marine infantry, Army infantry. We would not give them a weapon or a system unless we tested it. And, we tested it for mistakes.

My understanding of what went on, on the DOD side, is that they were testing it for mistakes, and they found them. I would rather find them there than down the line after we spent the $16 billion that you talked about.

My pledge is that we are going to be joined with DOD to make sure that this works and not just interoperable between DOD and VA, but if we are going to make MISSION work, we have to make the electronic health record interoperable with private pharmacies, small town doctors, hospitals in the community. Without that, MISSION does not work. So, we will be giving you regular updates.

Senator MANCHIN. Let me roll into something else because you know my really major concern has been the opioid addiction that we have and our veterans have been plagued with. I think we all know how some of that has perpetuated.

A study published August 2018 in the *Journal of Health Services Research* examined the numbers and times of opioid prescriptions filled for post-9/11 veterans at VA and non-VA pharmacies. They used the ones in the State of Oregon. It was a small study, but it was basically a study. It found that 15 percent of our veterans who filled a prescription for opioids at a VA pharmacy had also dually filled a prescription in a non-VA, and that is not just veterans. I mean, everyone, when they get addicted, they will do whatever it takes.

The likelihood of having those concurrent opioid prescriptions increased if the veteran was enrolled in the veterans Choice Program. You are aware of that. OK.

So, given the expansion of the community care expected with the VA MISSION Act, I guess, what does the VA plan to do to monitor prescriptions of potentially dangerous drugs?

Here is the thing that we said. I found out when I went to the veterans hospital—we have four in West Virginia—one, in particular, I was talking to the head nurse and I said, "How is our problem here?" and she said, "It is the same everywhere. It is severe." She says, "If you all would quit calling and raising Cain

about what we do and let us do our job, we can cure this a little bit better."

So, what happens is an addicted veteran calls a Senator or Congressperson raising holy Cain that they are not getting what they demand. So, we took that—we have taken that away from where we are rating how our VA veteran hospitals are going along with our regular hospitals. They get rated on reimbursement of Medicaid and Medicare.

Can you just check on that, sir? I know this is something new, but this opioid addiction is affecting our veterans. They should never be in this position to where we cannot get them back into a useful, productive life.

Secretary WILKIE. I agree with you.

Mr. Chairman, may I have a minute or so to fully answer?

Chairman ISAKSON. Let me say this. Senator Blumenthal just came in.

Secretary WILKIE. OK.

Chairman ISAKSON. He is going to have his chance. Senator Cassidy has been waiting a long time, and a lot of people got here early and took care of their business. So, let us be as quick as our 5 minutes as possible and be respectful for the people who have stayed.

Secretary WILKIE. Yes, sir. I will do it fast.

That is one of the beauties of electronic health record as I see it——

Senator MANCHIN. Yes.

Secretary WILKIE [continuing]. Is that with the interoperability, a veteran will no longer be in the position of getting opioids from a private doctor or hospital and then going to the VA and getting Ambien or another opioid because once that happens, a system kicks in, and red flags are raised. VA knows that that veteran is now on the spectrum.

Second part is I am talking to the President's opioid conference on Friday. I am going to talk about the good news at VA. We are doing groundbreaking work in getting our veterans off of opioids using things as simple as aspirin and Advil—they work just as well—and also rehabilitative therapies, orthopedic therapies.

We are getting the opioid addiction down in the VA system, and we still have a lot more work to do.

Senator MANCHIN. I appreciate this. This is a serious problem.

Secretary WILKIE. Thank you, sir.

Chairman ISAKSON. Thank you, Senator Manchin.

Senator Cassidy.

HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Yeah, several things. First, Secretary Wilkie, good to see you.

I thank the Chair for acknowledging the Blue Water issue at the outset and look forward to its resolution.

I also want to thank you. Again, you do take a fair amount of fecal material, as Colonel Sullivan said, but——

Secretary WILKIE. That is how the Air Force would describe it. He would say it is something different as a Marine. [Laughter.]

Senator CASSIDY. But, again, thanks for your support in the Preventing Veterans Death of Despair Act, which I will be introducing shortly. Your guys have worked extensively with us; it is a common mission, so thank you for collaborating.

Now, there has been a lot of conversation here on EHR. As a doc, of course, I am interested in it. I am just going to touch on a couple of things since you and we have all discussed the history so much, and then I would like to go a little more deeply because part of it involves what we, the Congress, have directed, which does not seem to be fulfilled. Not your problem—no, not your fault, but now your problem.

Just a couple things to point out. 2008, the NDAA established a joint Interagency Program Office, the IPO, to act as a "single point of accountability for the electronic health care exchange efforts." Fast forward, we have expanded it over time.

In February 2014, GAO reported that the VA and DOD had not addressed management barriers to effective collaboration. The IPO lacked effective control over central resources, such as funding and staffing, and decisions by both the VA and DOD had diffused responsibility for achieving integrating health care records, potentially undermining the IPO's role as a single point of accountability, so VA and DOD diffusing authority, even though Congress said IPO should have that authority.

Now, in May 2018, OMG, the VA gives Cerner a contract for $10 billion within this context of diffused responsibility.

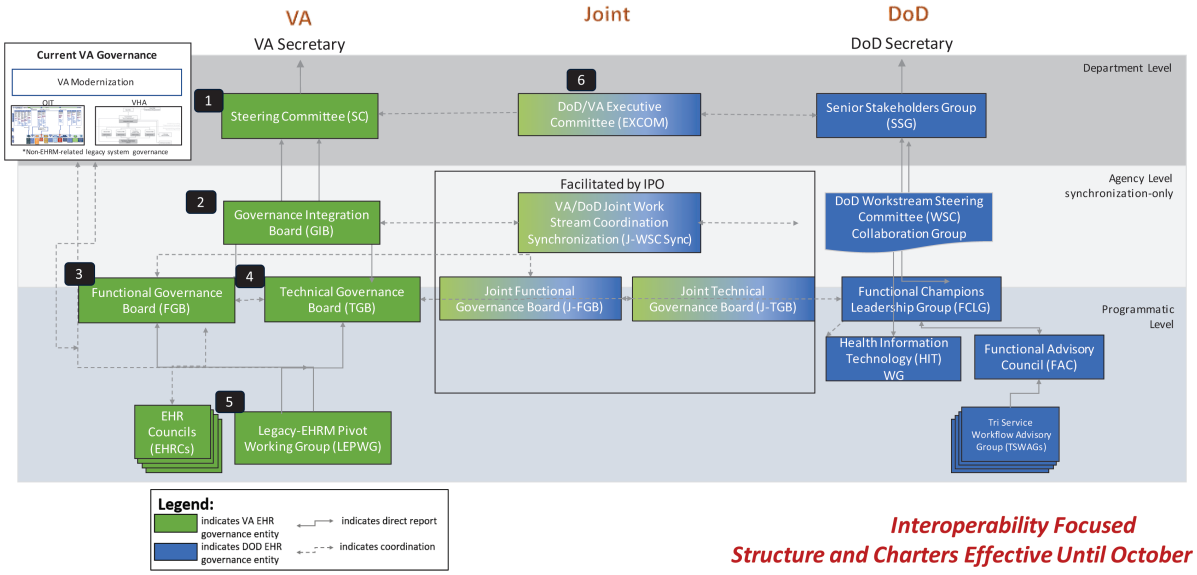
In September 2018, GAO reported to HVAC that the IPO has not been effectively positioned to be the single point of accountability as mandated by the NDAA fiscal year 2008.

Now, their recommendations, the Secretary of Veterans Affairs should ensure that the role and responsibilities of the Interagency Program Office are clearly defined within the governance plans for acquisition of the VA's new electronic health care record.

So, I can now kind of wrap this up and bring it into your comments.

May I see the chart, please?

Governance: Intra and Inter Agency



Interoperability Focused
Structure and Charters Effective Until October 1, 2018

Senator CASSIDY. This was given to HVAC by the VA, and, Mr. Chairman, if you do not have a copy of this—you can see that there is a blend here. This is facilitated by the IPO, and this is the joint work between the two, the VA and the DOD. There is no dotted line going up to the VA executive committee. It is operating merely as "Hey, do you mind giving somebody a call?"

Similarly, the DOD/VA executive committee does not appear to have you or your deputy on it. So, this is not within the highest reaches at least in the VA regarding responsibility.

Even like the language "facilitated by IPO" is not exactly what Congress had in mind. They wanted it to be the single point of authority and not a facilitator who I tend to think of as lacking authority, except why do we not all do it together?

So, I did not mean to bump you. I am sorry.

First, what is your response to the GAO's assertion that there is a critical need for a single point of accountability for VA and DOD's interoperability to be successful?

Second, why is the VA/DOD executive committee, the highest joint committee, not the top leadership of the two Departments? This is a $10 billion contract, just for one of them. Best I can tell, your office is not on that crew.

Third, how do you respond to the GAO's assessment that the IPO's role and responsibilities is not clearly defined and not effectively positioned to be the single point of accountability?

And, last, what are your plans to strengthen IPO's position to be that congressionally mandated single point of accountability and standardization, et cetera?

Secretary WILKIE. Senator, when I came to VA, I realized that it was, as you said, an organization of dotted lines. An organization like that is anathema to someone who has been raised in the military.

My objective——

Senator CASSIDY. The only thing worse than that is no dotted line.

Secretary WILKIE. So, we are in discussions, as we speak, with the Department of Defense to hopefully—I cannot be definitive right now, but we are working on it—make those solid lines and create that one single point of authority.

As to the issue of the deputy, I was able to get an acting deputy just a few weeks ago, put him in charge of our response. I have stated that my goal is to take the ideas that our working group with DOD is working on and take those to Secretary Mattis, so that we come to you with a plan that you all will see and hopefully bless because you are absolutely right. Dotted lines do not work; no lines, worse. We have to have a single point of contact that is responsible to the two Secretaries and makes this——

Senator CASSIDY. It is my experience that unless you empower that IPO person, she or he will continue to be ineffective, and granted, they theoretically would have more authority than you. But, practically speaking, it is going to be you and Mattis.

Secretary WILKIE. Right.

Senator CASSIDY. It is going to be, frankly, your responsibility to make sure that she or he, when they walk down the hall, people

give them the right of way because I understand that she or he represents you. Does that make sense?

Secretary WILKIE. Yes, it does. Yes, sir.

Senator CASSIDY. Then, it is fair to say that your conversations with Mattis will be along those lines to give whomever this is——

Secretary WILKIE. Yes.

Senator CASSIDY [continuing]. That authority?

Secretary WILKIE. Yes. I do not know what we are going to call it, but it is in line, I believe, with the dictates of NDAA from several years ago in that it will have that single office with DOD and VA running the show jointly.

Senator CASSIDY. Then just heads-up—and I know you will do this, but just to say those will be the kind of subjects of my questions going forward.

Secretary WILKIE. Yes, sir.

Senator CASSIDY. Thank you, sir.

Secretary WILKIE. Thanks, sir.

Chairman ISAKSON. Senator Blumenthal.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman.

I know that you talked to Senator Tester briefly about vacancies, and he emphasized to you—and I share this view strongly—that the VA should use resources given to it by Congress to fill those vacancies. Each of us on this Committee are aware of really staggering statistics regarding VA vacancies, 45,000 of them nationwide, 40,000 within the Veterans Health Administration. They are incredibly alarming, and they undermine VA care and services. This challenge has been longstanding in the VA, not new, and in fact, the numbers fail to articulate or portray the real-life impact.

Recently, a VFW district commander in Connecticut contacted me after his counseling session at the Norwich Vet Center. He explained that the center was short a director, an office manager, an outreach worker, and a counselor, and he said to me—and I am quoting—"I feel these staffing shortages directly and adversely affect the well-being and delivery of veterans counseling services to men and women veterans living in this area."

I would like you to commit that the Norwich Vet Center will be fully staffed and capable to delivering effective and efficient counseling services to Connecticut veterans.

Secretary WILKIE. Yes, sir. Senator, you and I talked about Norwich in your office before my confirmation hearing. I do intend to get up to Connecticut and take a look. I am not familiar with all of the details.

I will say on the 40,000 number, on its face, is staggering.

I will also say that if we try to fill all 40,000, we would never get where we need. The issues that you have just highlighted, we have to concentrate on, I think, four areas: primary care; internship, internists; mental health workers; and women's health.

The MISSION Act gives us the tools to help that situation—the repayment of educational debt, our ability to set new salary levels that you would not otherwise have to do in the other areas of the Federal Government. But, the three R's for us are recruit, retain,

and relocate. We have to give our leadership in VA the authority to relocate to places like Norwich. So, it is something I am very concerned about. I agree with you.

Senator BLUMENTHAL. Well, I am going to take that as a yes, that you will make that commitment, and I would welcome your visit to Connecticut to see the VA; that as a yes that you will make that commitment. I would welcome your visiting Connecticut to see the VA Center in Norwich but also in West Haven, where ,as you know—and I thank you—the VA has allocated $17 million to invest in new sterilization equipment in the department which will help resolve the current challenges—I will put it euphemistically—in the sterilizing and surgical commitment due to outdated infrastructure.

I would suggest to you more than just that sort of Band-Aid is necessary. There has to be a rebuilding and a refitting. In fact, there are many more infrastructure challenges to follow at West Haven, and West Haven is only one example of the infrastructure challenges faced by the VA.

As you work with the White House on the President's Budget Request for fiscal year 2020, I hope you have a plan and specific actions for the next 5 to 10 year to invest. It cannot be just 1 year. It has to be a multiyear investment in the bricks and mortar of the veterans' health care system.

Secretary WILKIE. Yes, sir. And, the other thing—I agree with that, and I am taking a close look at the Office of Construction and Logistics. I have made a commitment during my confirmation hearing that I would not produce budget numbers that appear to take from places like VHA to pay for other things.

It is going to be a fine balancing act, but I am going to do my best to make sure that we are balanced.

Senator BLUMENTHAL. Let me ask you finally about the Blue Water Navy Vietnam Veterans Act. I know that you have discussed it with Senators Brown, Heller, Tester, and Tillis.

In the Institute of Medicine 2008 report, as you know, the Committee states, "Given the available evidence, the Committee recommends that members of the Blue Water Navy should not be excluded from the set of Vietnam-era veterans with presumed herbicide exposure."

I want to be clear. You agree with that recommendation, correct?

Secretary WILKIE. I agree that I am going—I am not a doctor, and what I have talked with the Chairman about is that we are going to do everything we can to make sure that those veterans are taken care of with funding and science, and I pledge to work with the Committee.

My concerns were not one of saying absolutely no, because I grew up with those folks who fought in Vietnam as certainly part of my family. I just want to make sure we get it right because we have burn pits that we need to deal with—Camp Lejeune—and I pledge to you to give this my best effort.

Senator BLUMENTHAL. Well, I have to acknowledge that I am somewhat disappointed that you cannot give a yes or no.

Chairman ISAKSON. Let me help you. Can I help you a little bit on this point?

Senator BLUMENTHAL. Absolutely, Mr. Chairman. I always welcome help.

Chairman ISAKSON. You and I have had some conversations, and I have had conversations with every Member of the Committee, I think.

Senator BLUMENTHAL. I know what the conversations have been, Mr. Chairman, and I am really looking for a somewhat less equivocal answer.

Chairman ISAKSON. Oh, I know, but let me get to where I was going.

In my opening statement today—the Secretary and I have met on numerous occasions in the last 6 weeks. I have told him we need to fix the Blue Water problem. He has agreed to work with us to do that.

I realize there are scientific questions. There are policy questions. There are all kinds of questions, but that is an administrative decision the VA made in 1999 and 2002, where people who served in Vietnam in certain places got benefits and other places did not. We need to fix it so that it is equal for everybody, and we are going to do that. He has committed to doing that, working with us to do that.

What I want to do—and I want everybody to hear this loud and clear—I want to do something we can do under a unanimous consent where nobody objects. I do not want to do something that becomes a circus. I do not want to do something that forestalls the decision. I want to do right.

He has agreed to work with us and do that, and I believe the Administration will do the same. I am going to see this thing through, and I am not trying to cut you off. You missed that part of the meeting. I wanted to let you know that was the first item of business we talked about.

Senator BLUMENTHAL. I very much appreciate that point, Mr. Chairman, and I would like to join you in working toward that end, which also recognizes the need of veterans who suffer from other kinds of toxins and poisoning, where, as a matter of fact, you and I have worked together on legislation to achieve that goal because the modern-day battlefield is filled with poisons and toxins and so forth. I recognize that the Blue Water Navy Veterans Act—the Vietnam Veterans Act is just the tip of the problem. But, I do hope we can make some progress on it.

Chairman ISAKSON. Well, we are going to do what I said. We are going to address the Blue Water Navy, and that is going to get done. I am going to see to it. The Secretary is going to work with us, and I hope you will help us get there.

But, I will tell you this. I do not want to open the door to a multiplicity of debates over other things that end up causing us not to get something done. So, we are going to do Blue Water Navy being sympathetic to anything else that is going on. We are going to get that finished because that has been a drag for some time. The House has acted, and it is time we figure out a way that we could work it out so it is the best that we can possibly do and get it done.

Senator BLUMENTHAL. I thank you. By the way, Mr. Chairman, I do not think there is such a thing as beating this horse too much.

I do not think—and I say that for the benefit of my friend, Senator Tester, to use the farming analogy.

Chairman ISAKSON. Vernacular. I understand.

Senator BLUMENTHAL. But, I open with a quote to the Institute of Medicine, which is a scientific body——

Chairman ISAKSON. Right. I realize that.

Senator BLUMENTHAL [continuing]. To the effect that their recommendation is that members of the Blue Water Navy should not be excluded from the coverage here.

Chairman ISAKSON. I agree with that.

Senator BLUMENTHAL. I just want to close, Mr. Chairman—because I am over my time, and you have been very gracious—by saying that I hope that data privacy and security against foreign influence campaigns is high on your list of priorities, Mr. Secretary, because there is certainly evidence that during the election, Russia promoted disinformation that specifically targeted our military and veterans. As we go into this next election, it is highly relevant and important.

I hope that the VA cooperates with social media and tech platforms to address these threats.

Thank you.

Secretary WILKIE. Thank you, sir.

Chairman ISAKSON. Thank you, Senator Blumenthal.

Thank you, Mr. Secretary, for your attendance and your thoroughness. We appreciate it very much. I look forward to working with you ahead on Blue Water Navy and the other things we have to do together for the men and women who have served and represent so well.

Is there anything you want to say, Ranking Member?

Senator TESTER. Just one thing, which has to do with the MISSION Act implementation and the Under Secretary for VHA. Do you have somebody in mind, and when do you anticipate we will see them in front of this Committee?

Secretary WILKIE. I am looking. I am very happy with the executive in charge. You all have met Dr. Stone, Army general.

Senator TESTER. Yeah.

Secretary WILKIE. I have pledged to you that I would get somebody in that position as quickly as I could. I did, and now we are working on the confirmation.

Senator TESTER. OK. Thank you very much.

Chairman ISAKSON. We stand adjourned.

[Whereupon, at 4:49 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. VA health care has been on GAO's High Risk List since 2015 for a variety of reasons, including inadequate oversight and accountability, information technology challenges, and ambiguous policies and inconsistent processes. In a letter to you in April, when you were Acting Secretary, GAO highlighted 26 priority recommendations that VA has yet to implement, 17 of which were carried over from 2017.

Response. VHA is responsible for 14 of the 26 High Priority recommendations; 2 are closed, 4 are pending a closure decision from GAO, 5 have target completion dates within the next 60 days, 3 have target completion dates in the future and are on track for completion.

Question 2. Since GAO wrote to you in April, VA has only implemented 3 of GAO's 26 priority recommendations. These are just the priority recommendations. VA also has about 100 other open GAO recommendations that remain unaddressed. GAO tells me that VA has yet to submit a satisfactory action plan to address its high risk status in the almost 4 years that have passed since GAO put them on the list. What specific progress has been made during your tenure as Secretary?

VA Response:

- VA Actions on GAO's high risk listing titled "Managing Risks and Improving Veterans Health Care":
  - FY 2015: Established VA's GAO High Risk List (HRL) Area Task Force (Task Force) and provided GAO with an initial Strategy for Health Care High Risk Management that linked actions to the *MyVA* Initiative. Conducted listening sessions to gain field insights and potential solutions. GAO found this information interesting but not sufficient for an action plan.
  - FY 2016: Conducted root cause analyses for each of the five areas of concern and enterprise root causes. GAO found the root cause analyses acceptable and a good start to an action plan.
  - FY 2017: Work groups developed action plans for each of the five risk areas, and continued work to resolve the risk areas.
  - FY 2018: Work groups completed action plans and presented them to GAO on March 15, 2018. GAO considered the action plan to be a good start, and requested more clarification on metrics, and integration with modernization efforts.
  - FY 2019: VHA merged GAO high risk work with its Management Review Service to leverage strong liaison functions with GAO, improve communications, and build routine operations into management of the GAO HRL. VHA partnered with the Office of Strategic Integration to apply robust project management discipline to all GAO HRL projects. VHA partnered with the National Center for Organizational Development to apply robust change management to GAO High Risk List. VHA partnered with Office of Enterprise Integration to incorporate modernization efforts into the GAO High risk plan.
- Status of Open GAO recommendations to VHA:
  - At the close of FY 2018, VHA has 113 open GAO recommendations; 61 are new recommendations made in FY 2018; 47 were closed this fiscal year. VHA has completed work on 26 recommendations and awaits GAO's decision regarding closure.
  - Over the past 3 years, GAO averaged 50 new recommendations per year and averaged 51 closures per year—essentially no net decrease in recommendations despite constant actions toward completing actions.

Question 3. At your confirmation hearing, you affirmed the statutory independence of the Inspector General, after Acting VA leadership claimed that the IG is the Secretary's subordinate. It's essential that all VA employees know that you will continue to support and uphold this independence. It's also critical for veterans and taxpayers to know that an independent body exists to conduct oversight and help improve VA. Can you tell the Committee what you have done since taking the job to help reinforce and uphold the IG's independence?

Response. As I stated during the hearing, I view the Inspector General as a partner and not subordinate to the Secretary. The Inspector General works closely with the Office of Accountability and Whistleblower Protection and the Veterans Health Administration's Office of Medical Inspector to investigate allegations of misconduct or other improprieties. In my previous position, I worked with the Department of Defense Inspector General and plan to foster that same working relationship with Mr. Missal. I was asked during the hearing if I would commit to not interfere or hinder the independence of the Inspector General and be transparent with requested information. I would like to state again that I am committed to that. I have met with Mr. Missal as recently as October 5, 2018, and it is my goal to regularly meet with him for updates and discussion. I strongly support the Inspector General's investigations and mission.

Question 4. The Committee continues to receive concerns from whistleblowers and other employees about the implementation of the Accountability Act. Do you find it appropriate that facilities are investigating whistleblower complaints against themselves? Do you believe this can be done fairly? Do you believe that whistleblowers should have access to the findings of the reports and investigations conducted into their inquiries? What are the timelines given to OAWP, or by OAWP to administrations, within which they need to conduct investigations into reports of whistleblowers?

Response. The Department has developed a robust system of checks and balances related to the receipt, review, and reporting regarding whistleblower disclosures. The process ensures each disclosure is investigated thoroughly, timely, and impartially. The Office of Accountability and Whistleblower Protection (OAWP) has received approximately 3,100 submissions since its inception on June 23, 2017, with the signing of the VA Accountability and Whistleblower Protection Act, through October 1, 2018. Upon receipt, each submission is assigned to an OAWP Triage Division Case Manager. The Case Manager sends the disclosing party (if not submitted anonymously) an acknowledgement message that includes the date the submission was received and a tracking number. OAWP thoroughly reviews each submission to determine if a submission satisfies the Act's definition of a "whistleblower disclosure." Of the 3,100 submissions, OAWP determined approximately 1,000 met the definition of a "whistleblower disclosure" for referral. Once a submission is determined to be a "whistleblower disclosure" the disposition of the disclosure depends on its content.

The definition of "whistleblower disclosure" is found in 38 U.S.C. § 323(c)(1)(G)(3):

> The term 'whistleblower disclosure' means any disclosure of information by an employee of the Department or individual applying to become an employee of the Department which the employee or individual reasonably believes evidences:
>
> (A) a violation of a law, rule, or regulation; or
>
> (B) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

The VA Accountability and Whistleblower Protection Act requires OAWP to refer whistleblower disclosures to the appropriate investigative entity. Disclosures involving clinical matters are referred to the Office of the Medical Inspector (OMI). Disclosures involving potentially criminal conduct are offered to the Office of the Inspector General (OIG); however, if the OIG declines the disclosure it is returned to OAWP for further disposition. If the disclosure alleges misconduct or poor performance by a senior leader, the disclosure is referred to OAWP's Investigations Division. If the disclosure involves an allegation of whistleblower retaliation by a supervisor, it is likewise referred to OAWP's Investigations Division. If the disclosure does not fall within any of the aforementioned criteria, it is referred to the appropriate Administration or Staff Office for investigation and reporting.

Of the approximately 1,000 whistleblower disclosures received, they have been referred for investigation as follows:

- Allegations of misconduct or poor performance by a senior leader or whistleblower retaliation by any supervisor investigated by OAWP: 354
- Allegations involving potential criminal wrongdoing accepted by the OIG: 13
- Allegations involving clinical matters referred to OMI: 8
- All other allegations referred that are not included in the above:
  - VHA: 570
  - VBA: 31
  - NCA: 1
  - Staff Offices: 26

The remainder of this response only addresses those disclosures referred to an Administration or Staff Office.

Each disclosure referred to an Administration or Staff Office is referred with an instruction memo describing the requirements and standards for review and reporting. The timeframe for a responsive report is 30-days, although extensions can be granted with sufficient justification. The instructions describe the limitations on who may conduct the investigation and the specific items that must be addressed in the resulting report. OAWP also sends a template for the required report that describes the reporting requirements in detail. Each referral includes the prohibition:

> All investigations must be conducted by a neutral party who is not named or involved in any of the disclosures. It is not acceptable to send the referral notice to a party named in a disclosure as part of any investigation method you choose.

Once the completed report is submitted by the Administration or Staff Office to the OAWP Case Manager who reviews the report for technical adequacy based on the instruction memo and reasonableness of the response. If the Case Manager accepts the report, it is reviewed by the Case Manager's supervisor for concurrence and, if satisfactory, the disclosure is closed. A closure notice is provided to the disclosing party. The notice explains that the disclosure was investigated and is now

closed. If the disclosing party has further questions, the closure notice directs them to the Administration or Staff Office point-of-contact. If a disclosing party seeks a copy of any of the investigatory materials or report, they are referred to the appropriate Freedom of Information Act Office.

Question 5. Please provide the Committee with the PowerPoint Slide deck titled, "Next Steps for Agent Orange Benefits, including Navy Veterans in Territorial Water," which was produced by VBA on November 24, 2017.

Response. This deck cannot be shared externally as it was used for internal deliberate discussions regarding policy choices. The documents requested consist of internal policy discussions by and amongst VA employees regarding decisions on issuance of grant benefits and/or proof presumptions to groups of Veterans, including benefits related to Agent Orange and to groups of Veterans who served in waters in the vicinity of Vietnam. The confidentiality of these communications is critical to VA employees' faith in their ability to hold frank discussions regarding highly publicized and controversial issues such as these without such communications being disclosed to public.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JERRY MORAN TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

There's been much discussion about the poor implementation of the Choice program in terms of delays in scheduling, lack of robust provider network, and inability for participating community providers to get paid. In the midst of this bad news, I want to recognize and applaud VA's direct contracts with dialysis providers. This is a good example of VA's successful engagement of dialysis providers where Veterans receive high quality, timely dialysis care and 23 dialysis vendors are paid in a timely manner to provide a robust dialysis provider network with coast-to- coast coverage.

The direct dialysis contracts that are in place today are set to expire soon. VA has advised this Committee that there will be 6-month bridge contract to ensure that there's no disruption in dialysis care for Veterans. VA further informed this Committee of their plans to recompete the direct dialysis contracts that would be a total of 5 years in duration.

Question 6. Does the VA intend to include dialysis in the Community Care Network contracts that will be awarded in the coming months, or will the VA preserve the direct dialysis contracts as the sole path for acquiring dialysis services under the new MISSION Act?

Response. The new Nationwide Dialysis Services contracts (NDSC) will be separate from the Community Care Network contracts. VA issued a Request for Proposals (RFP) on October 29, 2018 and estimates award of the contracts no later than January 31, 2019.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DEAN HELLER TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 7. Secretary Wilkie—during your confirmation, we talked about getting a full-time doctor in a clinic in Pahrump. It was a great day two years ago to be there for the opening of this clinic—but we need to make sure it has the staff the veterans need. Can you provide a status update on getting a full-time doctor out to the Pahrump clinic?

Response. The last full-time physician who was employed in Pahrump, resigned January 31, 2017. Since that time, the position was re-posted October 1, 2017 and has remained posted since that date. This posting has yielded 1 candidate who was selected, but due to licensure issues, was unable to complete the hiring process. Two additional candidates were received, however, neither were viable candidates. Recruitment continues with the inclusion of recruitment incentives. Physicians applying for the position in Pahrump are being offered a higher salary than physicians in the Las Vegas metro area.

The VISN 21 physician recruiter has also been actively seeking physicians for Pahrump since January 2017. However, these efforts have yielded no viable candidates. VA patients in Pahrump are treated and managed through the following methods:

a. One full-time Nurse Practitioner (Monday through Friday);

b. One full-time Physician Assistant (Monday through Friday);

c. VA Southern Nevada Healthcare System Primary Care has collaborated with San Francisco's V-IMPACT program to provide one full-time physician via Tele-

health, which started September 4, 2018. This program also provides an additional one week of face-to-face physician coverage each quarter; and

d. If San Francisco is unable to see patients due to illness we have back up available via telehealth.

Question 8. Secretary Wilkie—As part of the VA MISSION Act, I secured a provision that requires the VA to implement a pilot program for the use of medical scribes. I believe Las Vegas would be a great location for this pilot program given we have a busy Emergency Department where scribes could be very helpful. Do you have a status update on when that pilot program will be implemented? Can you provide a timeline for implementation?

Response. Planning for implementation of the medical scribe pilot program is currently underway. Section 507 of the VA MISSION Act of 2018 is fairly prescriptive in the requirements for the program concerning such issues as selecting pilot site locations, hiring and distributing scribes, reporting, and evaluation. VA's timeline for implementation is still in development, but VA plans to complete site selection, scribe hiring and training, and to begin implementation over the course of FY 2019.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

HOMELESSNESS

HUD-VASH

Question 9. Data from the Department of Housing and Urban Development showed that there was an increase in veteran homelessness in 2017, and a significant increase in my home state of Washington. Secretary Shulkin stated before the Committee that VA will be implementing a new plan to address this issue in Seattle. Please provide a full description of what additional resources have been made available, any proposed programmatic changes, and a timeline for implementation.

Response. Since the 2017 Point in Time (PIT) Count results showing a significant increase in the number of homeless Veterans in Washington, and particularly in Seattle/King County, were announced, the Homeless Program Office (HPO) has provided targeted resources and technical assistance to the area. HPO assigned its National Director of Clinical Operations to work with the Director of the Homeless Programs at VA Puget Sound to develop strategies and identify resource needs. Resources and technical assistance provided over the past year include the following:

- New HUD-VA Supportive Housing (HUD-VASH) voucher allocations to increase permanent supportive housing resources:
  - FY 2017 award: 362 to Puget Sound (150 to Seattle/King County).
  - FY 2018 award (Round 1): 134 to Puget Sound (69 to Seattle/King County).
  - FY 2018 award (Round 2) not yet announced but expected to be: 54 to Puget Sound (44 to Seattle/King County).
- New lease signed for expanded, centrally-located Community Resource and Referral Center in Seattle (anticipated opening Spring 2019), to enhance homeless Veteran access to services.
- Two new Grant Per Diem (GPD) programs (Orting State Soldier's Home: 40 beds; expansion of Salvation Army William Booth Center by 14 beds).
- Expansion of Health Care for Homeless Veterans (HCHV) Contract beds (Seattle/King County) from 20 to 30 beds (Sept. 2018).
- Supportive Services for Veteran Families (SSVF) Rapid Resolution/Diversion Pilot (Seattle/King County).
- Continued, innovative collaboration with non-profit, local governmental, and Continuum of Care (CoC) partners to streamline services for homeless Veterans across the region, including King County to ensure a targeted utilization of King County Senior, Veterans, and Human Services Levy (VSHSL) funds to complement services provided through VA and fill identified gaps in care.
- Close collaboration with all CoCs to create and maintain "By Name" or "Master Lists" of homeless Veterans across our region, to better ensure that resources are optimally targeted based on need and availability.
- To help fill vacant case manager positions, VA assigned staff from VA Central Office Workforce Management and Consulting to assist in recruitment efforts, reducing the lag time associated with filling vacant positions.
- In terms of timeline for implementation, unless otherwise indicated, all resources and technical assistance listed above are ongoing.

• These efforts resulted in a 31 percent reduction in Veteran homelessness as identified by the 2018 PIT Count. This result provides concrete evidence of the effectiveness of the resources and technical assistance listed above.

Question 10. Unfilled case manager positions and un-used vouchers throughout Washington state continue to hamper efforts to help veterans. From discussions with local staff in the VA, housing authorities, and non-profit providers, it seems that the hiring process remains tedious and inefficient. Also, HUD and VA tracking systems are not able to communicate with one another, slowing down the rapid-rehousing process and potentially resulting in some veterans falling through the cracks.

• What will you do to ensure a streamlined hiring process and the filling of critical case manager positions?

Response. As noted above, VA assigned staff from VA Central Office Workforce Management and Consulting to assist in recruitment efforts. This addition of staff to assist in hiring will reduce the lag time associated with filling vacant positions.

Question 11. What will you do to ensure HUD and VA are able to coordinate more effectively?

Response. HUD and VA have recently implemented a shared data dashboard that is presented monthly at the Strategic Decision and Consultation Team meeting, a monthly meeting with the US Interagency Council on Homelessness (USICH). This process has ensured that HUD and VA establish shared data definitions which has enhanced the sharing of data at the Headquarters level.

Over the past two years, VA has also taken many steps to enhance the ability to share data across HUD and VA systems at the local level. These steps include but are not limited to the following:

• VA adopted HUD's Universal Data Elements into its data collection system and matching data elements related to housing outcomes wherever possible

• VA established a process by which staff may share protected health information across VA and HUD systems through an encrypted email system which complies with all privacy and security requirements.

• VA released extensive guidance requiring VAMC staff to participate in local coordinated entry efforts.

VA is piloting use of cloud-based software to enhance VA medical center (VAMC) staff ability to participate in community data sharing efforts using the cloud.

Question 12. What is the long-term VA plan to get ahead of increasing rates of veterans experiencing homelessness in areas with fast increasing populations?

Response. In brief, the long-term plan is to address these areas on both the demand and supply side. On the demand side, VA currently does and will continue to target resources to the areas that need them most. VA uses a sophisticated gap analysis model to predict homeless Veteran population growth and uses the results of this model to guide resource allocation in many of its key programs, including HUD-VASH, SSVF, and GPD. This ensures that resources go where they are needed most. On the supply side, VA is working closely with HUD and external partners to increase the available housing stock for permanent supportive housing and affordable housing. This includes targeted use of Project Based Vouchers in HUD-VASH, use of VA property through the Enhanced Use Lease (EUL) process, working with cities and counties on methods to incentive development of units dedicated to homeless Veterans, and working with landlords and developers to promote the need for the same.

Question 13. Please provide a national by-facility breakdown of:

i. The number of case managers
ii. Number of case manager vacancies
iii. Number of vouchers each case manager is responsible for
iv. How many vouchers are not in use
v. How many vouchers expired at the end of fiscal year 2018 and had to be reissued
vi. How many veterans are waiting for vouchers

Response. Please see the attached spreadsheet and the responses below:

i. The number of case managers:
   • Tab 1 (VA Staff) column D of the attachment shows the total number of case manager positions in HUD-VASH.

ii. Number of case manager vacancies:
   • Tab 1 (VA Staff) column C of the attachment shows the total number of case manager vacancies in HUD-VASH. Please note that many of these positions were just created, due to the recent FY 2018 voucher allocations.

iii. Number of vouchers each case manager is responsible for:

• It is not possible to obtain this number for each case manager, due to the unique make-up of case management teams at each VAMC. Nationally, however, there are approximately 3,100 VA case managers plus 273 contracted case managers, for a total of 3,373 staff providing case management for approximately 85,500 vouchers. This yields a ratio of roughly 25 vouchers for each case manager. The data showing the staffing breakdown by VAMC is in Tab 1 (VA Staff) and Tab 2 (Contracted CM) of the attachment.

iv. How many vouchers are not in use:

• Tab 3 (Voucher Utilization) column C of the attachment shows the number of vouchers not in use (i.e., available for use) by VAMC. Please note that in some cases many of these unused vouchers were just recently allocated by HUD. Negative numbers indicate that VAMCs have admitted more Veterans to HUD-VASH than there are available vouchers. This is a recommended practice to offset expected attrition prior to voucher issuance, similar in concept to airline "overbooking."

v. How many vouchers expired at the end of fiscal year 2018 and had to be reissued:

• We do not collect data on this at the VACO level and are thus unable to report it here.

vi. How many veterans are waiting for vouchers:

• Tab 3 (Voucher Utilization) column D of the attachment shows the number of Veterans awaiting vouchers. This is the number of Veterans who have been referred to the Public Housing Authority (PHA) for a voucher but have not yet received the voucher. This number does not include Veterans admitted to the HUD-VASH program who have not yet been referred to the PHA.

VA Staff (Tab 1)

Facility	Filled	Vacant	Grand Total
(1V01) (402) Togus, ME HCS	5	6	11
(1V01) (405) White River Junction, VT HCS	6	5	11
(1V01) (518) Bedford, MA HCS	22	1	23
(1V01) (523) Boston, MA HCS	41	9	50
(1V01) (608) Manchester, NH HCS	13	1	14
(1V01) (631) Central Western Massachusetts HCS	21	6	27
(1V01) (650) Providence, RI HCS	14	3	17
(1V01) (689) Connecticut HCS	24	9	33
(1V02) (526) Bronx, NY HCS	31	5	36
(1V02) (528) Western New York HCS	11	-	11
(1V02) (528A5) Canandaigua, NY HCS	8	-	8
(1V02) (528A6) Bath, NY HCS	5	1	6
(1V02) (528A7) Syracuse, NY HCS	12	2	14
(1V02) (528A8) Albany, NY HCS	12	4	16
(1V02) (561) New Jersey HCS	22	5	27
(1V02) (620) Hudson Valley, NY HCS	9	-	9
(1V02) (630) New York Harbor HCS	41	2	43
(1V02) (632) Northport, NY HCS	16	3	19
(1V04) (460) Wilmington, DE HCS	9	4	13
(1V04) (503) Altoona, PA HCS	2	2	4
(1V04) (529) Butler, PA HCS	6	-	6
(1V04) (542) Coatesville, PA HCS	18	1	19
(1V04) (562) Erie, PA HCS	7	-	7
(1V04) (595) Lebanon, PA HCS	14	-	14
(1V04) (642) Philadelphia, PA HCS	24	11	35
(1V04) (646) Pittsburgh, PA HCS	15	-	15
(1V04) (693) Wilkes-Barre, PA HCS	7	2	9
(1V05) (512) Baltimore, MD HCS	46	2	48
(1V05) (517) Beckley, WV HCS	6	-	6
(1V05) (540) Clarksburg, WV HCS	2	-	2
(1V05) (581) Huntington, WV HCS	10	-	10
(1V05) (613) Martinsburg, WV HCS	6	2	8
(1V05) (688) Washington, DC HCS	41	12	53

VA Staff (Tab 1)—Continued

Facility	Filled	Vacant	Grand Total
(1V06) (558) Durham, NC HCS	21	-	21
(1V06) (565) Fayetteville, NC HCS	12	4	16
(1V06) (590) Hampton, VA HCS	32	3	35
(1V06) (637) Asheville, NC HCS	13	1	14
(1V06) (652) Richmond, VA HCS	9	6	15
(1V06) (658) Salem, VA HCS	4	-	4
(1V06) (659) Salisbury, NC HCS	28	1	29
(2V07) (508) Atlanta, GA HCS	75	13	88
(2V07) (509) Augusta, GA HCS	10	1	11
(2V07) (521) Birmingham, AL HCS	24	1	25
(2V07) (534) Charleston, SC HCS	31	7	38
(2V07) (544) Columbia, SC HCS	17	6	23
(2V07) (557) Dublin, GA HCS	8	-	8
(2V07) (619) Central Alabama HCS	14	2	16
(2V07) (679) Tuscaloosa, AL HCS	10	1	11
(2V08) (516) Bay Pines, FL HCS	52	8	60
(2V08) (546) Miami, FL HCS	42	-	42
(2V08) (548) West Palm Beach, FL HCS	23	2	25
(2V08) (573) Gainesville, FL HCS	61	9	70
(2V08) (672) San Juan, PR HCS	11	4	15
(2V08) (673) Tampa, FL HCS	38	2	40
(2V08) (675) Orlando, FL HCS	56	-	56
(2V09) (596) Lexington, KY HCS	11	-	11
(2V09) (603) Louisville, KY HCS	21	-	21
(2V09) (614) Memphis, TN HCS	19	1	20
(2V09) (621) Mountain Home, TN HCS	14	2	16
(2V09) (626) Middle Tennessee HCS	28	7	35
(3V10) (506) Ann Arbor, MI HCS	17	5	22
(3V10) (515) Battle Creek, MI HCS	19	5	24
(3V10) (538) Chillicothe, OH HCS	8	1	9
(3V10) (539) Cincinnati, OH HCS	23	4	27
(3V10) (541) Cleveland, OH HCS	41	4	45
(3V10) (552) Dayton, OH HCS	11	1	12
(3V10) (553) Detroit, MI HCS	30	3	33
(3V10) (583) Indianapolis, IN HCS	20	5	25
(3V10) (610) Northern Indiana HCS	16	4	20
(3V10) (655) Saginaw, MI HCS	8	2	10
(3V10) (757) Columbus, OH HCS	13	3	16
(3V12) (537) Chicago, IL HCS	50	5	55
(3V12) (550) Danville, IL HCS	7	1	8
(3V12) (556) North Chicago, IL HCS	7	-	7
(3V12) (578) Hines, IL HCS	28	-	28
(3V12) (585) Iron Mountain, MI HCS	1	1	2
(3V12) (607) Madison, WI HCS	15	1	16
(3V12) (676) Tomah, WI HCS	7	2	9
(3V12) (695) Milwaukee, WI HCS	21	2	23
(3V15) (589) Kansas City, MO HCS	16	4	20
(3V15) (589A4) Columbia, MO HCS	6	-	6
(3V15) (589A5) Eastern Kansas HCS	16	2	18
(3V15) (589A7) Wichita, KS HCS	10	1	11
(3V15) (657) St. Louis, MO HCS	16	1	17
(3V15) (657A4) Poplar Bluff, MO HCS	6	1	7
(3V15) (657A5) Marion, IL HCS	2	1	3
(3V23) (437) Fargo, ND HCS	10	-	10
(3V23) (438) Sioux Falls, SD HCS	5	-	5
(3V23) (568) Black Hills, SD HCS	9	2	11
(3V23) (618) Minneapolis, MN HCS	24	6	30

VA Staff (Tab 1)—Continued

Facility	Filled	Vacant	Grand Total
(3V23) (636) Nebraska-W Iowa HCS	15	2	17
(3V23) (636A6) Central Iowa HCS	7	2	9
(3V23) (636A8) Iowa City, IA HCS	6	2	8
(3V23) (656) St. Cloud, MN HCS	2	2	4
(4V16) (502) Alexandria, LA HCS	12	1	13
(4V16) (520) Gulf Coast, MS HCS	29	5	34
(4V16) (564) Fayetteville, AR HCS	14	1	15
(4V16) (580) Houston, TX HCS	71	10	81
(4V16) (586) Jackson, MS HCS	17	4	21
(4V16) (598) Little Rock, AR HCS	16	5	21
(4V16) (629) New Orleans, LA HCS	35	3	38
(4V16) (667) Shreveport, LA HCS	11	2	13
(4V17) (504) Amarillo, TX HCS	7	2	9
(4V17) (519) Big Spring, TX HCS	8	1	9
(4V17) (549) Dallas, TX HCS	53	6	59
(4V17) (671) San Antonio, TX HCS	24	1	25
(4V17) (674) Temple, TX HCS	22	8	30
(4V17) (740) Texas Valley Coastal Bend HCS	9	2	11
(4V17) (756) El Paso, TX HCS	10	3	13
(4V19) (436) Montana HCS	12	5	17
(4V19) (442) Cheyenne, WY HCS	7	3	10
(4V19) (554) Denver, CO HCS	55	9	64
(4V19) (575) Grand Junction, CO HCS	5	2	7
(4V19) (623) Muskogee, OK HCS	18	-	18
(4V19) (635) Oklahoma City, OK HCS	11	5	16
(4V19) (660) Salt Lake City, UT HCS	22	6	28
(4V19) (666) Sheridan, WY HCS	4	2	6
(5V20) (463) Anchorage, AK HCS	11	2	13
(5V20) (531) Boise, ID HCS	10	1	11
(5V20) (648) Portland, OR HCS	47	17	64
(5V20) (653) Roseburg, OR HCS	13	7	20
(5V20) (663) Puget Sound, WA HCS	64	19	83
(5V20) (668) Spokane, WA HCS	20	1	21
(5V20) (687) Walla Walla, WA HCS	12	4	16
(5V20) (692) White City, OR HCS	12	4	16
(5V21) (459) Honolulu, HI HCS	37	7	44
(5V21) (570) Fresno, CA HCS	29	3	32
(5V21) (593) Las Vegas, NV HCS	57	4	61
(5V21) (612A4) N. California HCS	56	18	74
(5V21) (640) Palo Alto, CA HCS	79	7	86
(5V21) (654) Reno, NV HCS	20	2	22
(5V21) (662) San Francisco, CA HCS	44	22	66
(5V22) (501) New Mexico HCS	22	2	24
(5V22) (600) Long Beach, CA HCS	34	26	60
(5V22) (605) Loma Linda, CA HCS	39	14	53
(5V22) (644) Phoenix, AZ HCS	40	14	54
(5V22) (649) Northern Arizona HCS	16	1	17
(5V22) (664) San Diego, CA HCS	58	5	63
(5V22) (678) Southern Arizona HCS	31	4	35
(5V22) (691) Greater Los Angeles, CA HCS	175	108	283
Grand Total	3,100	632	3,732

Contracted Case Managers (Tab 2)

Facility	Contracted Case Managers
(1V02) (526) Bronx, NY HCS	14
(1V02) (561) New Jersey HCS	13
(1V02) (620) Hudson Valley, NY HCS	3
(1V02) (630) New York Harbor HCS	14
(1V02) (632) Northport, NY HCS	7
(1V04) (503) Altoona, PA HCS	1
(1V05) (688) Washington, DC HCS	13
(5V20) (653) Roseburg, OR HCS	4
(5V20) (663) Puget Sound, WA HCS	6
(5V21) (662) San Francisco, CA HCS	13
(5V22) (678) Southern Arizona HCS	1
(5V22) (691) Greater Los Angeles, CA HCS	184
Grand Total	273

Voucher Utilization (Tab 3)

Facility	Vouchers Allocated	Vouchers Available for Use	Veterans Waiting for a Voucher
(1V01) (402) Togus, ME HCS	216	-19	2
(1V01) (405) White River Junction, VT HCS	204	19	1
(1V01) (518) Bedford, MA HCS	544	10	3
(1V01) (523) Boston, MA HCS	918	82	0
(1V01) (608) Manchester, NH HCS	281	6	1
(1V01) (631) Central Western Massachusetts HCS	645	35	7
(1V01) (650) Providence, RI HCS	376	-5	3
(1V01) (689) Connecticut HCS	818	32	4
(1V02) (526) Bronx, NY HCS	1,339	-36	3
(1V02) (528) Western New York HCS	323	-3	0
(1V02) (528A5) Canandaigua, NY HCS	201	5	0
(1V02) (528A6) Bath, NY HCS	125	2	5
(1V02) (528A7) Syracuse, NY HCS	257	18	0
(1V02) (528A8) Albany, NY HCS	350	-20	6
(1V02) (561) New Jersey HCS	957	0	20
(1V02) (620) Hudson Valley, NY HCS	349	17	0
(1V02) (630) New York Harbor HCS	1,776	-39	17
(1V02) (632) Northport, NY HCS	464	2	0
(1V04) (460) Wilmington, DE HCS	217	6	3
(1V04) (503) Altoona, PA HCS	83	7	4
(1V04) (529) Butler, PA HCS	125	2	0
(1V04) (542) Coatesville, PA HCS	479	23	0
(1V04) (562) Erie, PA HCS	121	7	0
(1V04) (595) Lebanon, PA HCS	284	-38	0
(1V04) (642) Philadelphia, PA HCS	926	16	0
(1V04) (646) Pittsburgh, PA HCS	422	5	0
(1V04) (693) Wilkes-Barre, PA HCS	219	-27	6
(1V05) (512) Baltimore, MD HCS	944	-69	18
(1V05) (517) Beckley, WV HCS	143	-6	0
(1V05) (540) Clarksburg, WV HCS	67	-6	0
(1V05) (581) Huntington, WV HCS	215	12	1
(1V05) (613) Martinsburg, WV HCS	172	2	2
(1V05) (688) Washington, DC HCS	1,495	-14	10
(1V06) (558) Durham, NC HCS	480	3	0
(1V06) (565) Fayetteville, NC HCS	366	-3	4
(1V06) (590) Hampton, VA HCS	747	53	0

Voucher Utilization (Tab 3)—Continued

Facility	Vouchers Allocated	Vouchers Available for Use	Veterans Waiting for a Voucher
(1V06) (637) Asheville, NC HCS	338	-10	6
(1V06) (652) Richmond, VA HCS	369	23	1
(1V06) (658) Salem, VA HCS	98	-6	0
(1V06) (659) Salisbury, NC HCS	744	20	33
(2V07) (508) Atlanta, GA HCS	1,955	111	48
(2V07) (509) Augusta, GA HCS	237	-11	4
(2V07) (521) Birmingham, AL HCS	606	-19	1
(2V07) (534) Charleston, SC HCS	649	5	0
(2V07) (544) Columbia, SC HCS	549	-20	12
(2V07) (557) Dublin, GA HCS	200	5	2
(2V07) (619) Central Alabama HCS	306	-10	0
(2V07) (679) Tuscaloosa, AL HCS	267	-15	5
(2V08) (516) Bay Pines, FL HCS	1,309	45	6
(2V08) (546) Miami, FL HCS	1,038	56	11
(2V08) (548) West Palm Beach, FL HCS	560	1	4
(2V08) (573) Gainesville, FL HCS	1,688	-20	15
(2V08) (672) San Juan, PR HCS	197	23	0
(2V08) (673) Tampa, FL HCS	987	-12	22
(2V08) (675) Orlando, FL HCS	1,262	58	0
(2V09) (596) Lexington, KY HCS	302	2	0
(2V09) (603) Louisville, KY HCS	475	55	1
(2V09) (614) Memphis, TN HCS	492	-46	8
(2V09) (621) Mountain Home, TN HCS	355	37	0
(2V09) (626) Middle Tennessee HCS	763	-31	13
(3V10) (506) Ann Arbor, MI HCS	450	38	2
(3V10) (515) Battle Creek, MI HCS	557	11	5
(3V10) (538) Chillicothe, OH HCS	228	13	0
(3V10) (539) Cincinnati, OH HCS	548	-7	12
(3V10) (541) Cleveland, OH HCS	955	16	12
(3V10) (552) Dayton, OH HCS	225	13	3
(3V10) (553) Detroit, MI HCS	912	113	0
(3V10) (583) Indianapolis, IN HCS	641	45	27
(3V10) (610) Northern Indiana HCS	427	25	12
(3V10) (655) Saginaw, MI HCS	219	8	0
(3V10) (757) Columbus, OH HCS	372	-22	0
(3V12) (537) Chicago, IL HCS	1,220	-2	1
(3V12) (550) Danville, IL HCS	226	9	1
(3V12) (556) North Chicago, IL HCS	194	13	0
(3V12) (578) Hines, IL HCS	609	17	0
(3V12) (585) Iron Mountain, MI HCS	36	-1	0
(3V12) (607) Madison, WI HCS	276	8	0
(3V12) (676) Tomah, WI HCS	161	2	4
(3V12) (695) Milwaukee, WI HCS	628	-7	7
(3V15) (589) Kansas City, MO HCS	397	4	6
(3V15) (589A4) Columbia, MO HCS	153	30	0
(3V15) (589A5) Eastern Kansas HCS	400	11	4
(3V15) (589A7) Wichita, KS HCS	238	16	2
(3V15) (657) St. Louis, MO HCS	370	8	7
(3V15) (657A4) Poplar Bluff, MO HCS	129	-4	0
(3V15) (657A5) Marion, IL HCS	90	8	0
(4V16) (502) Alexandria, LA HCS	263	9	3
(4V16) (520) Gulf Coast, MS HCS	652	14	5
(4V16) (564) Fayetteville, AR HCS	241	-15	4
(4V16) (580) Houston, TX HCS	1,919	60	7
(4V16) (586) Jackson, MS HCS	447	20	3
(4V16) (598) Little Rock, AR HCS	398	40	1

Voucher Utilization (Tab 3)—Continued

Facility	Vouchers Allocated	Vouchers Available for Use	Veterans Waiting for a Voucher
(4V16) (629) New Orleans, LA HCS	801	45	10
(4V16) (667) Shreveport, LA HCS	282	15	0
(4V17) (504) Amarillo, TX HCS	240	2	0
(4V17) (519) Big Spring, TX HCS	213	5	6
(4V17) (549) Dallas, TX HCS	1,330	-113	46
(4V17) (671) San Antonio, TX HCS	719	-31	8
(4V17) (674) Temple, TX HCS	779	51	0
(4V17) (740) Texas Valley Coastal Bend HCS	239	-1	2
(4V17) (756) El Paso, TX HCS	294	-15	0
(4V19) (436) Montana HCS	410	14	1
(4V19) (442) Cheyenne, WY HCS	235	15	1
(4V19) (554) Denver, CO HCS	1,359	62	21
(4V19) (575) Grand Junction, CO HCS	187	6	0
(4V19) (623) Muskogee, OK HCS	336	-10	10
(4V19) (635) Oklahoma City, OK HCS	372	0	2
(4V19) (660) Salt Lake City, UT HCS	601	40	17
(4V19) (666) Sheridan, WY HCS	112	8	2
(5V20) (463) Anchorage, AK HCS	311	4	2
(5V20) (531) Boise, ID HCS	221	11	4
(5V20) (648) Portland, OR HCS	1,210	-90	12
(5V20) (653) Roseburg, OR HCS	503	40	6
(5V20) (663) Puget Sound, WA HCS	1,893	-101	44
(5V20) (668) Spokane, WA HCS	411	-17	8
(5V20) (687) Walla Walla, WA HCS	396	-7	9
(5V20) (692) White City, OR HCS	385	40	5
(5V21) (459) Honolulu, HI HCS	742	13	27
(5V21) (570) Fresno, CA HCS	545	29	4
(5V21) (593) Las Vegas, NV HCS	1,419	159	19
(5V21) (612A4) N. California HCS	1,465	-9	14
(5V21) (640) Palo Alto, CA HCS	1,997	-128	72
(5V21) (654) Reno, NV HCS	483	27	7
(5V21) (662) San Francisco, CA HCS	1,593	-33	20
(5V22) (501) New Mexico HCS	548	17	2
(5V22) (600) Long Beach, CA HCS	1,508	121	45
(5V22) (605) Loma Linda, CA HCS	1,082	-16	0
(5V22) (644) Phoenix, AZ HCS	1,103	232	6
(5V22) (649) Northern Arizona HCS	327	7	6
(5V22) (664) San Diego, CA HCS	1,641	68	32
(5V22) (678) Southern Arizona HCS	810	45	7
(5V22) (691) Greater Los Angeles, CA HCS	6,189	892	36
(3V23) (437) Fargo, ND HCS	244	23	2
(3V23) (438) Sioux Falls, SD HCS	151	4	0
(3V23) (568) Black Hills, SD HCS	205	13	2
(3V23) (618) Minneapolis, MN HCS	651	-24	8
(3V23) (636) Nebraska-W Iowa HCS	494	38	6
(3V23) (636A6) Central Iowa HCS	200	-3	0
(3V23) (636A8) Iowa City, IA HCS	176	-13	2
(3V23) (656) St. Cloud, MN HCS	74	0	2
Grand Total	85,461	3,402	975

FACILITIES

Yakima CBOC

Question 14. The Yakima CBOC funds were allocated in 2016. After a delay on construction due to a contested bid, we do not have a current estimate for date of

construction beyond a vague assertion of 18 months to two years. Please provide a more detailed account of projected construction timeline.

Response. In order to address prior protests associated with what has been determined to be a geographic area of consideration that was too restrictive, the Yakima lease area of consideration has been revised. The updated lease solicitation will be issued no later than December 2018 and an award is anticipated by Fall 2019 or earlier. Upon award, the new lease may take 18–24 months to be completed for VA occupancy. The lessor's construction timeline depends on what type of space lessor offers and VA leases, existing space to be renovated or new construction.

Bremerton CBOC

Question 15. The Bremerton CBOC was slated to be updated nine years ago. A month ago the notice to proceed was finally obtained and construction has begun on a new facility in neighboring Silverdale. The timeline for construction is now 18 months. Since the authorization of funding, the needs of the community have changed and the slated construction of a site that can serve 7,200 veterans will not meet the needs of the area given the rate of growth in the veteran population, the number of beds being added to the new facility, and the expected return of veterans who have gone to the Choice program due to backups at the current facility.

- Please provide a full timeline of construction and expected end date.
- Please provide details on most recent assessment of community capacity and needs.
- Please provide assessment of recently announced Auburn and Olympia facilities as well and explain rationale for different sizes.
- The Bremerton CBOC still lacks a Women's Care Team despite Secretary Shulkin assuring me in 2016 that one would soon be there. Please update me on the timeline for this team to be operating in the clinic.

VA Response:

- Please provide a full timeline of construction and expected end date. The lease was awarded on July 7, 2017 and in August 2018 VA issued the lessor a Notice to Proceed with construction per VA approved clinic design. The lessor is currently scheduled to complete construction of the building October 2019.
- Please provide details on most recent assessment of community capacity and needs. Currently, Market Assessments are being planned for all facilities nationwide. A contract was let to accomplish this starting this fiscal year. These assessments will analyze both in-house workload and do a comprehensive review of community capacity and needs.
- Please provide assessment of recently announced Auburn and Olympia facilities as well and explain rationale for different sizes. Newly approved CBOC leases in Auburn and Olympia, Washington are similarly sized at approximately 25,272 and 25,179 net usable square feet respectively. Both sites intend to provide PACT Primary Care, Primary Care Mental Health Integration (PCMHI) and Specialty Mental Health services, along with basic laboratory and diagnostic imaging services. Differences in programing space can occur based on the number of staff, number of rooms or the size of a room.
- The Bremerton CBOC still lacks a Women's Care Team despite Secretary Shulkin assuring me in 2016 that one would soon be there. Please update me on the timeline for this team to be operating in the clinic. The current Bremerton CBOC has four designated Women's Health (WH) Providers. Two of them have been WH providers since 2016. The most recent ones have been on station since August 2017. The New Silverdale CBOC has space designated for WH.

Tonasket Rural Medical Clinic

Question 16. As of May 2017, the VA intended to close the Tonasket Rural Health Clinic, located within the North Valley Hospital, and roughly a year ago they did. More than 850 veterans relied on that clinic to receive care from the VA. Without the clinic, they are forced to travel either two hours each way to Wenatchee, or three hours each way to the Mann-Grandstaff VA Medical Center (MGVAMC) in Spokane. The medical center has been unable to provide an accurate picture of the status of the replacement clinic, and previously told my office an award was expected in February 2018. As of last week, medical center had no update or information on this extended delay due to a lack of transparency in contracting.

Please provide a full details of current status of Tonasket reopening, including a firm date for the clinic to be operational.

Response. Tonasket Contract Clinic proposals have been received and are currently under review. Upon award and notice to proceed, the contract clinic is to be operational within 120 days.

Puget Sound VA

Question 17. During his confirmation hearing in 2017, Secretary Shulkin committed to following up on concerns I raised about the condition of the VA Puget Sound Health Care System and obstacles Washington veterans faced in accessing care. The problem then seemed to stem from unfilled management positions and frequent turnover in leadership. A management improvement team was sent to the facility, and measures have been taken to ensure physician and nurse positions are filled, but many problems persist. The problems again seem to center on unfilled rolls and overburdened existing staff. I am very concerned with low levels of support staffing overall, specifically in the maintenance and human resources departments and the effects this understaffing is having on patient care.

• I ask that you investigate these issues and take action expeditiously to resolve these problems. In particular, if additional staff or resources are necessary for patient care or for human resources in order to expedite hiring of providers, I ask that you take all necessary actions to meet those needs, including temporarily detailing staff to the facility.

• I also ask that you undertake a review of the long-term feasibility of hiring in this region. With increasing costs of living and significant competition for employees among hospitals in the Seattle area, VA will have to be sure it can recruit and retain the top talent. Please describe whether and how VA can keep pace with the market and any additional authorities that are necessary.

I am also specifically concerned about reports I have received about deficiencies in the radiology department, especially in light of reports of hundreds of thousands of radiology consults being improperly closed, potentially putting veterans at risk. The specific concerns raised about Puget Sound include the lack of an efficient scheduling system and lack of compliance with scheduling policy, lack of sufficient clerical staff, as well as possible mishandling of patient images including CDs being stored unsecured or improperly, images not being entered into the medical record, or patient images being deleted. Please investigate these concerns and take appropriate corrective action.

Response. VA Central Office's H.R. Team is supporting the Puget Sound facility with direct impact to hiring is actively filling vacancies. Currently, this team has vacancies for two H.R. Specialist and one H.R. Assistant which are expected to be filled within the next 90 days. Additionally, an additional nurse recruiter (part-time) was supported for hire in Patient Care Services this year to assist with recruitment in this area. The following strategies are being employed:

• Utilization of Recruitment and Retention flexibilities (recruitment, relocation and retention incentives, student loan repayment, education debt reduction, accelerated leave accrual) for hard-to-fill occupations for the facility, including human resources.

• Pay authorities such as above-minimum entry and highest previous rate are also applied, as appropriate, to assist in achieving and offering salaries commensurate with an applicant's qualifications and/or in recognition of prior Federal service.

• Telework options have been leveraged in an effort to recruit and retain H.R. staff while maintaining a customer-service focus to support medical center operational needs.

• In January 2018, OPM authorized direct hire authority to VA for 15 critical occupations to include Human Resources Specialist and Human Resources Assistants, which we are actively using as a flexibility to hire.

• H.R. consolidation to the VISN is actively moving forward to create a more efficient, effective and standardized means to deliver H.R. services in VHA.

• Adjusted salary rates or new special salary rates established for numerous occupations to create more competitive wages. VISN 20's compensation team has been providing assistance in this area and will continue to support the facilities, including Puget Sound.

• Utilizing non-competitive hiring authorities available to fill positions, appropriately, with qualified quality candidates (trainees, VRA, schedule A, 30%+ Veterans)

• Policy changes are creating greater efficiencies and flexibilities (i.e. physician market pay review, Title 38 hybrid conversions, elimination of professional standards boards, etc.)

Continued Barriers/Challenges:

• The Seattle-Tacoma labor market is unique, since the greater Seattle area was minimally affected by the economic downturn and the area has been a major hub for growth in both technology and healthcare over the last decade. In addition, the minimum wage for the Seattle area is $15.00 per hour. This is slightly below the

annual rate of an employee at GS–4, Step 1 on the Seattle-Tacoma locality scale. The local minimum wage has limited our competitiveness, since it provides a higher hourly rate than that paid to a GS–3, a grade widely used in our hiring for the same region.

• VA Puget Sound, Seattle campus, is in a prime location and property with a high growth rate and cost of living. Competition is not only with private sector hospitals but also with other Federal agencies as the area is saturated with other agencies.

• Available flexibilities are not available to recruit and retain personnel at VA, if they are existing Federal employees or taking an opportunity with another agency. Limited funding for education reimbursement.

• Length of job posting—15 business days as negotiated by the union is often too long to leave a position open if you have a viable pool of applicants.

• Professional Standards Boarding timeliness presents a delay with some Title 38 and Title 38 Hybrid occupations, with emphasis on those at a regional or national level.

• Required use of multiple systems for same or similar purposes that do not talk to each other causing additional admin work for H.R. team and users.

– Downgrading of positions such as H.R. Specialists, Engineers, Radiation Safety Officer, Credentialing Assistants, Administrative Officers of the Day (AOD), and other occupations.

• While there have been positive regulatory and policy changes occurring to support a more effective and efficient hiring process, it frequently increases the workload required of the local H.R. team members to enact.

Question 18. I have also received troubling reports about insufficient staffing and operations in the emergency department. Please provide an update on staffing levels and vacancies, by position type, and describe any barriers to achieving full staffing and retaining ED staff.

Response. As of 9/26/18, there are 570.7 approved-budgeted vacancies for VA Puget Sound HCS. Of these, there are 185 selections to fill positions ranging from administrative support to direct patient care, 40% of these selectees have a firm Entry on Duty between October–December while the others pending are undergoing the pre-employment process.

The ED currently has the following vacancies:

• 4 Physicians
• 1 Physician Assistant
• 1 Advanced Registered Nurse Practitioner
• 6 Registered Nurses
• 6 Nursing Assistants
• 2 Medical Support Assistants

Question 19. a. Please describe wait times at the ED over the year to date, and any instances of bed shortages. b. What impacts are projected as flu season begins, and what mitigation steps are being taken? (VHA 10NC)

Response. During FY 2017, VA Puget Sound's average time from the decision to admitting the patient was 178 minutes, compared to the national average time of 130 minutes at other VA hospitals. The average time in FY 2018 is slightly longer at VA Puget Sound at 197 minutes, compared to a national average of 131 minutes. Some of the ongoing ways we are actively addressing these challenges include patient flow assessment projects, daily huddles to optimize available beds, planned discharges, admissions, surgeries and staffing, and continuous process improvement to enhance quality, efficiency, safety and the overall Veteran experience.

b. What impacts are projected as flu season begins, and what mitigation steps are being taken?

Response. Flu season will increase the volume of Emergency Department patient encounters and subsequently the number of inpatient admissions, in particular, for vulnerable populations such as the elderly and those with chronic disease. Patients with suspected flu will need respiratory isolation to prevent the nosocomial spread of infection. There will be an increase in staff illness during the flu season which will decrease workforce productivity.

Risk mitigation steps include:

• We have hired additional staff in the Emergency Department, with approved and budgeted additional increases in process.

• We have hired additional staff in the inpatient medical units, with approved and budgeted additional increases in process.

• We have a contract with a nurse staffing agency for short term nurse staffing increases.

• We have improved processes around timely discharges to increase available isolation beds for patients with influenza.
• We have designed a process for continual and proactive assessment of bed availability that raises awareness and shares resources across units at times of high hospital census.
• We have met with local area hospitals (Madigan Army Medical Center) to improve collaboration around patient transfer at times of high hospital census.
• We have coordinated a robust staff influenza vaccination campaign.

VA PROGRAMS

IVF

Question 20. It has been two years since Congress gave VA the authority to provide IVF and other necessary fertility treatments for ill or injured veterans and their spouses. These treatments can help veterans realize their dream of starting a family, but access to this care promised to our veterans is still limited. We should not cut corners when it comes to our veterans and their families. Consistent and nationwide access to this program is essential to meet the commitments we have made, and the dreams for which these veterans fought so hard.

• Please describe how you are currently working to ensure additional providers are enrolled into the program and any other necessary steps taken to make sure our veterans have easy access to this treatment in the country. What steps can the Department take to more quickly enroll providers? Please also discuss how provision of ART will be incorporated into the Department's planning and implementation of the new Veterans Community Care Program.
• Please describe how VA is ensuring veterans and spouses receiving such treatments or about to start such treatments are not adversely impacted by repeated changes in non-VA care programs and contractors.

Response. IVF services are a very specialized medical procedure, and as such are only provided by a discrete number of clinicians around the country. When an IVF provider is needed by a Veteran and/or his or her family, VA's third party administrators actively work to bring the clinician into the community care network, if they are not already part of it. Active outreach is being performed for couples either approved for VA IVF health care benefits or those who are eligible for VA IVF health care benefits but whom we know are actively receiving IVF care outside our health care system. In the latter case, the couples can decide if they wish to transfer responsibility for their future/continuing IVF care and services to a VHA-authorized provider(s). VA has developed a mechanism to track these patients to ensure care coordination (including identification of preferred providers) for these Veterans and their families. Identifying these Veterans as early in the process as possible will help ensure more timely access to providers and the IVF care. IVF care that cannot be provided in-house will continue to be purchased in the community (invoking available contract or similar purchase authority.)

Electronic Health Records

Question 21. According to the reports from this spring, the Defense Department's $4.3 billion Cerner medical record system failed to achieve many of its initial goals at the first hospitals that went online and transition systems seamlessly. Technical problems and poor training resulted in numerous errors and reduced the number of patients who can be treated, according to interviews with more than 25 military and VA health IT specialists and doctors, including six who work at the four Pacific Northwest military medical facilities that rolled out the software over the last year. Recently, DOD has added a $1.1 billion contract to extend Leidos' work order to include EHR standardization since the VA had hired Cerner as its prime contractor. This is in addition to the original $4.3 billion Leidos- Cerner contract. A recent briefing to Congressional staff by VA Puget Sound cited Madigan Army Medical Center experiencing a 50 percent drop in clinician productivity during the transition. Clearly, already overburdened VA hospitals cannot afford to see this same effect.

a. Please provide a detailed description of the measures you are taking to ensure the VA EHR implementation will not fall victim to similar problem that the DOD implementation did.

Response. To mitigate possible impacts to the deployment of VA's new EHR in VA hospitals, VA is leveraging DOD's lessons learned from their IOC sites. Several examples of efficiencies VA is leveraging include: revised contract language to improve trouble ticket resolution based on DOD challenges; optimal VA EHRM governance structure; fully resourced PMO with highly qualified clinical and technical oversight

expertise; effective change management strategy; and, utilizing Cerner Corporation as a developer and integrator consistent with commercial best practices.

b. Please provide an updated timeline for EHR implementation in VA Puget Sound and VA Tacoma.

Response. By implementing the same electronic health record (EHR) solution as the Department of Defense (DOD), the Department of Veterans Affairs (VA) is not only taking advantage of a commercial solution and industry's best practices, but VA is also able to leverage lessons learned from DOD. These lessons learned are tracked to proactively reduce and address challenges at VA Initial Operating Capability (IOC) sites. As challenges arise throughout the deployment, VA will work urgently to mitigate the impact to Veterans health care.

Furthermore, there have not been any changes made to the deployment timeline provided to your staff on October 23, 2018, which includes the timeline for EHR implementation in VA Puget Sound and VA Tacoma.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 22. Mr. Secretary, as you stated in your testimony provided ahead of the hearing, one of your priorities is to address the 45,000 vacancies at the VA. One of the ways I proposed to address this issue was to increase the maximum amount the VA will provide to participants in the Education Debt Reduction Program, a measure I was proud to have included in the VA MISSION Act. Can you expand upon the measures you mentioned in your testimony on how you and your staff are addressing this crisis, and how you hope to recruit and retain the best candidates to these positions?

Response. The Education Debt Reduction Program (EDRP) is one of VHA's most viable tools for recruiting and retaining critically needed healthcare providers. VA is looking forward to implementing additional flexibilities authorized by the MISSION Act, specifically the increase in the maximum EDRP award amount to $200,000 and the establishment of a program targeted to recruit recent medical school graduates, residents and fellows by repaying student loans in exchange for service at VA. VHA will also be expanding the Health Professions Scholarship Program to include offers of medical school scholarships for 50 individuals as required under the MISSION Act.

Question 23. Mr. Secretary, I'm sure you know that today, veterans with no service-connected disabilities who have higher incomes are not able to get care from the VA. My office gets calls from Vermont veterans who know they don't qualify for VA health care, but want to get their care there. Many have even suggested that they'd be willing to pay to access VA health care. I think this idea makes a lot of sense. Do you think that all veterans—regardless of income—should be able to choose VA if they want? Are you willing to work with me on figuring out what it would take to give these veterans the choice of VA health care?

Response. The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104–262) mandated that VA deliver services to Veterans in accordance with statutory requirements who have service-connected conditions, to Veterans unable to pay for necessary medical care, and to specific groups of Veterans, such as former prisoners of war. The legislation permitted VA to offer services to all other Veterans to the extent that resources and facilities were available; it also required VA to develop and implement an enrollment system to facilitate the management and delivery of health care services. This has been accomplished through the establishment of eight (8) Priority Groups with Priority Group 1 (Veterans who are 50 percent or more service-connected and medal of honor awardees) and Priority Group 8 which includes Veterans whose incomes are above certain thresholds.

In 2003, VA made the difficult decision to stop enrolling new Priority Group 8 Veterans in order to ensure the provision of timely and quality medical care. However, on June 15, 2009 regulations were issued that allowed VA to reopen enrollment for VA health care to Veterans whose previous calendar year's household income exceeded the current VA national income thresholds or Geographical Means Test Thresholds by 10% or less. While this new provision did not remove consideration of income, it did increase established income thresholds allowing more Veterans to qualify for enrollment in VA's health care system. Also, in 2015 VA eliminated the use of net worth as a determining factor for both health care programs and copayment responsibilities. This change made VA health care benefits more accessible to lower-income Veterans

Question 24. Mr. Secretary, I know we've had a lot of conversations around choice and privatization. VA remaining strong is central to the whole idea of "choice"—that veterans should have the choice of where they go for care because VA must be one of the choices given to the veteran. I am worried, however, that right now—even with the changes from the MISSION Act—the VA is set up to fail as an organization, and fail our veterans, because of the current bureaucracy we've set up. Let me walk you through what I mean by that.

Take a veteran, who calls the VA CBOC in Burlington, my home town, for an appointment—let's say it's a dermatology appointment. The veteran is told the next available appointment is in 60 days, making her eligible for Choice. So she is referred to the UVM Medical Center, where the wait is 12 MONTHS for a new patient. So, two months at VA—12 months in the community. At that point, the veteran has two choices—call VA back and say she wants the appointment at the VA CBOC in 60 days, or make the appointment for community care in a year. There are two problems with this: First, we're relying on the veteran to understand this nuance—that she still has the choice of VA care—and relying on her to take the extra step of calling the VA back and setting up the appointment. But here's the second problem: If the veteran does that—calls back the VA and sets up the appointment for two months from now, that VA appointment ends up making the CBOC's wait times look bad, because they're not hitting their wait time goals. That leaves the CBOC to decide between either doing what's good for the veteran but knowing it will mess up their numbers, or doing the wrong thing for the veteran but what looks better administratively for them.

Mr. Secretary—Do you really think this makes sense? How will you make sure that VA medical centers and clinics aren't ultimately hurt when they do the right thing for their patient?

Response. VA is working toward taking back community care scheduling and care coordination from contractors. VAMCs will be responsible for scheduling and care coordination activities. Owning customer service is a top priority for VA and the third-party administrator will only assist with these activities when a VA facility has requested the support. VA is developing a tool that allows the Veteran and VA to see the average wait time for the community care appointment. VA's plan is to phase in the use of this tool prior to MISSION act implementation so Veterans may make a more informed decision on the best location to receive the requested care.

Question 25. Mr. Secretary, last month VA testified on my legislation to expand access to dental care for veterans. I want to thank you for supporting the idea of expanding access to veterans for dental care. I'm glad this is something the VA supports. Now, I understand you're worried about the cost. First, this Committee doesn't get to make the decisions about how much money the VA gets—that is the job of the appropriations committee. But let me promise you that I will do everything I can to make sure the VA gets the money needed to accomplish any expansion that this Committee approves. And I hope we can work together on that. Will you work with me on that?

Response. To be clear, VA did not support many of the sections in the draft legislation presented at the August 1, 2018, Senate Veterans' Affairs Committee hearing, as several were unnecessary given our current authority and other provisions either required significant additional resources or relied on unproven approaches to treatment. With that said, we are always ready to provide technical help. We agree the preventive model of dental care is the most cost-effective. Section 3 of the draft bill would have required VA to assess the feasibility and advisability of furnishing dental services and treatments to Veterans enrolled in VA health care but who are not eligible for such care under other authorities. We note that expansion of dental benefits would create a surge of new patients who we believe would have unmet dental needs due to their prior lack of dental care. These previous unmet needs would be more involved with a higher associated cost to treat and take more dentist time. We expect the increased demand and time would create access to care hurdles based on our current resource allocation. In the short-term, we expect an initial surge in demand for dental care and individual costs would stabilize over time. Of the 9.1 million Veterans enrolled for VA health care, only 1.2 million are currently eligible for dental care, and approximately 530,000 of those Veterans received dental care through VA in fiscal year 2018. We expect that a 758 percent increase in dental eligibility would create a significant short-term spike in resources needed to meet the increased demand. Following the short-term spike, VA would need a substantial increase in resources for the long-term due to the sheer number of newly eligible Veterans. There may be opportunities to explore expansion of dental benefits to these 8 million Veterans who currently are not eligible or have not used dental benefits in the past, in a way that is considerate of financial impact in both the short-term and long-term, and we would be happy to discuss any such options with you.

Question 26. Mr. Secretary, to my mind, VA is already spending this money on dental care—it's just that you're spending it on the back end, when costly health care problems have already occurred rather than on the front end, preventing these problems in the first place. Let me give you some data, which you might find helpful. UnitedHealthCare—a private insurance company, which you probably won't hear me site very often—did a study where they found that—and I quote: "individuals with chronic conditions who regularly received recommended dental care . . . had medical claims that averaged nearly $1,500 lower annually than those with chronic conditions who received . . . no dental care at all." Given the especially high rates of veterans with chronic conditions, I think it's reasonable to assume this same cost savings of $1,500 per person would easily translate to the veteran population. That is to say, by providing dental care to veterans, we'd actually have the opportunity to save money, not spend more. So, Mr. Secretary—can you tell me that if we can show that providing dental care wouldn't actually cost the VA more money, that you'd support it?

Response. Yes, VA will work closely with Congress to estimate utilization and work toward implementing any legislation that is approved. The President's FY 2018 budget of $1.2 billion for VA dental care covered oral health care services for the 530,000 Veterans that were served. The budget is approximately $2,300 per year per Veteran. As previously stated, these dental needs will be more complicated with a higher associated cost to treat for newly eligible Veterans. Our research found no data to estimate utilization of new benefits such as those proposed for an additional 7.9M Veterans. Published data on dental utilization varies ranging from 35% to 60%. The higher usage is associated with those that have third-party dental benefits. If eligibility is expanded, the Office of Dentistry will collaborate within VHA to works toward the goal of using dental care to improve Veterans' overall health care.

Question 27. Mr. Secretary, I have always believed that the cost of war must also include taking care of our veterans when they return home. To my mind, this includes providing benefits to those who may have been exposed to dangerous chemicals in service to our country, such as Agent Orange. While the VA provides benefits to these veterans, the burden of proof is much higher for those who served in Vietnam's territorial waters compared to their counterparts who served on the ground. I have heard from many Vermonters that this increased burden of proof has negatively impacted their ability to receive the care they need. Mr. Secretary, will you work with me and the overwhelming majority of Congress who want to create a more lenient burden of proof for our Blue Water Navy veterans, and ensure they receive the care they need due to their service?

Response. VA stands ready to work with Congress to ensure the equitable administration of disability compensation for all Veterans including Blue Water Navy Veterans. VA's current regulatory definition of service in Vietnam excludes service in the offshore waters of Vietnam unless the conditions of service involved duty or visitation in the Republic of Vietnam. This is because there is not sufficient scientific evidence showing that individuals who served in the offshore waters risked exposure to Agent Orange. However, VA has developed procedures for Veterans who served in the offshore waters to ensure that each case is reviewed individually on a facts-found basis. This procedure allows adjudicators to grant benefits for presumptive service-connected conditions when the evidence demonstrates that a ship operating in the offshore waters:

1) temporarily enters an inland waterway,
2) docks to a pier or shore, or
3) sent personnel or supplies ashore.

VA has established a lenient burden of proof for the latter as a statement provided by the Veteran saying he went ashore would be sufficient to grant benefits.

Question 28. Mr. Secretary, as you know, the White River Junction VA Medical Center has been without a permanent director for some time now. Now that we have a new VISN 1 Director, will you commit to working with me and Mr. Lily to quickly fill the White River Junction director role with someone who will be there for the foreseeable future?

Response. We recognize your concerns about filling the Medical Center Director position at White River Junction VA Medical Center. Strong medical center leadership is critical to maintaining the high standards and quality of care of Veterans being served by this system. You can be assured that VA is committed to hiring the best qualified candidate for the Director position as soon as possible. The position was announced on September 12, 2018 and closed on September 26, 2018. VA's selection of Senior Executive Service (SES) leaders is a thorough and rigorous process. We anticipate completing the hiring process for this position as soon as possible.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

AGENT ORANGE

Question 29. Your letter to the Committee neglects to mention several sections of the "Blue Water Navy Vietnam Veterans and Agent Orange" report issued by IOM in 2011, which corroborates the Australian report finding "that in experiments simulating the water-distillation systems used on Navy Ships the systems had the potential to enrich TCDD concentrations." You also ignore IOM's Veterans and Agent Orange 2008 Update, published in 2009 that states, "a presumption of exposure of military personnel serving on those vessels is not unreasonable." The effort to cherry-pick details from the report undercuts your opposition to extending presumption of service connection to Blue Water Navy veterans. Does the Department dispute the science behind the IOM and Australian studies related to distillation? Why does VA refuse to act when IOM presents the Department with scientific evidence linking health conditions, such as bladder cancer, Parkinson's like conditions, etc. to herbicide exposure, as was clear in the 2016 release report?

Response. Advocates for Blue Water Navy Veterans have framed the issue as there being a lack of science from the National Academy of Medicine, as well as other sources, to exclude these Veterans from a presumption of Agent Orange exposure. However, this is a mischaracterization of the standards for determining that exposure occurred. When Congress passed the Agent Orange Act, it required that there be "sound medical and scientific evidence" to support such exposures.

VA has determined that this threshold has not been met. In 2011, the Institute of Medicine (IOM), now the National Academy of Medicine, reviewed all available scientific evidence and concluded that exposure among Blue Water Navy Veterans "cannot reasonably be determined." The IOM's report indicated that Agent Orange was destroyed by sunlight within hours of application and any that survived would rarely make it out to the South China Sea because of the major dilution factor.

Media and several Veterans Service Organizations supporting the legislation have relied on an Australian study from 2002 that was designed to mimic Royal Australian Navy distillation policies and procedures; however, this study is irrelevant to U.S. Navy policy and practice. U.S. Navy ships were required to draw up seawater for conversion to shipboard potable water at least 12 miles offshore from any river, a distance at sea where the presence of Agent Orange was highly unlikely. As points of reference, 12 cubic miles of water is equal to 13.2 trillion gallons, and 1 trillion gallons of water flow over Niagara Falls in a single month. Thus, the dilution factor would have been significant. IOM considered the Australian study in its 2011 review and stated the significance of the study's findings was highly uncertain for U.S. Blue Water Navy ships.

VA continues to study the science behind this issue. In late 2019, VA will publish the peer-reviewed Vietnam Era Health Retrospective Observational Study. The study will compare the health and morbidity of deployed Vietnam Veterans versus a cohort of non-deployed Veterans and similarly-aged U.S. residents who never served in the military. VA collected data from nearly 43,000 participants including nearly 1,000 Blue Water Navy Veterans. VA believes it is necessary to be informed by the finding of this study before further action is taken.

Question 30. What is the timeline for VA and OMB to act on the IOM recommendation regarding bladder cancer, Hypothyroidism, Parkinson's-like conditions, and hypertension?

Response. The National Academy of Medicine (NAM) issued a contracted Veterans & Agent Orange report in March 2016. VA organized work groups and deliberated, as it had under the Agent Orange Act. The workgroups made recommendations to then-Secretary Shulkin. Secretary Wilkie is currently reviewing the recommendations made to Secretary Shulkin. A new NAM on Veterans & Agent Orange was issued November 2018 and is also currently under review. The timeline for this review is expected to extend to this summer.

ELECTRONIC HEALTH RECORD

Question 31. a. Please discuss how patient information will be housed under the new Electronic Health Record between DOD and VA?

VA Responses: Patient information for the Department of Defense (DOD) and the Department of Veterans Affairs (VA) will be physically housed at the Cerner Federal Hosted Enclave, which is comprised of two facilities. One facility serves as the failover and continuity of operations (COOP) back-up for the other. Data is encrypted at rest and in transit, before it leaves the facility. Connectivity between

the two facilities is achieved via fully redundant with no single points of failure high-speed networks.

b. How will VA ensure that patient data is shared between community providers and VA? How will you ensure that the data is protected against cyber intrusion?

VA Responses: VA's new EHR will have the capability to connect and securely exchange patient data with community care providers, specifically, but not limited to, CommonWell Health Alliance and DirectTrust by supporting their specifications, security, and content specifications. Once the VA EHR is deployed, the solution will participate in a Health Information Network (HIN) or Qualified Health Information Network (QHIN) that has agreed to the terms of the Trusted Exchange Framework and Common Agreement (TEFCA). Participation is defined as being in production with HIN or QHIN, under a participation agreement that aligns with the TEFCA.

c. Do you think that you have the appropriate team in place to implement the Cerner contract?

VA Responses: VA will deploy DOD authorized security boundary protections using a combination of Cybersecurity Service Provider (CSSP) services and joint Department cybersecurity operations centers (CSOC) visibility and incident response capabilities. The joint electronic health record (EHR) system is stored within the DOD-authorized enclave (MHS GENESIS) hosted at Cerner Corporation. MHS GENESIS risk management and continuous monitoring activities are supported through Defense Health Agency (DHA), DOD Health Management System Modernization (DHMSM) Program Management Office (PMO), and Office of Electronic Healthcare Record Modernization (OEHRM) unified interagency cybersecurity programs.

d. Will you commit to keeping the Committee informed about the implementation of the contract?

VA Responses: Yes, VA understands the importance of transparency and will continue to keep Congress informed about the Department's new EHR rollout. VA meets quarterly with with staff from the House and Senate Appropriations and Veterans' Affairs Committees to brief on the progress of the EHRM development and implementation.

OFFICE OF INSPECTOR GENERAL

Question 32. Several Members of the Committee have voiced concerns regarding the independence of the Office of the Inspector General; in fact, we approved an amendment to affirm the role of the Inspector General and to preclude VA from impeding in any IOG investigation. Since your confirmation, have you met with IG Missal? Have you reaffirmed VA's commitment to providing OIG with any and all documentation the office requests for investigations?

Response. As I stated during the hearing, I view the Inspector General as a partner and not subordinate to the Secretary. The Inspector General works closely with the Office of Accountability and Whistleblower Protection and the Veterans Health Administration's Office of Medical Inspector to investigate allegations of misconduct or other improprieties. In my previous position, I worked with the Department of Defense Inspector General and plan to foster that same working relationship with Mr. Missal. I was asked during the hearing if I would commit to not interfere or hinder the independence of the Inspector General and be transparent with requested information. I would like to state again that I am commitred to that. I have met with Mr. Missal as recently as October 5, 2018, and it is my goal to regularly meet with him for updates and discussion. I strongly support the Inspector General's investigations and mission.

PERSONNEL

Question 33. Currently there the Deputy Secretary and Under Secretary of Health Affairs positions are filled with someone in an acting capacity. How are you working with the Administration to find individuals to fill these senior leadership positions?

Response. To fill the Under Secretary for Health (USH) position there is a process that includes forming a commission which is convened under the provisions of 38 U.S.C. Section 305. The commission consists of the Deputy Secretary of VA along with specific members who have experience in various areas of the Health Administration fields. VA's Corporate Senior Executive Management Office (CSEMO) begins the process by gathering all the applicants' resumes and conducting a minimum qualifications review. After that, the remaining candidates are referred to a Subject Matter Expert (SME) panel, who then provides a rating and ranking of the candidates' applications. The scores are then compiled, and a "best qualified" list is then presented in the form of a binder (with all supporting documents) to the Com-

mission, which conducts the interviews. We are currently at the stage where we are compiling the scores to identify those best qualified. We expect to present the list to the Commission and have the interviews conducted during the last week of November. After those interviews are conducted, the Commission will make a recommendation of at least three individuals to the Secretary. The Secretary will then forward the recommendations to the President with appropriate comments for the President's consideration.

Currently, there is a permanent Principal Deputy Under Secretary for Health (PDUSH) in place (Dr. Richard Stone) and he is currently serving as the Executive in Charge of VHA. Because of his role, there is an "Acting" in place for the PDUSH position, but that is only until a new USH is identified and onboarded. After that, Dr. Stone will resume his duties as PDUSH.

PATIENT SAFETY

Question 34. Does VA leadership review OIG reports related to patient safety with adverse outcomes? And if leadership does review these reports, are the recommendations and findings applied throughout the entire VA healthcare system?

Response. VA and VHA leadership reviews OIG reports and involves the National Center for Patient Safety to ensure any findings that risk harm to Veterans are assessed and used to inform system wide improvements.

In general, VA leadership learns of adverse outcomes to patients through communications with facility or VISN leadership and takes actions as soon as possible upon learning of a potential risk to patient safety. Understandably, if a serious safety issue has been reported to the OIG, VA cannot (and does not) wait for the OIG to complete its review and publish its investigative report before assessing the situation on the ground and determining what corrective action, if any, is needed to eliminate any actual or potential patient safety risks. In other words, VA does not delay any needed corrective action but acts promptly in the interim. Typically, the OIG will assess, as part of its investigation or review, any interim corrective action taken by VA and its sufficiency. Patient safety is paramount.

In response to reported adverse events for which there may be systemic root causes, VHA's National Center for Patient Safety assesses patient safety findings, usingindustry standards. If a safety risk is of nationwide concern, the National Center for Patient Safety issues a nationwide alert that informs the field both of the problem, affected facilities or service-lines, and the follow-up actions to be taken in response. See VHA Handbook 1050.01 for a fuller discussion of the Patient Safety Program.

VA MISSION ACT

Question 35. As VA begins to implement the VA MISSION Act, can you discuss what metrics you will use to ensure care that veterans receive in the community is the same standard and timely? What metrics will you use to track whether community providers are trained in veteran specific conditions?

Response. Section 133 of the MISSION Act requires VA to develop competency standards for community providers in which VA has clinical expertise. At this time, the Section 133 group is still working out the metrics that will meet the spirit of Section 133. Currently, this includes all community providers completing an overview course covering military culture, caring for Veterans, suicide prevention, and other resources. Moreover, required training for sub-specialty providers in the areas of Traumatic Brain Injury (TBI), post-traumatic stress syndrome (PTSD), and Military Sexual Trauma (MST) is also being reviewed by the Section 133 team.

As for tracking the completion of the courses previously discussed and opioid training through Section 131 of the MISSION Act, the courses will be accessed through VHA TRAIN, which is the external system that houses community provider training. At this time, VA currently tracks community provider completion of opioid training and additional courses will be added (as noted above). Once a training course is uploaded into VHA TRAIN, course completion will be cross-referenced with a master list of community providers the VHA Office of Community Care maintains for tracking and reporting.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

VA UNDER SECRETARY FOR HEALTH VACANCY

Question 36. President Trump has yet to nominate someone for the important role of Under Secretary for Health. The Veterans Health Administration has a lot on its

plate in the coming years including implementation of the new Veterans Community Care Program and Electronic Health Record modernization so a permanent, stable leader is vital. However, instead of moving toward a permanent lead, Dr. Carolyn Clancy, Acting Under Secretary for Health, was replaced in mid-July by Dr. Richard Stone. Could you please provide an explanation for that staffing change and an update on any progress toward a permanent Under Secretary?

Response. To fill the Under Secretary for Health (USH) position there is a process that includes forming a commission which is convened under the provisions of 38 U.S.C. Section 305. The commission consists of the Deputy Secretary of VA along with specific members who have experience in various areas of the Health Administration fields. VA's Corporate Senior Executive Management Office (CSEMO) begins the process by gathering all the applicants' resumes and conducting a minimum qualifications review. After that, the remaining candidates are referred to a Subject Matter Expert (SME) panel, who then provides a rating and ranking of the candidates' applications. The scores are then compiled, and a "best qualified" list is then presented in the form of a binder (with all supporting documents) to the Commission, which conducts the interviews. We are currently at the stage where we are compiling the scores to identify those best qualified. We expect to present the list to the Commission and have the interviews conducted during the last week of November. After those interviews are conducted, the Commission will make a recommendation of at least three individuals to the Secretary. The Secretary will then forward the recommendations to the President with appropriate comments for the President's consideration.

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MAR-A-LAGO

Question 37. On April 20, 2018, as Acting Secretary, you traveled to West Palm Beach and attended a meeting with the "Mar-a-Lago Crowd" at Mar-a-Lago, a property owned by President Trump. Chief of Staff Peter O'Rourke also traveled with you on that trip. In documents obtained by ProPublica through the Freedom of Information Act, Mr. O'Rourke's expense report for the trip details that he stayed at Mar-a-Lago the night of April 19, 2018 at a cost of $195. Mr. O'Rourke also incurred lodging fees of $202.27 for that same night at a Holiday Inn, the original hotel that was canceled late on the same day as check in, resulting in a charge of one night's stay. In an email, it is explained that Mr. O'Rourke was "redirected by a White House task after the 24-hour cancellation period." Could the Department please provide additional information regarding what official task Mr. O'Rourke was directed to carry out that required him to redirect to one of the president's properties, at additional cost to taxpayers?

Response. The COS was redirected to stay at this lodging in order to facilitate his attendance at a required meeting with the then-Acting Secretary of Veterans Affairs.

PROVIDER RECRUITMENT AND RETENTION

Question 38. The most recent data from the VA Office of the Inspector General shows that nationwide the VA is still dealing with staffing shortages. In Honolulu, psychiatry is the number one shortage and there are 42 clinical shortage areas. Can you provide an update on what VA is doing to improve provider recruitment and retention in Hawaii and nationally?

Response. In response to a Government Accountability Office Report in March 2018, VA Pacific Islands HCS (VAPIHCS) organized a multidisciplinary systems redesign group to review and evaluate strategies to promote physician recruitment and retention. The group identified a list of best practices (some of which were already being utilized by VAPIHCS) that have proven beneficial at other VA facilities, including the use of a task force to explore options for improving recruitment and retention. In May 2018, VAPIHCS appointed a physician recruitment and retention taskforce aimed at identifying additional actions that could be taken to improve physician recruitment and retention. To date, the task force has identified several recommendations, which are currently being implemented:

1. Initiate the hiring process immediately after being notified of an upcoming vacancy
2. Utilize open continuous recruitment
3. Expedite the credentialing and privileging process

4. Maximize use of Recruitment/Retention/Relocation incentives ("3 Rs")
5. Maximize use of the Education Debt Reduction Program (EDRP)
6. Present salary offer early in the hiring process
7. Utilize other recruitment events in addition to USA Jobs

In addition, VAPIHCS authorized more than $200,000 in relocation and retention funds for physicians. Of the nine physicians who received funds on 2018, eight are still on staff at VAPIHC.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO HON. ROBERT L. WILKIE, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 39. Each generation of veterans have had their own form of toxic exposure, whether Mustard Gas, Agent Orange, or any number of chemicals and hazardous environments our service personnel work in today.

a. What efforts are currently being undertaken to identify and track toxic exposures?

Response. There are several Department of Veterans Affairs (VA)/Department of Defense (DOD) collaborative activities aimed at improving the identification and tracking of toxic exposures. The primary initiative, which has been 25 years in the making, is the development of the web-based solution, Individual Longitudinal Exposure Record (ILER). The ILER pilot was launched on October 1, 2018. ILER addresses a critical gap in current readiness and healthcare capabilities to assess and better document individuals' service related exposure.

ILER will bridge this gap by providing an easily accessible and searchable electronic record of a servicemember's occupational and environmental exposures (garrison- and deployment-related) from initial entry to end of service.

ILER will enable improvement of exposure knowledge, healthcare, epidemiological assessments of exposures, exposure-related medical research, and disability evaluation and claims processes for servicemembers and veterans.

ILER will leverage and collate the exposure and deployment data available to present the most relevant information to DOD and VA. The ILER Pilot version 1.0.0.0 will leverage information provided from the following sources:

- Defense Occupational and Environmental Health Readiness System—Industrial Hygiene (DOEHRS-IH)
- Military Exposure Surveillance Library (MESL)
- Military Health System (MHS) Data Repository (MDR)
- Armed Forces Health Surveillance Branch (AFHSB)
- Defense Manpower Data Center (DMDC)
- Defense Enrollment Eligibility Reporting System (DEERS)
- Contingency Tracking System (CTS)

These systems will provide the initial data source of the pilot and will provide a person-centric record that can be utilized by Clinicians, Claims/Benefits Processors, Program and Policy Analysts, Researchers and Informatics/Analytics Professionals to enhance medical care and perform a more comprehensive health surveillance.

b. What steps can be taken to prepare the Department of Veterans Affairs and the next generation of veterans with toxic exposures for the next 20 years?

Response. Please see efforts described in response to (a) above.

c. Is the tracking of toxic exposures being considered in the design of the new Electronic Health Record?

Response. Yes, VA will track self-reported toxic exposures to Veterans with its new EHR. The EHR will utilize a commercial population health platform, HealtheIntent, which provides registries as part of its suite of capabilities. Migration of current VA self-reporting registries, such as Traumatic Brain Injury (TBI), military sexual trauma (MST), airborne hazards and open burn pit registry (AHOBPR), will be transitioned into the HealtheIntent platform as part of VA's data migration efforts.

Question 40. The Departments of Defense and Veterans Affairs previously attempted to replace their separate EHR systems with a single shared system through the Integrated EHR (iEHR) initiative, unfortunately this effort was abandoned in 2013. Communication and collaboration between the two departments will be essential for the success of the current, interoperable EHR rollout.

Please detail the current structures in place to facilitate communication and collaboration between the two departments. What systems and structures are planned to be put in place as the rollout continues?

Response. VA and DOD are continuing to work closely together to advance transparency and hone governance through an interagency decisionmaking perspective

through the DOD/VA Interagency Program Office (IPO) established by Congress. The Departments' Secretaries recently announced a joint statement reconfirming their commitment to a joint and interoperable EHR rollout. VA is currently working with DOD and IPO to analyze and assess prospective additional efficiencies that may optimize the utilization of other resources across VA, DOD, and IPO's organizational EHR implementation and modernization portfolios.

Question 41. It was reported that the DOD's rollout of the Cerner system in the Pacific Northwest was plagued with problems that significantly impacted patient care. Any rollout of a new EHR system is going to experience significant challenges, but it is important to learn from those and adjust future strategies.

a. Does the VA have detailed reports on the problems encountered during the DOD's initial Cerner EHR rollout?

Response. Yes, DOD lessons learned were shared with VA during the alpha contract negotiations phase with Cerner Corporation. These lessons learned were immediately leveraged to improve the quality of the Indefinite Delivery, Indefinite Quantity contract that was ultimately signed on May 17, 2018 between VA and Cerner Corporation. VA maintains a running log of lessons learned, and incorporates regular feedback from DOD, DHA, and DHMS PEO into its lessons learned documentation. By learning from DOD, VA will be able to proactively address challenges and further reduce potential risks at VA's IOC sites.

b. What were the underlying causes of those problems? Which of these underlying causes are likely to impact deployment of a Cerner EHR system in VA hospitals?

Response. To mitigate possible impacts to the deployment of VA's new EHR in VA hospitals, VA is leveraging DOD's lessons learned from their IOC sites. Several examples of efficiencies VA is leveraging include: revised contract language to improve trouble ticket resolution based on DOD challenges; optimal VA EHRM governance structure; fully resourced PMO with highly qualified clinical and technical oversight expertise; effective change management strategy; and utilizing Cerner Corporation as a developer and integrator consistent with commercial best practices. For additional specificities on DOD's lessons learned, VA recommends reaching out to DOD.

c. What office will be responsible for cataloguing the "lessons learned" from the DOD rollout and who will be leading that office?

Response. VA, specifically the Office of Electronic Health Record Modernization (OEHRM), is responsible for cataloguing and utilizing DOD's lessons learned to mitigate potential challenges throughout its deployment.

Question 42. One in ten Veterans Affairs jobs are currently unfilled. As of September 26th, there are 128 positions posted in USAJOBS for West Virginia Hospitals and Benefits offices, including for many important clinical and social work positions. Vacancies have the potential to increase the burn out rate of employees as well increase the number of veterans that need to be sent out into the community for care.

a. In the 60 days that you have been in office, has there been discussion of developing and/or implementing a vacancy action plan?

b. If no such plan is in place will you commit to working on one and reporting back to us?

Response. I understand your concern about vacancies in VA. It is important to note that staffing plans consider workforce turnover and growth, and built into those staffing plans, is the expectation that there will always be vacant positions in some stage of recruitment. We know that Veterans receive the same or better care at VA medical centers as patients at non-VA hospitals. Vacancies reflect a hiring demand signal, but do not indicate significant shortages in most instances. In areas where vacancies are higher due to factors such as rurality, high cost geographic areas, and market competition, VA utilizes the authorities granted under the VA MISSION ACT to partner with community care providers. The best indicators of adequate staffing levels are Veteran access to care and health care outcomes, and we are continuing to make substantial progress on these measures.

Question 43. We are pleased to see that the VA is implementing an appeals improvement and modernization plan. However, our office alone is currently working with the department on 200 cases. Some constituents are dealing with claims that have been lost or put off for over 5 years.

a. What have you observed that could improve the appeals process?

Response. The current appeal process for VA benefit claims does not serve Veterans well, with resolution times for veterans averaging 3 to 7 years depending upon whether the Veteran appeals to the Board of Veterans' Appeals (Board). To improve this process, VA worked closely with its stakeholders (including Veterans Service Organizations, private attorneys, and Congressional staff) to develop a new, more efficient, decision-review process for claims. The President signed this process

into law as the Veterans Appeals Improvement and Modernization Act in August 2017. VA is on track to implement it in February 2019 for claimants who receive decisions on their claims after the February implementation date.

The new law provided VA several options to improve the appeals process by increasing efficiencies in established practices and by providing Veterans with opportunities to opt into a new system that provides claimants with the opportunity to file supplemental claims based on new evidence, have higher-level adjudicators review prior decisions, or appeal directly to the Board.

b. What steps are you taking to better address the initial veteran claim process to ensure there is not a backlog of appeals?

Response. Historically, Veterans consistently initiate appeals of claim decisions at a rate of 10 to 12 percent. The solution to effectively managing disagreements is through more review options and timely decisions under the new statute, which has replaced the long, complex, and confusing legacy appeals process.

VA remains committed to resolving its legacy appeals as quickly as possible by adding additional appeal processing resources both in VBA and at the Board, and implementing RAMP. As noted above, RAMP provides Veterans with legacy appeals an opportunity to opt into the process authorized by the Modernization Act. If they elect to participate in RAMP, Veterans have access to the key features of the new process, to include more review options, quicker decisions, protection of the effective date for payment of benefits regardless of the review option chosen, protection of favorable findings made in VA decisions, and processes that are easier to understand.

Beyond the legal changes that will go into effect in February, VBA is looking to increase operational efficiencies. Accordingly, effective October 1, 2018, VBA established three new Decision Review Operations Centers (DROCs) at the St. Petersburg and Seattle Regional Offices, as well as the former Appeals Resource Center in Washington, DC. The DROCs will consolidate the processing of all Board remands, Board full grants under the new system, and higher-level reviews under the new system.

Question 44. The VA Office of the Inspector General reported that the claims backlog only covers about 79 percent of relevant cases, with a host of others misclassified, mistakenly excluded and, in some cases, only acknowledged as overdue after the files had finally been processed. What steps are being taken to more accurately count and report the number of claims awaiting decision for more than 125 days?

Response. The VA Office of Inspector General (OIG) reported, and the Veterans Benefits Administration (VBA) acknowledged, that VBA's claims backlog has historically and consistently included only a set of rating-related end products that grant entitlement to disability compensation and pension benefits. OIG notes that additional claims are not counted in the backlog that, in their opinion, should be, because they require a rating decision. The relevant claims identified by OIG that are not counted in VBA's rating claim inventory or backlog but do require a rating decision, are those that do not consider entitlement to the core disability compensation and pension benefits. Examples of these end products are provided by OIG and include technical corrections to rating decisions (where a rating-related end product had already been completed by the agency) and entitlement to special housing benefits.

Additionally, OIG identifies a very small number of claims missing from backlog reporting due to human error. OIG identified situations where some claims are erroneously excluded from the backlog and other situations where claims are erroneously counted as backlog, when they are in fact not. However, OIG also acknowledged that VBA staff who discovered these errors made the necessary adjustments to properly reflect the backlog status. VBA has concurred in principle with the OIG's recommendation to consider revising which claims are included in VBA's reported disability claims backlog and will engage with stakeholders to ensure that any proposed changes are well understood. VBA is currently reviewing how best to supplement or adjust reporting on the rating-related backlog, which has followed consistent rules since the backlog was defined and reporting began in 2009.

Question 45. The most recent data from HUD found that the number of homeless veterans increased by almost 2 percent from 2016 to 2017, the first time the number has risen since 2010. Meanwhile, over the past year, VA has issued and subsequently reconsidered proposals to terminate or reallocate funding within programs like Grant Per Diem and HUD-VASH. This has left providers in West Virginia concerned about whether their grants will be renewed and forced difficult decisions on staffing and capacity.

How do you plan to keep local providers informed of changes relevant to their grant programs in a timely manner?

Response. The GPD National Program Office provided regular communication regarding the grant selection timeline, notifications of conditional selection and non-selection of applicants, as well as the transition process for non-selected applicants who had grants that would be ending September 30, 2018.

• May 14, 2018—GPD National Program Office held a conference call reviewing the anticipated timeline regarding the grant selection process. This included the plans for notification via correspondence which was to occur at the end of the month of May. Presentation slides for this call were subsequently posted on the GPD provider website https://www.va.gov/HOMELESS/GPD_ProviderWebsite.asp

• May 29, 2018—Correspondence was mailed to all applicants noting whether their application was conditionally selected or non-selected. Additional correspondence was sent to non-selected applicants that had a GPD grant award that would be ending on September 30, 2018, which provided instructions for winding down their grant projects. This included working with the local VA medical center to ensure the placement of any homeless Veterans in the program to permanent housing or alternative services by September 30, 2018. In addition the GPD National Program Office was in communication with the Directors of VHA's other homeless programs to alert them of coming changes and coordinate support with these program services to assist homeless Veterans as needed.

• June 11, 2018—GPD National Program Office held a conference call to review the notification correspondence that had been sent to grant applicants, as well as to review the status of grantees who were eligible for an option year renewal in Fiscal Year 2019. The presentation slides were posted on the GPD provider website.

• The GPD National Program Office also responded to inquiries from applicants via phone call and a special email group available to communicate with the grant office.

• In addition to the notifications of grantees, the GPD National Program Office was in communication with the Network Homeless Coordinator for VISN 5 and the GPD liaison in Martinsburg, WV (where Potomac Highlands Supported Services, a non-selected applicant with grant ending September 30, 2018 is located) to monitor the status of all the Veterans residing there and to ensure these Veterans were successfully placed. All the Veterans in the program were successfully placed by September 5, 2018.

Question 46. Staffing shortages are a persistent challenge at the VA as well as many other Federal agencies. In order to fulfill its vital missions it is important that the VA is adequately staffed with well trained and highly motivated employees, in both clinical and non-clinical positions. A recently released Office of the Inspector General report stated the most commonly cited challenges to staffing at VHA facilities fit into three categories: (1) lack of qualified applicants, (2) non-competitive salary, and (3) high staff turnover. In a letter to congressional leaders announcing there would be no pay increases for Federal Employees in 2019 President Trump stated "These alternative pay plan decisions will not materially affect our ability to attract and retain a well qualified Federal workforce."

Do you agree with the President's assessment that canceling scheduled pay increases will have no material effect on recruitment and retention of well-qualified VA employees?

Response. I understand your concern about vacancies in VA. It is important to note that staffing plans consider workforce turnover and growth and the expectation that there will always be vacant positions in some stage of recruitment. We know that Veterans receive the same or better care at VA medical centers as patients at non-VA hospitals. Vacancies reflect a hiring demand signal, but do not indicate significant shortages in most instances. The best indicators of adequate staffing levels are Veteran access to care and health care outcomes, and we are continuing to make substantial progress on these measures. Cancelling the scheduled annual pay adjustment for 2019 will make it even more challenging for VA to recruit and retain staff in clinical and non-clinical positions. In most, it not all of the rural locations, and even in some major cities, VA salaries lag significantly behind the local labor market for some occupations. In addition, several clinical occupations with special rates continue to have recruitment and retention problems due to VA's inability to offer competitive salaries.

A P P E N D I X

PREPARED STATEMENT OF MAX STIER, PRESIDENT AND CEO,
PARTNERSHIP FOR PUBLIC SERVICE

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS, Thank you for the opportunity to offer the views of the Partnership for Public Service on the progress the department is making during the first 60 days of Secretary Wilkie's leadership. As a nonpartisan, nonprofit organization that strives for a more effective government for the American people, we help agencies attract mission-critical talent, advocate for systemic changes to modernize government's outdated personnel system and develop high-performing Federal leaders. The topic of leadership is core to the Partnership's mission and one that we know to be crucial to agency mission success.

Secretary Wilkie and his leadership team have a big job ahead of them and limited time in which to do it. The secretary is responsible for leading an organization of over 300,000 employees, 145 medical facilities, one-hundred-plus burial sites, dozens of benefits offices and 9 million veteran patients with just a handful of years to lay out a vision and set a course.[1] There will be strong incentives to focus on policy implementation at the expense of strengthening the management systems that are the groundwork for the department's long-term success. To position the VA to meet the needs of current veterans while setting itself up for the future, Secretary Wilkie and his team must effectively collaborate with Congress, the veterans community and other key stakeholders, promote greater accountability at all levels of the department and assume responsibility for the overall health of this organization that is so important to the millions of veterans they serve.

Congress is an essential stakeholder and steward of the government's solemn commitment to veterans and their families. The Partnership believes that the VA performs best when it is supported by and accountable to the legislative branch. The Committee deserves recognition for the way it has conducted rigorous bipartisan oversight, promoted constructive dialog with the department's leaders and committed itself to the difficult work of transforming the department. The commitment of this Committee to proactive and thorough oversight of the VA's management and programs sets a positive example for other committees to follow.

An ongoing area of emphasis for the Committee has been personnel, and for good reason—dedicated, mission-driven employees are critical to VA's success. While this Committee has focused on the need for the department to hold its employees accountable for their performance, and understandably so, we believe it is equally important to learn from the hundreds of thousands of Americans, many of whom are veterans themselves, who accomplish great things for veterans and on behalf of veterans every day as department employees. The secretary and the Committee can learn from their success, and find ways to replicate it throughout the department.

The Partnership's Service to America Medals (Sammies) program is an annual event that recognizes incredible civil servants who have led significant accomplishments on behalf of the American people, and VA employees are well-represented among our honorees. These individuals each demonstrate just some of the incredible work of the department's employees and their dedication to serving veterans.

One such employee is Marcy Jacobs, the executive director for VA's Digital Service Team, who worked with her team to enhance the Vets.gov website to help veterans apply for, track and manage their benefits. By giving veterans a single point of contact, her team has made it easier for veterans to access the department's services,

[1] Statement of Hon. Michael J. Missal Inspector General of the Department of Veterans Affairs before the Committee on Veterans' Affairs U.S. House of Representatives Hearing on "The Curious Case of the VISN Takeover: Assessing VA's Governance Structure," 115th Cong., 13 (2018).

with more than 1.6 million veterans having logged into an account. Another honoree, Dr. Rory Cooper, led the VA's Human Engineering Research Laboratories to help improve mobility and quality of life for hundreds of thousands of disabled veterans. Dr. Cooper and his team spearheaded innovations that include wheelchairs with robotic arms, improved motorized wheelchairs, and other features that have earned his team 25 separate patents.

VA employees are also on the front lines of addressing homelessness among the veteran population. Dr. Thomas O'Toole of the Providence VA Medical Center helped found the National Center on Homelessness Among Veterans, which helps veterans access the comprehensive medical care, housing assistance and social services they need to reclaim their lives. Another VA employee, Anne Barker Dunn, created two programs that provided support to incarcerated veterans that offered access to critical services and assisted with substance abuse and housing needs.

We recommend that the Committee do more to engage the secretary and the department's staff in understanding why these civil servants are able to innovate and solve problems, and how those lessons learned can be applied across the department. While the passage of the Veterans Affairs Accountability and Whistleblower Protection Act of 2017 represents a significant shift in the department's approach to addressing accountability and leadership challenges, the cultural changes this Committee would like to see at the VA will not occur simply by firing underperforming employees. As the stories above demonstrate, the VA's employees are the department's greatest asset-not a cost to be borne. The focus of VA's leaders should be on supporting, encouraging and engaging high-performing employees and building a culture of excellence. This is hard work and requires a critical view of every aspect of the organization-accountability is simply one part. Perhaps most critical is the need to examine the effectiveness of the department's most senior political and career leaders who are charged with motivating, inspiring and managing each of the VA's three hundred thousand-plus employees.

Capable leadership is essential to a healthy organizational culture. Research by the Partnership for Public Service as part of our Best Places to Work in the Federal Government Rankingsr has found that leadership is the single biggest driver of employee satisfaction and commitment across government and within the Department of Veterans Affairs specifically. The rankings show that in 2017 VA ranked second to last among large agencies in employee satisfaction with senior leaders and last in satisfaction with supervisors.[2] I strongly encourage the Committee to take a hard look at VA's All-Employee Survey and the non-VA Federal Employee Viewpoint Survey to assess the impact of last year's accountability legislation and the administration's progress in turning around the department's culture. As the administration's nominee for the Office of Accountability and Whistleblower Protection, Tamara Bonzanto, told the Committee earlier this month, "[I]f you improve the culture and employees are satisfied with their environment that they're working in and they feel safe working in that environment in reporting concerns, hopefully, we can get improvement in customer services" and, ultimately, better care for veterans.

Undergirding the transformation pursued by the Committee and Secretary Wilkie must be a commitment to the stewardship of the Department of Veterans Affairs as an organization—in other words, the management systems, infrastructure, and employees who make the department's success possible. The VA's leaders, particularly its political appointees, must assume a sense of ownership for the long-term health of the institution. Secretary Wilkie should, even now, be thinking beyond his tenure at the department to the department he will be leaving to the individual who follows him as secretary. As a practical matter, such leader ownership requires prioritizing the VA's organizational health by building a pipeline of future leaders, connecting management to performance outcomes using data, institutionalizing key reforms, and holding leaders at every level accountable, including through the use of performance plans as required by the VA Choice and Quality Employment Act.[3]

I believe the priorities Secretary Wilkie laid out during his nomination hearing-to improve the department's culture, to focus on customer service and access to care, to strengthening mission support functions like information technology and human resources-are the right ones. Secretary Wilkie can promote a sense of ownership while effectively addressing those priorities by taking advantage of promising practices and innovations already occurring within the VA. For example, the Veterans Health Administration's Innovators Network promotes and spreads promising practices initiated by frontline employees across the VHA healthcare system. Innovative

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[2] "Department of Veterans Affairs." Best Places to Work in the Federal Government. 2017. Accessed September 25, 2018. http://bestplacestowork.org/BPTW/rankings/detail/VA00#tab_category_tbl.

[3] Section 203 of S. 1094, 115th Cong. (2017) (enacted).

ideas developed by employees include using 3D printing to help surgeons prepare for procedures and interviewing veterans about their lives so that their stories can help medical providers offer improved care.[4] While these improvements are occurring in pockets of the agency, the department can do more to promote innovation widely: data from the 2017 FEVS found that just 32.4 percent of employees believed that the VA rewarded creativity and innovation.

The department has the talent, resources, and commitment to mission that it needs to allow innovation in the service of veterans to thrive. The secretary set the right tone in his initial address to VA employees in July, stating that "[I]t is from you that the ideas we carry to the Congress, the VSOs and to America's Veterans will come."[5] It will be up to Secretary Wilkie and other leaders across the department to follow through and create an environment in which that is truly the case.

Congress and this Committee can and should play an important role in supporting innovation and promoting a sense of ownership and accountability in spirit and practice. Through its oversight, the Committee can look for bright spots within the VA and ways to replicate them across the department. The Committee can ensure that the VA is maximizing the use of new personnel and programmatic authorities granted to it over the last several years to improve service and care. Finally, it can continue to work with Secretary Wilkie, his leadership team, and others in the department in a collaborative spirit. I believe Ranking Member Tester's words during Secretary Wilkie's confirmation hearing, that "if there is good communication between you and the Members of this Committee, particularly the chairman and myself, I think we can smooth a lot of those rough waters."[6] I urge the Committee to continue in that spirit.

Chairman Isakson, Ranking Member Tester and Members of the Committee, thank you for the opportunity to share the Partnership's views on the opportunities and challenges confronting the Department of Veterans Affairs as Secretary Wilkie begins his tenure and the next chapter in the story of the VA's transformation. Success now and in the future will require close collaboration between the VA and Congress, a focus on engagement as well as accountability, leaders taking ownership of the department as an institution, and a continuing commitment to innovation. It is an important way to honor our shared commitment to America's veterans.

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[4] Ogrysko, Nicole. "How the VHA Innovators Network Is 'changing Narrative' of Complacency." FederalNewsRadio.com. September 12, 2018. Accessed September 25, 2018. https://Federalnewsradio.com/veterans-affairs/2018/09/how-the-vha-innovators-network-is-turning-changing-narrative-of-complacency/.

[5] Wilkie, Robert. "A Message to VA's Workforce from Secretary Wilkie." VAntage Point. August 03, 2018. Accessed September 25, 2018. https://www.blogs.va.gov/VAntage/50910/a-message-to-vas-workforce-from-secretary-robert-wilkie/.

[6] Hearing on the Nomination of Robert Wilkie to be Veterans Affairs Secretary before the Committee on Veterans' Affairs, U.S. Senate, 115th Congress. 2 (2018), https://www.veterans.senate.gov/hearings/pending-nomination_-secretary-06272018