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

Question 1. During your nomination hearing, you stated with regard to President Trump's Hiring Freeze, that the most important factor was having the resources to hire the people you need to take care of our veterans. You added that you felt very comfortable about where VA is after receiving all of the hiring freeze exemptions you requested from the White House. What would it take for you to ask for exemptions for the Veterans Benefits Administration and the Board of Veterans' Appeals? What metrics would you use to determine whether hiring exemptions are necessary for VBA and BVA?

Response. There is no doubt that if the hiring freeze were to continue for an indefinite period of time that we would begin to see a real degradation of service levels of Veterans I would be specifically concerned that if there was a delay in new enrollments for benefits that access to healthcare may be impacted, which would be unacceptable. As I mentioned in my hearing I have spoken to the Acting Under Secretary for Benefits, Thomas Murphy. He is prioritizing new enrollments and will inform the Secretary if significant changes occur as a result of attrition that may be impacting service levels. If there is a significant change in the number of days that Veterans are waiting for benefits the Acting Secretary of VA would address this with the White House and request an exemption from the hiring freeze. Currently, VBA is in the process of submitting an exemption request to permit the hiring of direct labor occupations to ensure reduced impact on VBA's ability to serve Veterans.

Regarding appeals, while staffing is important we will not significantly impact the pending inventory without appeals modernization legislation that discontinues the flow of appeals into the current broken process and a temporary surge of additional resources. During the 114th Congress, VA worked with VSOs and other stakeholders to design a new appeals process that is fair, transparent, and timely. This new framework for appeals was introduced in several bills in the 114th Congress and has been reintroduced in the 115th Congress. VA intends to address its need for a temporary surge of additional resources to eliminate its current inventory of appeals in the annual budget process.

Question 2. How hands-on of a leader have you been in problem solving on controversial issues that VA has faced since your arrival—for instance, high-profile suicide incidents, Veterans Crisis Line issues, or the aftermath of the Tomah opioid crisis. What was your personal role in resolving these challenges?

Response. My management style is one that leads by example. In response to the access crisis I began seeing patients in the walk in access clinic in New York and by telehealth in Grants Pass, Oregon. In our homeless programs I participated in our midnight point in time counts in LA and in both years I have been here at our homeless stand-down's in DC. I personally called for and led our urgent call to action to prevent suicides among Veterans that we help with Members of Congress in 2016. In issues such as VA's response to the opioid crisis I led public forums with our elected Members of Congress and the Surgeon General to address the issue and then wrote up our approach to opioid reduction for publication in a major medical journal. These are just examples, but I believe they demonstrate my belief that leaders must get personally involved in issues that matter and it is essential that leaders be seen as having personal involvement in areas that they want the organization and the community to effectively address.

Question 3. VA has been criticized for how it distributed medical staff hired under the Veterans Access, Choice and Accountability Act of 2014. Please discuss your role in these decisions and if you had no role, what you would have done differently?

Response. I did not arrive at VA until July 2015. However, in September 2014, VHA completed a Nation-wide data call to identify staffing needs for clinical and medical support staff, with a special emphasis on Primary Care, Mental Health, and Specialty Care. After further analysis, VHA identified the need for 10,682 additional Full-Time Equivalent Employee (FTEE) to be hired by September 2016. VHA directed a prioritization of the VACAA 801 funds distribution to 33 VAMCs experiencing the greatest challenges with Veterans access. Since access remained a critical priority across the entire VA Health Care System, the remaining funds were distributed proportionally across all sites, based upon the Veterans population to be served. This decision was made by the Acting Under Sectary for Health, Dr. Carolyn Clancy. By December 31, 2015, VHA had achieved 102% of the VACAA target, having hired 10,854 FTEE. Primary Care, Mental Health, and Specialty Care areas were VHA's most urgent needs at the time and were appropriate for prioritization of the VACAA staffing allocations.

Question 4. It seems to me that technology is the underpinning of success at VA and things are pretty far behind—there still is no new scheduling system, no decision on EHR, no consistency of systems between processing of initial claims and appeals on those claims. With respect to the various important and pressing IT needs facing the Department, how do you intend to prioritize? Where do you stand on VISTA Evolution vs. DOD and VA simply using the same system?

Response. The goals of the VistA Evolution program are improving the efficiency and quality of Veterans' health care by modernizing VA's health information systems; increasing data interoperability with DOD and private sector care partners; reducing the time it takes to deploy new health information management capabilities; and continuing to provide safe, efficient health care IT tools to VA medical providers so they can continue to deliver Veteran-centric, team-based, and quality-driven care. The VistA Evolution Program manages the development of what is known as VistA 4 which is a collection of approximately 60 projects and initiatives focused on VA's interoperability efforts with DOD and the private sector; the flagship Enterprise Health Management Platform (eHMP) and Joint Legacy Viewer (JLV) projects and other projects. Among many achievements, the work of the VistA Evolution Program has enabled VA to certify to Congress, together with Department of Defense (DOD), that VA had met the FY 2014 National Defense Authorization Act (NDAA) interoperability standards.

As of January 2017, the VistA Evolution Program had completed approximately 27 projects and 31 remain to be finished by the end of FY 2018. The investments and work of the VistA Evolution Program have and continue to deliver value for Veterans and VA providers regardless of whether VA's path forward is to continue with VistA, shift to a commercial EHR platform as DOD is doing, some combination of both or other alternatives. VA is currently reviewing options regarding long-term EHR modernization courses of action.

Question 5. Same Day Access has been one of your initiatives. What is your definition of Same Day Access?

Response. In primary care, when a Veteran contacts a VA about a healthcare need, VA will either address that need the same day or schedule appropriate follow up care. Veterans with urgent issues will be provided care the same day. VA may address the needs of Veterans by providing a face to face visit at a VA medical center, returning a phone call, arranging a telehealth or video care visit, responding by secure email or scheduling a future appointment. For mental health, if the Veteran is in crisis or has another need for care right away, the Veteran will receive immediate attention from a health care professional at the VA medical center.

Question 6. Are you satisfied with the level of communication between VA central office and the field? If yes, how quickly did you find out about problems in the field, and if no, what have you done to improve communication?

Response. As one of my first steps as Under Secretary I sought candid feedback about the adequacy of communication with the field. What I consistently heard was that the communication was unidirectional, in that the field would get directives from central office but they did not feel that their input into directives and other policies was being adequately considered. I sought to improve these communications, and to make the discussions bi-directional by having more forums in which to communicate with the field. This has included quarterly town hall meetings, the use of an intranet communications tool (called Pulse) that has close to 100,000 users from the field, regular and frequent calls with the field and Central office where I participate in many of these, and regular videos and emails that I send to the field to communicate important priorities, events, and milestones. In addition, our leaders developing leaders program has helped to improve communication with the field among thousands of our field staff and central office staff. Having detailed some of the progress we have made, we have much more work to do to close the deficits that have long existed between central office and the field. We have prioritized our efforts in internal communications and will continue to work on this as a priority. I can commit that if confirmed as Secretary that improved communications will be a vital element for my leadership team.

Question 7. Do you share my belief that Bob McDonald was an effective and successful VA Secretary? In your testimony, you said you would seek "major reform and a transformation of VA." How does your vision of "transformation and reform" differ from Bob McDonald's?

Response. Secretary McDonald entered VA in 2014 at a time of crisis. His leadership allowed VA to begin a path of recovery and he was able to lay the foundation for the transformation of VA. As such, yes I believe that Secretary McDonald was both effective and successful. My vision of transformation and reform can buildupon the good work that Secretary McDonald began. I do believe that for VA to be suc-

cessful we must now begin to address some of the long term systems problems that VA faces. First is our need to act as an integrated enterprise both within our three separate administrations and across the country. This will allow us to take advantage of VA's economies of scale and also begin to deliver a more consistent experience for our Veterans. We must also modernize many of our systems that have been long neglected. We must address the need for greater integration of our services between VA and the private sector and other Federal entities, whether this relates to healthcare or to building and maintaining our current infrastructure and facilities. This action will take dedicated focus by our leadership but I believe can be accomplished and will result in meaningful improvements for our Veterans.

Question 8. As VA Secretary, what are you going to do to make VA a more attractive place to work—whether we're talking about Montana or Georgia?

Response. VA is undergoing one of the most ambitious Department-wide initiatives to transform its workplace culture in its history, known as *MyVA*. The *MyVA* initiative is predicated on five foundational strategies, one of which is Improving the Employee Experience. This core strategy is aimed at fundamentally changing the VA culture to focus on two key and inextricably linked goals: improving leadership and increasing employee engagement in every corner of the Department. To that end, we have implemented a new ILEAD campaign that promotes leadership development for leaders at every level, characterized by principle-based leadership and demonstrated though "servant leader" behavior. These two powerful concepts shift the emphasis from self-serving behaviors and blindly following bureaucratic rules, to behaving in ways that put principles first, and service to others as the driving force. With respect to employee engagement, I will reply on feedback from our employees through the OPM Federal Employees Viewpoint Survey and the VA All Employee Survey. As a result of these surveys I am committed to:

- Moving pay setting for our healthcare employees to a market-based pay system
- Working with the Committee to establish an alternate personnel system for all VHA personnel, and proposals that will allow VA to offer more competitive pay (special rate increase, elimination of dual compensation waiver, and changes to Physician and Dentist Pay)
- Implementing changes to the Title 38 leave system for Physicians and other "24/7" providers, creating more flexible work schedules that will address critical staffing needs while being more desirable to Physicians.

In addition, I need the ability to use all recruitment and retention tools and flexibilities; however the CARA Act has significantly reduced VA's ability to offer recruitment, relocation, and retention incentives.

Question 9. What are you going to do differently than your predecessor to make the Choice program work better in states like mine?

Response. VA has worked to make many changes and improvements to the Veterans Choice Program and will continue to do. We now have completed over 60 contract modifications with Health Net and TriWest to improve the program from the original implementation. VA has improved communications with the contractors by developing a standardized referral form for care. The referral form, VHA 10–0386 "VHA Choice Approval for Medical Care," provides a set format for VA facilities to request needed care, and helps to avoid any miscommunication and misdirected to inappropriate specialties. VA has embedded contractor staff in facilities to assist in resolving questions and issues timely. In addition, VA implemented Provider Agreements to assist Veterans in receiving timely care. Provider Agreements have been utilized in to provide care to Veterans, when the contractors were unable to schedule such care timely. The Provider Agreements are initiated at the VA medical center level, and allow Community Care providers to work directly with VAMC to schedule care for referrals that have been returned in certain circumstances from the contractors. These agreements have augmented the care provided under contractors to ensure Veterans receive timely community care.

Question 10. In response to question 6 of my pre-hearing questions, you raised VA's Whistleblower Protection Program. As you may know, section 247 of the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2017 (P.L. 114–223) directs VA to establish a new process for VA employees to file whistleblower complaints. Section 247 of Public Law 114–223 is based on legislation, the VA Patient Protection Act of 2016, which was considered before the Senate Veterans' Affairs Committee in November 2015. According to testimony from VA, VAOIG, and the U.S. Office of the Special Counsel, the new process established by section 247 is unworkable, unnecessary, and may undermine current whistleblower protections. What are your views on section 247? If confirmed, will you work with the Senate Veterans' Affairs Committee to ensure that whistleblower protections in the Department are effective?

RESPONSE. I HAVE SEVERAL CONCERNS ABOUT SECTION 247.

First, I believe strongly that VA employees should be entitled to the same whistleblower protections as other Federal employees, to include an easy-to-access and easily understood process for disclosing concerns about safety or about fraud, waste, or abuse in the workplace and about retaliation they may encounter after making a disclosure. Section 247 imposes on VA, alone among Federal agencies, an additional set of rules and requirements around disclosures and retaliation complaints that are frankly confusing for employees, duplicative of existing processes, and expensive to carry out from a manpower perspective. It also imposes on VA supervisors, alone among Federal supervisors, a more draconian set of penalties for retaliation.

I would prefer to see the whistleblower protection rules apply equally across the entire government. Rather than impose this unfunded mandate on VA to handle these matters differently than anyone else does, I'd prefer to see Congress properly resource the Office of Special Counsel, which is in essence the Central Whistleblower Office for all Federal employees, and VA's Inspector General, which has the mandate and the expertise to investigate many of the concerns that VA whistleblowers raise.

Another concern I have about section 247 is the burden in places on VA's first-line supervisors—many of whom are doctors or nurses who supervise in addition to caring for Veteran patients, or are claims processors or cemetery workers who serve Veterans directly while also supervising. Section 247 says that when an employee submits a whistleblower claim under this new process, the supervisor has to stop what he or she is doing in support of Veterans to carry out this complicated process of determining whether the claim meets the legal definition of whistleblowing and, if it does, to provide a formal written response back to the employee within four days. That is not the best use of our supervisory health care providers or claims representatives or cemetery staff, and I think it will create an unhelpful formal or even adversarial dynamic between our supervisors and their employees.

Question 11. VA's fiscal year (FY) 2017 budget request states that there is a direct and proportional correlation between the number of employees at the Board of Veterans' Appeals (Board) and the resolution of claims for VA benefits that reach the Board. As you acknowledged in your confirmation hearing, today there are over 450,000 appeals pending. To address the appeals inventory, VA's FY 2017 budget called for an increase of full-time equivalent (FTE) employees in fiscal years 2017 and 2018. For FY 2017, the Board received funds from Congress to hire 242 FTEs. I fought to get VA these funds.If confirmed, will you ensure that the President's across-the-board hiring freeze does not negatively impact VA's ability to meaningfully address the over 450,000 appeals that are pending?

Response. I am committed to addressing VA's pending appeals inventory. As of January 31, 2017, there are over 469,000 appeals pending in the Department, with over 135,000 pending with the Board. VA is grateful for the additional funds received in FY 2017, enabling the Board to hire 242 FTEs, for a total of 922 cumulative FTE. The Board has been aggressively hiring and onboarding staff to a current level of 738 cumulative FTE, but has many more FTE to hire and onboard to reach its FY 2017 FTE goal. While a hiring freeze would negatively impact the Board's ability to provide appeals decisions to Veterans regarding appeals, VA cannot significantly impact its pending inventory without appeals modernization legislation that discontinues the flow of appeals into the current broken process and a temporary surge of additional resources. I would note, for clarification, that although the Board projected continued FTE growth in FY 2018 as part of its workload projections in VA's FY 2017 budget, we are aware that any increase in resources above the FY 2017 baseline will be contingent on annual budget appropriations.

Question 12. In the 2016 Commission on Care report, the Commission projected that by 2034, 60 percent of veteran users could be using private care. Under your vision for the future of VA health care, would this be acceptable? Are you concerned about the impact on specialized services such as spinal cord injury, prosthetics, Traumatic Brain Injury, Post Traumatic Stress Disorder, and other mental health needs, given the more costly private sector is not as equipped to provide these services to veterans? Please discuss.

Response. Under my vision for the future of VA health care, I would project that although 100 percent of enrolled Veterans could be using either VA or Community care, because they would have a real choice, that we would still see a majority of enrolled Veterans choosing to use VA for integrated primary care and mental health services, along with most of the specialized services designed for people who served in the military. We would use community care often for specialty care that does not require tailoring for the military, like obstetrical care, optometric services and care

for management of chronic disease for veterans who live where it would not be convenient to reach VA care.

You make an excellent point in your question that many of these services tailored to the needs of prior servicemembers are simply not available in most communities, but are quite costly when they are. For those reasons, and because so many Veterans prefer to receive these services alongside comrades who served, I am not too concerned that use of an integrated VA/community care network will erode our ability to provide these specialized services to America's heroes.

Question 13. What is your plan to support VA's Office of Tribal Government Relations, in their efforts of continued collaboration and outreach to Native American Veterans in their communities?

Response. I will rely on the support and counsel of our Office of Tribal Government Relations (OTGR) to coordinate the agency's tribal consultation efforts, and to ensure both the Secretary and other senior VA leadership are engaged in communicating and working with tribal leaders as part of the enduring government to government relationship that exists between the United States and Indian tribes. We also rely on OTGR to assist the VA enterprise with cultivating informed, trusting relationships with tribal leaders, national intertribal organizations and service providers to identify opportunities for sharing of resources and pursuing partnerships that ensure access to care for our Veterans living within or near tribal communities.

It is our expectation that OTGR will play a key role in leading VA's efforts to connect VA, other members of the Federal family, state governmental organizations, private and non-profit organizations, with tribal communities. Additionally, I will rely on OTGR to coordinate the agency's response to the identified priorities which include access to medical care, addressing housing and homelessness, treatment for PTSD and mental health, understanding benefits, including benefits for families and transportation. By recognizing and adhering to these culturally specific requests, VA will be informed, demonstrate trustworthiness and continue to understand the nuances of working within Indian Country. An organization that understands the people and population it serves has the best odds of success.

Question 14. What are your thoughts on the proposed consolidation of the Indian Health Service and Tribal Reimbursement Program into one standard program?

Response. Consolidation of the agreements with the IHS and Tribal Health Programs into one program could make the program more straightforward to administer; however, given VA values its relationships with these partners, we would recommend consultation with these stakeholders be initiated to determine what tribes' concerns and recommendations may be regarding the potential impact of a consolidation with Indian Health Service.. This could also have implications for tribal health programs who opt to serve as community care providers that deliver care to non-native Veterans because IHS is fairly limited to delivering care to IHS-eligible patients. This would also continue to multiply the different ways VA purchases community care rather than consolidating and streamlining into one overall program for the VA.

Question 15. What is your plan to ensure the Department of Housing and Urban Development-Veterans Affairs Supportive Housing program, Tribal HUD-VASH, is permanently funded in order to combat homelessness of Native American Veterans who live on tribal lands?

Response. Tribal HUD-VASH is an important and necessary joint effort between HUD and VA, with HUD providing the housing vouchers and VA providing the necessary case management. To date, Tribal HUD-VASH has 26 tribal grantees and each tribal grantee is funded for one case manager. VA includes case management funding in its overall budget requests for HUD-VASH and it is included in our FY 2017 appropriation, and we expect to continue to fund the positions in subsequent years. For the continued support of the Tribal HUD-VASH program, HUD has requested $7 million in its FY 2017 Budget, a request both the House and Senate Committees on Appropriations supported in their draft fiscal year 2017 appropriations bills. In a similar show of support, Congress included a Tribal HUD-VASH funding anomaly for HUD in the second FY 2017 Continuing Resolution (CR) to ensure program continuity of operations during the CR period.

Question 16. How do you intend to work with the National Association of State Departments of Veterans Affairs?

Response. I will continue to prioritize working closely with our state partners and with NASDVA. NASDVA President Randy Reeves and I have already been in frequent contact and I look forward to building upon the great relationship between VA and NASDVA that my predecessors have forged before me. Additionally, I also intend to reaffirm VA's commitment to partnering with the states by signing a new

Memorandum of Agreement between VA and NASDVA at their winter conference later in February.

Question 17. Please describe your plan to address national physician assistant recruitment and retention issues.

Response. The National Recruitment Program (NRP) provides a centralized in-house team of skilled professional recruiters employing private sector best practices to fill the agency's most critical clinical and executive positions. The national recruiters, all of whom are Veterans, work directly with executives, clinical leaders, and local human resources departments in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs. At facility request, NRP targets hard-to-fill recruitments in their regions.

VHA markets directly to direct patient care providers through partnerships such as National Rural Recruitment & Retention Network (3RNet), a national network of non-profit organizations devoted to health care recruitment and retention for underserved and rural locations, as just one example. Through these partnerships, VHA has access to a robust database of candidates interested in working for VHA. National Recruiters routinely post VHA practice opportunities on career sites such as www.vacareers.gov.

Question 18. At your hearing, you said that colleges that engage in deceptive and misleading recruiting practices would "not be tolerable." In May 2016, 23 major national veterans and military organizations wrote a letter to the VA Secretary requesting action on this critical issue. Would you commit to reporting back to this Committee within three months with your recommendation for practical and realistic steps VA can take to ensure student veterans are protected from predatory and deceptive practices and given the information they need to make an informed choice about their college?

RESPONSE. YES

Question 19. On behalf of the National Alliance on Mental Illness, Montana, I submit the following question: According to a March 2016 report prepared by the Veterans Legal Clinical at Harvard Law School, approximately 125,000 post-9/11 veterans cannot access basic VA services, such as mental health care because of Other Than Honorable or "Bad Paper" discharges. The report details that VA has never evaluated the service of 90 percent of the veterans in this category, many having sought healthcare or housing services from VA, only to be turned away without any Character of Discharge review. Even more alarming, about 22,000 veterans with service-connected mental illness have received Other Than Honorable discharges since 2009. If confirmed, will you commit to thoroughly reviewing each of these cases, and where necessary allow veterans to receive the VA services, including mental health care, they deserve?

Response. Yes I will, Veterans with OTH discharges can potentially receive VA care, including MST-related care, upon review of their discharge by the Veterans Benefits Administration (VBA). Following this review, VBA issues a decision as to whether or not the Veteran's discharge is a bar to receipt of health care benefits. VA has taken steps to ensure staff are aware that Veterans with OTH discharges are potentially eligible for some services and that there have been no shifts in policy to tighten eligibility requirements.

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

Question 20. Many individuals that participate in the VA Caregivers Program for severely wounded veterans are working dramatically reduced hours outside the home or have left the workforce completely. This reduction in outside earnings can result in significant difficulties meeting financial obligations, including student loan debt held by the caregiver. How do you plan to identify and assist such caregivers facing financial hardship due to student loan debt?

Response. Family Caregivers participating in VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) receive an average stipend amount ranging from $624.84 to $2,372.22 in December 2016, based on the Veteran's level of required assistance and geographic location. Eligibility for PCAFC is based on the Veteran's required level of assistance and not on financial need. VA does not have the authority to request or monitor this type of personal financial caregiver information for participation in PCAFC or any of VA's Caregiver Support Programs. Because there is no requirement for Caregivers to report financial status, I anticipate

that family Caregivers will oppose providing information to VA about their student loan debt.

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

Question 21. What role do you see the VSO community playing under your leadership? Please give at least five (5) specific examples of how you anticipate involving the VSOs.

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

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

There are several areas of planned collaboration and ongoing communication between VA and the VSO community going forward to include Appeals Modernization, *MyVA* Access, Care in the Community, Patient Experience and partnering on communications at the national, regional and local level to share success stories/best practices as well to address opportunities for improvement.

Question 22. What are your top three goals as Secretary of Veterans Affairs?

Response.

(1) Getting the right people in place in management positions at VA in order to have the biggest impact across the organization. These positions include the Secretary's direct reports, VISN Directors, Medical Center Directors and clinical leaders. This then cascades down throughout their respective organizations to get the right employees who are serving our Veterans.

(2) Addressing the critical access issues in the system. While we have made real progress in improving access for the urgent care needs of our Veterans, much work still needs to be done. We must have a system that fully addresses the needs of Veterans at the time that they need those services.

(3) Restoring the trust of Veterans in VA through creating a Veteran centric organization. Everything we do must be focused on serving our Veterans and as we begin to move in this direction I believe we will see that our Veterans will increasingly have confidence and trust in VA.

Question 23. The Veterans Health Administration has made undeniable progress over the past two years in integrating more community care into the VA healthcare system. Do you believe that a veteran's primary care clinician should continue to be part of the VA system or can s/he be any clinician a veteran chooses?

Response. Our goal is to provide all eligible Veterans with access to an integrated, high-performing network that allows Veterans to achieve the best health outcomes and patient experiences possible. This network takes the best of VA and the best of the private sector and combines them together. VA wants to ensure that all Veterans have a primary care provider to coordinate their care in the high performing network. In those cases where VA cannot provide a primary care provider, than Veterans should be able to select a primary care provider from the high performing network.

Question 24. The Commission on Care rejected the idea of granting veterans who use the VA unfettered choice in seeking care outside of the VA. Do you agree with this position, or do you believe that a veteran who is eligible for VA health care ought to be provided with a voucher to seek care wherever s/he chooses, with the VA footing the bill?

Response. Our goal is to provide all eligible Veterans with access to an integrated, high-performing network that allows Veterans to achieve the best health outcomes and patient experiences possible. This network takes the best of VA and the best of the private sector and combines them together. Today, 80% of Veterans already

have a choice between VA and private sector care as they have other health insurance options. Last year 1/3 of all of our appointments were in the community, up from 20% less than two years ago. The Commission on Care considered a few options and rejected the idea of unfettered choice. Given what they were considering I do agree with their decisionmaking. However, if confirmed as Secretary I would consider a number of new alternatives to a system restricting care based upon wait times and mileage. I believe that there are new models that need to be considered that are clinically based and that maximizes the strengths of VA and the private-sector, is mindful of taxpayer dollars, and puts the Veteran at the center of decision-making. I would welcome the opportunity to work with you further to ensure that we consider all of the options available to us to ensure that Veterans are getting the care that they need.

Question 25. Are you in favor of or are you opposed to Recommendation 17 of the Commission on Care, which would grant veterans with other-than-honorable administrative discharges eligibility to access VA health care on at least a temporary basis? VBA

Response. If confirmed, I would commit to using the regulatory authority available to the Secretary to ensure that Veterans with other than honorable discharges are getting access to care. In the situation where we need legislative change I would work with both the White House and Congress about ways that we can address this population.

Question 26. What specific plans can you offer to reduce the number of veteran suicides, which are unacceptably high?

Response. VA's comprehensive, integrated, data-driven approach to preventing Veteran suicide connects Veterans to an array of resources and support in order to reach Veterans before challenges become crises. VA's Office for Suicide Prevention (OSP) is using findings from completion of the most comprehensive analysis of Veteran suicide data to date examining more than 55 million Veteran records from 1979 to 2014 from all 50 states and 4 territories to inform suicide prevention activities:

- Providing immediate outreach and enhanced care to Veterans found to be at highest risk for suicide (top 0.1%) through predictive analytics; rapidly expanding this program to include outreach to Veterans who are at moderate risk for suicide
- Increasing staffing and resources for Suicide Prevention Coordinators integrated at every VAMC and large CBOC (over 300 nationwide who solely work on Veteran suicide prevention efforts)
- Training every VA employee to specifically respond to Veterans at risk for suicide and crisis, including staff at VBA, NCA, VACO, and Vet Centers
- Rapidly disseminating evidence-based treatments (Dialectical Behavioral Therapy, Collaborative Assessment and Management of Suicide, Cognitive Behavioral Therapy) for Veterans experiencing suicidal ideation across VA's healthcare system
- Engaging all U.S. Governors to prioritize combatting Veteran suicide in every state; immediately coordinating with 5 states with highest rates of Veteran suicide to develop suicide prevention initiatives to include strategic partnerships, targeted outreach, and enhanced care for all Veterans who may be at risk for suicide
- Distributing gun locks, gun safes, and other safe storage resources to at-risk Veterans and their families
- Disseminating nationally community toolkits for safe firearm storage in partnership with National Shooting Sports Foundation (NSSF) and other firearms stakeholders
- Developing comprehensive OSP-DOD Transition program to identify and follow all Servicemembers who may be at risk for suicide upon separation
- Establishing partnerships to train employers of large concentrations of Veterans (e.g. IBM, Johnson & Johnson, Homeland Security, etc.) in recognizing and responding to suicide risk and help employers understand specific assets and needs of Veterans to retain them in the workforce
- Improving the performance and capacity of the Veterans Crisis Line by opening a second call center and reducing calls that go to backup centers to nearly 0%. Over 2.6 million calls have been answered since VCL opened in 2007
- Immediately convening a VA Secretary Advisory Board on Suicide Prevention to include Congressional members, Veteran Service Organizations, Federal Partners, Non-profit Partners, Family Members, Veteran Suicide Attempt Survivors, and others to inform and enhance VA's suicide prevention initiatives.

Question 27. What specific recruitment and retention plans can you offer to increase the organizational capacity of VA mental health clinicians and support personnel?

Response. VHA has added 3,946 additional mental health providers over the past 5 years and has increased the number of patients provided mental health treatment by 355,500 (28%). VHA offers education loan assistance via the Education Debt Reduction Program (EDRP) to mental health providers in hard to recruit/retain positions and locations. 26% of physicians receiving EDRP are psychiatrists. In the EDRP pilot program established by the Clay Hunt Act, the amount of the annual award will be increased and the program will be extended to psychiatrists in their final year of their residency training. VHA is helping to build a pipeline of highly-trained mental health professionals. VHA's Office of Academic Affiliations trains roughly 6,400 trainees in mental health occupations per year, and roughly 70 percent of VA psychiatrists and psychologists received some of their clinical training at a VA facility. VHA's Mental Health Education Expansion Initiative, a new five-year commitment, will increase clinical education in mental health professions. In the first year, Academic Year 2013–2014, over 200 training positions were added. In the second year, Academic Year 2014–2015, 126 positions at 45 different sites were added. VHA has increased mental health training opportunities for several years through increases in mental health training positions and approval of new sites for training. For example, as of July 2014, VHA psychology internships are present in 49 states, Puerto Rico, and the District of Columbia. There has been some targeted expansion in training in rural and highly rural facilities. VA had the first accredited Psychology residency program in the state of Alaska. In FY 2016, VA awarded eighteen pre-degree Licensed Professional Mental Health Counselor internship positions to seven VA medical centers. For FY 2017, VA awarded 3 pre-degree Marriage and Family Therapist internship positions at one site.

Question 28. During the 114th Congress, I was proud to sponsor the Veterans Mobility Safety Act (PL: 114–256) (hereinafter "the Act"). The purpose of the Act is to require certain safety and quality standards of providers of automobile adaptive and special adaptive equipment so that disabled veterans, and the driving public, are safer on the roads. Providing quality care for disabled veterans is something that I have taken very seriously as both a member of the U.S. Senate Committee on Veterans' Affairs, and the Chairman of the U.S. Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies.

In your new role as the Secretary of the U.S. Department of Veterans Affairs (hereinafter "VA"), will you commit to providing disabled veterans with the highest quality of care that you, and the VA, can possibly provide?

Response. Yes, absolutely. VA will maintain our commitment to ensure disabled Veterans receive the specialized services they need. In addition to the longstanding Automobile Adaptive Equipment benefit, and VA Driver's Training Program, VA has established programs and systems of care to maintain and ensure the provision of lifelong specialized care and services for these severely disabled Veterans. VA's systems of care for Polytrauma/Traumatic Brain Injury (TBI), Amputation, Spinal Cord Injury and Disorders, and Blind Rehabilitation are well established. Specialized care and services are provided across tiered networks of specialty rehabilitation centers that serve as regional referral centers for acute inpatient rehabilitation for severe injuries. Ongoing care and services are provided for these Veterans in VA facilities with specialized interdisciplinary teams closer to the Veteran's home community. These VA programs uphold the highest standards of rehabilitation, such as CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation for inpatient rehabilitation facilities, and participating in Department of Health and Human Services 'Model Systems' for VA's TBI and SCI programs (consortium of premiere private and academic rehabilitation centers). VA is further committed to ensuring Veterans continue to receive the prosthetic items and services they need. In FY 2016, VA expended $2.8 Billion to provide 20 million medical items, prosthetic devices and items to 3.3 million Veterans. Finally, VA maintains its priority and visibility for these Veterans in partnership with our Federal Advisory Committee for Prosthetics and Special Disabilities—the longest standing Federal advisory committee serving the VA. Established by Congress in 1992, this Committee advises the Secretary on VA prosthetic and special disabilities programs that serve Veterans with spinal cord injury, blindness or visual impairment, amputation, deafness or hearing impairment, and other serious disabilities. An annual report is also provided to Congress regarding this Committee's recommendations and VA's actions taken in response to those recommendations. Finally, the Office of Quality, Safety, and Value will ensure that these veterans are receiving the highest quality medical care with our multiple mechanisms for tracking safety and quality metrics for these complex patients.

Question 29. On February 2, 2017, the VA filed a "Notice of Inquiry" in the *Federal Register* to "request information and comments from interested parties to help

inform VA's development" of a quality and safety policy for providers of modification services under the Automobile Adaptive Equipment program. However, the Act requires that the Secretary develop this comprehensive policy in "consultation" with different stakeholders, including the National Highway Transportation Safety Administration, and industry representatives.

Unfortunately, in VA's Notice of Inquiry, VA confirms that it is going to use this notice as the platform to receive the aforementioned required consultation. This is entirely unacceptable, as the law requires consultation, and should not be misinterpreted as merely a comment period for the Notice. Moreover, I believe that a robust consultation with different stakeholders will provide superior safety and quality standards. If you do indeed believe that disabled veterans deserve a high quality of care, in your new role as Secretary of the VA, will you follow the clear language of the statute and require consultation with specific stakeholders?

Response. Yes, VA fully intends to comply with establishing this program in consultation with stakeholders and AAE entities across the national and state level, and public sector. VA has already been in contact with many of these stakeholders, and in doing so has discovered a number of entities with established quality and safety programs related to automobile adaptive equipment. Given the short suspense to implement this comprehensive program and supporting policy, and in order to be as broadly inclusive as possible, VA issued this public notice to expeditiously gather information from across all entities. Once this information is coalesced, VA will be fully informed about, and will have identified, all stakeholders for subsequent extensive consultation. This plan will then be presented in proposed regulation to all for review/public comment.

Question 30. Will the major Information Technology (IT) modernization projects and programs currently underway at the VA lead to improvements in VA vendor reimbursement? More specifically, will the aforementioned IT projects produce a reliable system for ensuring the prompt and accurate payment of VA vendor invoices?

Response. Yes, the Community Care Reimbursements Systems (CCRS) Project align with industry standard claim reimbursements to fully automate and integrate with other business systems including Referral and Authorization, Revenue, Fraud, Waste, and Abuse (FWA), data analytics and financial systems. This system will align with the future state, highly-integrated Community Care model, supporting both contracted Community Care Networks and Out of Network claims processing.

Question 31. During a July 2016 hearing, the need for VA IT modernization and pursuit of a commercial off-the-shelf (COTS) HER was discussed and you stated "We reached consensus . . . that looking at a commercial product is the way to go. It has to be done recognizing the unique needs of our community and providers."

Can you provide an update in pursuing a COTS solution, please describe in detail and include projected timing on this effort?

Response. VistA was one of the first broadly used Electronic Health Records (EHR) in the country. It has been recognized for effectiveness and is still a high quality EHR used as the primary tool across the country. VA is proud of VistA, but we recognize the need for improvements.

We will complete the next iteration of the VistA Evolution Program—VistA 4—in fiscal year (FY) 2018, in accordance with the VistA Roadmap and VistA Lifecycle Cost Estimate. VistA 4 will bring improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient health care platform for providers and Veterans.

We have made substantial progress in delivering new capabilities leveraging VistA, while also strategizing for our future needs. VA is considering the future of VistA and VA's EHR as one component of a Digital Health Platform (DHP). The previous Administration delivered a Business Case for DHP, which included 3 options for the EHR component. This Business Case needs to be evaluated and a decision will be made on our path forward with respect to DHP and our EHR modernization efforts. However, the success of the digital health platform is not dependent on any particular EHR.

The issue of moving away from VistA to a commercial EMR has been a subject of discussion at VA for years. VA has not always been clear on the future direction with regards to a COTS solution. I believe it is time that we make a firm decision and once a decision is made we will need to work closely with the Administration and Congress to define the path toward a successful outcome. If confirmed as Secretary I will commit to a decision on the COTS vs. Vista upgrade by July 1, 2017. The time leading up to July will be required to do a full assessment of the options in the context of the Digital Health Platform and work that is still required to make an informed decision.

Question 32. The Commission on Care's Final Report included a recommendation to "modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes." (Recommendation #7). Further recommending, "the VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report." Former Secretary McDonald, recommended to former President Obama that the VA found this recommendation feasible and advisable.

Do you agree with this recommendation? What are the barriers to implementing this recommendation?

Response. Yes. Approximately 90% of OI&T's budget goes toward sustaining our aging infrastructure and applications, compared to around 60% in the private sector. OI&T has sacrificed modernizing these legacy systems and turning off older applications in exchange for adding incremental improvements and new capabilities. OI&T has developed a comprehensive strategy to substantially decrease its legacy system footprint and sustainment costs moving forward. A cornerstone of that strategy is VA's cloud implementation, which will improve efficiency and reduce costs. Implementing new functions like cloud will decrease sustainment costs because it requires significantly less maintenance.

Question 33. Although DOD has just begun its implementation of a new COTS solution, they reportedly carried out a successful procurement and testing process. How closely have you worked with DOD to learn from their experiences and processes? Will you pursue working with the DOD to capitalize on the COTS experience?

Response. Yes, I have been told that VA has been working with DOD throughout the entire process and is learning from DOD's experiences while also helping to continue to advance on our Interoperability efforts. O I and T was did not report to me directly as Under Secretary, although we worked closely together on many projects. If confirmed as Secretary, I would work directly with DOD to determine how we might work closer together to leverage their work in this area.

Question 34. Do you believe that VISTA can manage the business and clinical commitments of Care in the Community or the idea and concepts embedded in the VA Choice Program? Does the VHA currently have the ability to create an electronic longitudinal health record that veterans simultaneously incorporates the care of veterans at the VA and in the community?

Response. Yes. The VistA Evolution Program manages the development of a collection of approximately 60 projects and initiatives. Many of these are focused on VA's interoperability efforts with DOD and the private sector.

The VistA 4 work managed by the VistA Evolution Program was first funded in FY 2014 and is scheduled to be completed by the end of FY 2018 (September 30, 2018). However, just because I believe VistA is capable of performing these functions, does not mean that the best ultimate decision is to stay with VistA. As stated above we will have a decision on a COTS product vs. VistA by July 1, 2017.

Question 35. In the 114th Congress, provisions from the Toxic Exposure Research Act were signed into law as subtitle C of H.R. 6416. Simultaneously, the VA entered into a contract with the National Academy of Medicine to conduct a study on the health conditions of descendants of veterans exposed to toxins during the Gulf War. This is an important step forward, however, the aforementioned legislation that is now law requires a broader application and does not stipulate a certain conflict, time periods, group of veterans or type of exposure. The law requires the VA to contract with the National Academy of Medicine to conduct a review of health conditions potentially related to the toxic exposure of veterans who may have been exposed during their military service, which is intended to address veterans from any or all conflicts where they may have been exposed regardless of timeframe and locale. As Secretary, will you incorporate this statute into the currently contracted National Academy of Medicine study? It would seem redundant and duplicative to execute this statute at a later date when the VA has contracted with the National Academy of Medicine to conduct similar but limited work.

Response. At the time VA contracted with the National Academy of Medicine (NAM) for both Gulf War & Health, Volume 11 and Veterans & Agent Orange, Volume 11, VA subject matter experts (SMEs) were well aware of Congress' upcoming legislative requirement and wrote the two contracts accordingly—to have major focus on intergenerational health effects. With the final passage and signing into law of the Toxic Exposure Research Act, VA SMEs took further steps to discuss with NAM staff each of these two contracts and the exact language of the Act to ensure that NAM would be able to deliver reports which met the explicit requirements of Congress. On 12 January, 2017 VA SMEs took the additional step of discussing with

the seated NAM ad hoc committee for Gulf War & Health, Volume 11 both the charge to the Committee (from the contract) and the language from the Act. VA SMEs will do the same with the NAM ad hoc committee for Veterans & Agent Orange, Volume 11 in March 2017. Both of these NAM reports are due to be completed in early 2019. Both of these reports, but especially Gulf War & Health, Volume 11, will have broad applicability to all Veteran cohorts and their descendants.

VA does oppose additional legislation on this matter as we feel that we have this legislative requirement covered. The NAM has already empaneled "top scientists, epidemiologists, clinicians, and investigators to research the literature on health conditions" for the Committee preparing the Gulf War & Health, Volume 11 report.

Question 36. Would you favor or oppose legislation that would require the VA to extend its contract with the National Academy of Medicine (formerly the Institute of Medicine) to empanel top scientists, epidemiologists, clinicians, and investigators to research the literature on health conditions associated with exposure not only to Agent Orange but to other toxic agents as well?

Response. VA does oppose additional legislation on this matter as we feel that we have this legislative requirement covered. The NAM has already empaneled "top scientists, epidemiologists, clinicians, and investigators to research the literature on health conditions" for the Committee preparing the Gulf War & Health, Volume 11 report, and NAM will soon do so for the Veterans & Agent Orange, Volume 11 committee. Both committees will address the key elements of the Toxic Exposure Research Act.

Question 37. How do you plan to address improving the quality of benefits claims decisions and appeals? With public pressure to decrease the backlog of both claims and appeals, there is an increasing preference for adjudicating claims speedily at the expense of the quality and thoroughness of decisions. What are your specific ideas for how you expect to improve the quality of claims decisions that will ensure that veterans are provided all the due process and duty to assist rights afforded them under the law?

Response. VBA has emphasized the importance of completing claims decisions in a timely and accurate manner. Quality is a critical performance element for all claims processors as is productivity. VBA has developed a multi-faceted approach to continuous quality improvement. Quality reviews completed on a national level provide data for error correction and tracking, targeted employee training, and station performance metrics. Consistency studies are regularly administered to claims processing employees to assess consistency of decisionmaking and provide training and feedback on any targeted areas of concern identified. Local offices complete systematic quality reviews on individual employees and quality checks on cases during the adjudication process. The results of these reviews are used for error trend analysis, targeted training and individual employee performance evaluations.

With regard to appeals, a critical flaw in the current appeals process is that VBA's initial claim adjudicators do not receive effective quality feedback from VBA appeal decisions or from Board of Veterans' Appeals decisions. This is because the appeals process features an open record and continuous duty to assist and it generally takes several years to finally decide an appeal. As a result, a resolved appeal is based on a record that is different than the record considered by the initial VBA adjudicator. To address this concern, VA worked with VSOs and other stakeholders to design a new appeals process that features two quality feedback loops based upon a review of the same record, one in VBA and one from the Board. In addition, under the new framework, appeals to the Board will feature a more concise record that is easier to review. VA expects that this design will improve the quality of its initial decisions and reduce appeals. This new appeals framework was introduced in several bills in the 114th Congress and reintroduced in the 115th Congress. In addition, VBA has realigned all of its appeals operations and policy under a new organization, its Appeals Management Office, for improved oversight and quality assurance. The Board has also changed its quality assurance process to focus on known areas of concern and expanded the scope of its review to allow for identification and improvement of issues in all parts of the appeals system.

Question 38. Do you endorse or oppose the creation of a fourth entity within the VA, a Veterans Economic Opportunity Administration?

Response. While VA appreciates the focus on improving employment services for Veterans by consolidating various programs, we do not support the creation of a separate Veterans Economic Opportunities Administration (VEOA). The current Veterans Benefits Administration (VBA) structure reflects the Under Secretary for Benefits' overall responsibility for Veterans benefit programs, including compensation, pension, survivors' benefits, VR&E, educational assistance, home loan guaranty, and insurance. A separate Administration for economic opportunity programs would neg-

atively impact Veterans and would result in a redundancy of management support services. Additional staff would be required to support the administrative and management functions for the new administration which would be at the expense of direct FTE associated with the delivery of benefits, which would reduce support to Veterans. In 2011, the Office of Economic Opportunity (OEO) was established in VBA under the authority of the Under Secretary of Benefits to directly oversee Education Service, VR&E Service, Loan Guaranty Service, and Economic and Employment Initiatives. We believe there is currently an appropriate management structure in which there is internal collaboration among these program offices to oversee Veteran programs related to economic opportunities. We are concerned that dividing the benefit programs between two Administrations will result in a redundancy of management support services and add an administrative burden.

Question 39. The Choice Act authorized the Secretary of the VA to seek the removal or transfer of Senior Executives based on poor performance or misconduct. To date, the VA has used its authority to fire only six senior executives. Last year, the VA and the Justice Department informed Congress that it would no longer enforce the removal provisions of the Choice Act. In addition, previous VA leadership vigorously opposed congressional efforts to enact additional accountability measures on non-senior executive VA employees:

a. Do you agree with the previous administration's refusal to enforce the removal provisions of the Choice Act?

b. If confirmed, will you use your powers Congress has given you under the Choice Act to remove Senor Executives who fail to serve our Nation's veterans?

c. If confirmed, will you work with Congress to enact additional accountability measures to hold all VA employees accountable?

Response. The Department of Justice is frankly in a much better position than I am to determine whether a particular statute is or is not consistent with the U.S. Constitution. The issue DOJ has flagged in this case is a fairly nuanced legal issue, and it's not really up to me to say whether their analysis is right or wrong. That said, I want to be sure that we can sustain through the appeal process any action we take against an executive who failed to serve Veterans well or who has acted inconsistent with our values. If that means we need to amend the Choice Act to correct the issue DOJ flagged, I am supportive of that. At the same time, we should consider adding language to the statute that directs the Merit Systems Protection Board to defer to VA's actions unless our actions are arbitrary or illegal in some way. Ideally Congress would look at ways to improve the accountability and appeals processes for all Federal employees rather than singling VA employees out for different treatment. I look forward to working with Congress to identify and implement whatever solutions we need get this critical process right. If confirmed I would use my full powers as Secretary to remove Senior Executives that have failed in their responsibility to care for our veterans.

Question 40. Your predecessor frequently claimed that 90 percent of VA medical centers have "new leadership teams." Please provide detailed analysis that justifies this figure. If analysis does not exist to justify this statistic, please provide your own, personal assessment of how many "new leadership teams" exist. However, those who have engaged in misconduct and are transferred from one VA facility to another do not factor in this equation. Most of these senior employees have appeared to avoid any accountability for their actions:

Response. Unfortunately, the 91% was an erroneous estimate that was mistakenly included in VA's March 2015 Accountability Fact Sheet. The correct fact at that time should have read as follows:

Since June 2014, 84% of our medical facilities and VISNs have newly placed leaders or leadership team members onboard. This percentage is inclusive of both newly placed and permanent leaders. The leadership team is defined as the Medical Center Director, Chief of Staff, Associate Director, Assistant Director, Nurse Executive, and Deputy Medical Center Director, Network Director, Chief Medical Officer, and Deputy Network Director. (Source: VHA Executive Recruitment Quad Report as of 12/3/2015; Timeframe: June 2014 to February 2015).

I have not quoted statistics like this as I am not sure it is the most meaningful way to determine if we are getting the right management teams on board. What is more important to me is to make sure that our searches for medical center leadership are bringing us the best candidates. I am not in favor of continuing with the same ways that we have recruited leaders in the past. I have publicly stated on numerous occasions that I am looking for a mix of leaders that come from VA who are promoted for the right reasons into management positions but to also bring in outside leaders who are familiar with private sector practices. I believe that the se-

lection of new leaders for our organization is among the highest priorities for the Secretary.

• If confirmed, will you commit to ending the practice of merely transferring VA leaders when they engage in misconduct and instead ensure they are really held accountable for their actions?

Response. Beginning in 2014, allegations of misconduct or poor performance by a Medical Center Director or other senior VA leader have been referred to the Office of Accountability Review, an independent investigative body aligned within VA's Office of General Counsel but with dotted-line reporting to the Secretary through the Deputy Secretary and Chief of Staff. When OAR substantiates that a Director has engaged in misconduct or failed to act in accordance with our values, OAR has made recommendations for appropriate action to the Chief of Staff and Deputy Secretary. We do not move bad actors around—we take whatever action is warranted, up to and including removal. If confirmed as Secretary, I will make sure that several things are done. I would be seeking faster decisions on disciplinary actions of senior executives to either clear them of the allegations or to remove them from service. Of course, anything we do must be consistent with the current law and uphold the employee's due process. I am not in favor of routinely transferring employees to other positions (detailing) or in using paid administrative leave.

Question 41. For fiscal year 2015, the Office of Special Counsel (OSC) processed 2,165 cases from the VA. The agency with the next highest case load was the Department of Defense (DOD), with 1,322 cases—despite the fact that the DOD has twice as many civilian employees as the VA. Last Congress, OSC testified that the overwhelming volume of VA complaints presented numerous challenges to the agency charged with investigating and enforcing our Nation's whistleblower protection statutes.

a. Do you agree that the VA has a cultural problem with respect to reprisal on whistleblower?

b. How will you improve the culture of the VA with respect to whistleblowing?

c. If confirmed, how will you work with the Office of Special Counsel to investigate whistleblower claims and ensure that VA whistleblowers are protected?

d. If confirmed, will you commit to holding managers that engage in whistleblower retaliation accountable?

Response. We have made a lot of progress since Fiscal Year 2015 in the way we approach whistleblower disclosures and whistleblower retaliation claims. We've been working with OSC in closer collaboration than I think any other Federal agency does, working jointly with them to train our supervisors and managers on the whistleblower laws, to expedite relief to employees who may be experiencing retaliation, and to improve the sense of psychological safety that we need our employees to have so they feel comfortable speaking up when some aspect of our service to Veterans is in some way flawed. We've also reorganized the functions within VA that investigate whistleblower disclosures and retaliation claims, as well as the functions that track referrals we receive from OSC and from our Inspector General's office, to provide greater visibility over these issues and ensure we are thorough and consistent in our approach.

With respect to the volume of disclosures and retaliation complaints that OSC receives from VA employees, I do think we need to be mindful that only a small percentage are substantiated, but of course OSC needs to review all of them to be sure VA's programs are being conducted properly and our employees are being treated fairly. I am hopeful that Congress will continue to properly resource OSC to do this critical work. If confirmed, I would hold mangers accountable for whistleblower retaliation.

Question 42. If confirmed, how will you work with the VA Office of Inspector General to investigate whistleblower claims and ensure that VA whistleblowers are protected?

Response. I would refer any whistleblowers claims of serious misconduct to the OIG and would implement any recommendations that result from that review. As well as ensure any disciplinary actions are taken by any misconduct identified by the OIG. Also, I will take the necessary steps to ensure the whistleblowers identity is kept confidential, if so requested.

Question 43. There have been several instances when VA employees who are also veterans blow the whistle on wrongdoing at their facilities, they have had their private medical records improperly accessed by coworkers and used to discredit their claims.

a. Do you believe that HIPPA provides enough protections for VA employees that encounter these experiences? If not, will you work with us to enact additional protections into law?

Response. Yes, I believe that HIPPA provides the necessary protections. I would be willing to consider and work with you on additional protections if they are necessary.

b. Will you commit to ensuring that employees that VA employees who improperly access VA whistleblowers' medical records as a means of retaliation are held accountable?

Response. Working collaboratively with OSC and the Privacy officer here within VHA, we have developed a new process to investigate and deal with issues of this type. I don't think we need any additional statutory protections to address this issue; we just need to keep enforcing the statutes and other legal authorities we already have. I will of course commit to ensuring that whistleblowers are protected from all manner of retaliation, including improper access to their medical records, and to holding accountable anyone who engages in retaliatory conduct.

Question 44. In August 2016, the VA released its comprehensive report on veteran suicides after analyzing 3 million records in only 20 states, with the result being 20 veterans a day taking their life. Another study commissioned by the Senate VA committee in 2013 directly linked the prescription of psychiatric drugs to an increase in the veteran suicide rate, and it cited a report that Health and Human Services and Centers for Medicare and Medicaid Services published in August 2013, stating, "Antidepressant medications have been shown to increase the risk of suicidal thinking and behavior."

In the 114th Congress, I was visited by a veteran and his service dog, who informed me of the training his dog received to help with his specific symptoms of PTSD. He prvided a peer-reviewed study from researchers at Purdue University and the Human Animal Bond Research Initiative on the efficacy of service dogs for suicidal veterans with positive results. Shortly after the meeting, I cosponsored the PAWS Act, which would provide VA-supervised service dogs to our nations veterans as a complementary or alternative method of treatment. Will you commit to exploring this option during your tenure as Secretary, and more broadly commit to research involving other alternative methods of treatment in an effort to continue reducing the tragically high rate of veteran suicides?"

Response. VA is aware of the interest in the potential therapeutic value of service dogs in the treatment of PTSD and other mental health disorders. That is why, on my initiative, VA's Center for Compassionate Innovation has launched a pilot program pairing Veterans with Mental Health Mobility Service Dogs. At the same time, VA is in the process of completing a landmark study on service dogs in the treatment of PTSD. We are also continuing to work with your office on the PAWS Act and look forward to coordinating with you on next steps in this direction. I will gladly commit to further research involving this and other alternative methods of treatment during my tenure as Secretary.

We are committed to evaluating the impact of service dogs on the quality of life for Veterans with mental health conditions in the following three ways:

- *Animal Assisted Therapy* programs where Veterans are part of the training process for service dogs, particularly around socialization of the service dogs in different settings
  - – Socialization of the dog in crowds, on elevators, in public places, etc. necessitates the Veteran involved in the training to be in these settings
  - – Allow the Veteran to apply coping strategies learned in therapy to real-life situations while training the dog
  - – Gives the Veteran a sense of purpose and 'giving back' to others since the dogs are ultimately paired with another Veteran with a physical disability
  - – Several programs across the country; program at Palo Alto has been in place almost 9 years with many success stories
- *Mental Health Mobility Impairment Service Dog Initiative* where Veterans with substantial mobility limitation secondary to a mental health condition are eligible for the veterinary health benefit
  - – Evaluation by a multidisciplinary team, including a mental health clinician, determines that a service dog is the optimum intervention to overcome or mitigate the mobility limitation
  - – Mobility limitation may include difficulty navigating public spaces, completing the activities of daily life such as shopping in a grocery store, and coming into the clinic for appointments
  - – Center for Compassionate Innovation, Mental Health, and Prosthetics and Sensory Aid Services are teaming up to evaluate quality of life and satisfaction outcomes from 100 Veterans under this initiative

– 7 Veterans have been approved for the veterinary benefit, 4 have dogs and 3 are in the process of being paired with a service dog, and 20 are going through the evaluation process with their multidisciplinary teams

- *PTSD Service Dog Study*
  – Recruitment is at greater than 80%; recruitment anticipated to be completed by spring
  – Fully staffed with all dog trainers (on board). Two per study site at three study sites equal six (6) trainers. A seventh trainer serves as the supervisor

VA supports a range of studies on post-deployment mental health concerns such as PTSD, depression, anxiety, substance abuse, and suicide. Research aims to:

- describe the incidence and prevalence of mental health disorders,
- identify their risk factors, including pre- and post-deployment assessments,
- quantify effect of deployment on future health outcomes
- understand the basic mechanisms underlying disorders,
- identify new effective treatments, and
- develop models of care that will deliver effective treatments more quickly, widely, and reliably to Veterans in need.

During the last 18 months, VA and other Federal research funding agencies have worked together to address the mental health needs of Veterans through the National Research Action Plan (NRAP), developed in response to President Obama's Executive Order 13625. The plan outlines the vision for PTSD, TBI, and suicide prevention research and describes requirements intended to help the agencies successfully reach important research goals over the next few years.

VA also participates in developing cross-agency priority goals for Veterans' mental health. These goals, coordinated by the Office of Management and Budget (www.performance.gov), will establish common data elements for PTSD and suicide prevention, which will improve the coordination of research efforts across Federal agencies. Earlier efforts produced common data elements for TBI and substance use.

VA is also implementing a randomized program implementation: Block randomization or step-wedge design techniques, is a method by which one can assess the efficacy of a program during and after implementation, which is the strength of randomized clinical trials. This technique, if it can be made to work on a large scale, is much more reliable as a program assessment tool than the use of historical controls or pilot projects. This research work stream will attempt to use randomized-program implementation in several program rollouts to determine feasibility and barriers to implementation of this approach in the VA healthcare system. The function of assessment tools will depend upon the output of the Measurement Science work stream; and the rollout strategy employed may benefit from output of the Operations Research work stream. Current randomized program implementation initiatives have been launched to determine effective approaches for suicide prevention, opioid prescribing, telehealth, and home-based geriatric services.

VA is also studying the use of service dogs for Veterans with PTSD. A multisite study will provide eligible Veterans with either an emotional support dog or a service dog that has been specifically trained to perform tasks that mitigate PTSD. Researchers will look for improvements in participants' PTSD symptoms, quality of life, participation in society, and employment status.

As of the second week in December 2016, 180 of 220 Veterans (82%) have been recruited and assigned to receive either a service dog or an emotional support dog. At the current rate of recruitment, the remaining 40 Veterans should be enrolled by May 2017.

Question 45. Do you believe the VA can benefit from public/private partnerships, specifically with existing healthcare facilities and new construction?

Response. Yes. Public private partnerships can support the right sizing and adaptation of VA's owned infrastructure that could realize a better return on investment for Veterans and taxpayers. Partnerships can take various forms and should be evaluated against VA's needs and on a lifecycle cost basis compared to a traditional public sector project.

VA is presently exploring up to five infrastructure partnerships pursuant to the Communities Helping Invest through Property and Improvements Needed for Veterans (CHIP IN) Act that passed in late December 2016. VA enjoys collaborations with numerous healthcare affiliates, universities and community hospitals, which could be enhanced with the ability to share space and facilities that is limited by current laws and regulations. VA has also had success through its enhanced use lease (EUL) partnership program to leverage private investment with little or no government funding. Further flexibility, including expanding EUL legislation and a broader authority for public private partnerships will provide VA the potential partnerships to build or lease new or renovate/reuse existing facilities.

Question 46. The VHA has been attempting to address the issues of interoperability with other departments, including Defense and HHS along with the general healthcare community. With the growth of the Choice Act, what is your plan to achieve interoperability with these diverse entities?

Response. One of the goals of VA Community Care is to establish a clear process for Veterans to seamlessly transition between VA, DOD, HHS and community providers. In order to improve the coordination of care and reduce administrative burden, VA will implement integrated administrative systems for eligibility, referral, authorizations, provider payments and customer service. To that end, we will leverage technology to:

(1) Provide easy to understand eligibility information to Veterans, community providers and VA staff
(2) Provide Veterans timely access to a community provider by automating referral and authorization process
(3) Provide tools to ensure access to high-quality care inside and outside VA
(4) Coordinate care through seamless health information exchange
(5) Increase automation to support accurate and timely payment of community providers
(6) Provide tools for quick resolution of questions and issues for Veterans, community provider and staff.

These improvements will be implemented through a system of systems approach which involves the design, deployment, and integration of systems. Implementation of this approach will be executed through rapid cycle deployment using agile methodologies. This will allow VA to fix the most pressing issues with community care today, while making continuous updates to promote a learning health system that evolves with the needs of the Veteran population.

Question 47. The Choice Act has shown the need for outside providers to service veterans, at least those geographically removed from department operated sites. How do you envision creating a better system for coordinating care and services of veterans utilizing the choice program and monitoring the outcomes of choice providers and ensuring all veterans receive the same excellent level of care and services wherever they go?

Response. VA's high performing network will have preferred providers that meet quality, safety and reliability metrics to ensure excellent level of care for all Veterans. Our contracted network TPAs will work collaboratively with the VA provider relations office, and local VAMCs to ensure local and regional community care partners join the network to meet the unique needs in a Veteran's community. We will also have regional quality and peer review committees with membership from both our contractors and the VA. We will match as closely as possible community standard quality metrics and VA metrics to ensure Veterans receive excellent quality of care within our integrated network which includes VA and our community partners. VA is also creating tools for the secure and seamless exchange a vital health information. These tools are currently being tested in the field at several VAMCs and their community partners.

Question 48. The private sector has made many advances in both technology and procedures in the medical field. How do you implement these advances into the department? Will you implement these through pilot projects to better evaluate their applicability to the Veteran environment? How will you encourage private entities to bring their innovations to the department in a timely manner?

Response. VA must take advantage of technology advances in the private sector to improve care and services for Veterans. OI&T has shifted its mindset from complex customized acquisitions to leveraging the best of private sector existing technology and innovative mechanisms like public private partnerships. This not only improves speed to market, but allocates resources efficiently, and ensures VA is using the best technology available. Our strategic sourcing approach consolidates VA's IT purchasing power to obtain and deliver the best solutions to our Veterans from the best industry talent at the best price. Strategic Sourcing will provide access to best-in-class suppliers; ensure strong contractual performance through continuous monitoring; improve our speed to market, product compliance, and quality; ensure our compliance with Federal Information Technology Acquisition Reform Act (FITARA); provide greater technical capabilities for VA and our Veterans; and foster the most responsible allocation of taxpayer dollars.

Initiatives like this have been proven successful in efforts such as the Digital Health Platform (DHP) proof of concept, which utilized the public private partnership construct with an academic partner. DHP is a first-of-its-kind public-private partnership that will redefine the concept of "interoperability." DHP is a cloud-based platform. It is not hampered by software updates and changing technology. It is

flexible and open. DHP already works with existing health platforms such as VistA, Cerner, Epic, and more. Future developments can be sourced industry wide.

Additionally, we are utilizing private sector solutions through VA's Center for Innovation (VACI). The work of VACI is driven by a strong commitment to a Veteran-centered approach to service delivery, and dedication to data-drive decisionmaking, design thinking, and agile development. We do this through competitions, special projects, human centered design, innovators network, open innovation, and fellowships.

Question 49. I request specific data regarding the number of VA employees who are currently or were held on administrative leave due to offenses of misconduct. Of those, how much has the VA exhausted on their salaries while on administrative leave and unable to fulfill the duties for which they were hired?

I requested this information as an advance question prior to your hearing but it was not answered. Your response was a 29-page spreadsheet listing individuals with "proposed actions" and "actions taken" regarding their "sustained offenses." There is no data regarding the number of days each individual was on administrative leave due to the "sustained offenses" and just as important the dollar amount exhausted on administrative leave during the time period when the individual was put on administrative leave and when they were reinstated, if at all. The response also does not include a summary clearly explaining the total number of VA individuals and total cost incurred by the Federal Government. Please furnish this data and if there is no method by which the VA has tracked and collected this data, please explain why and how intend to furnish this data.

Response. In response to your request for specific data regarding the number of VA employees placed on administrative leave related to misconduct, and the salary costs associated with such administrative leave, the attached table lists 25 employees who are/have been placed on administrative leave during the current Fiscal Year. The table lists the total number of days each employee was on administrative leave, the salary dollar value of the administrative leave, and date the administrative leave period ended.

I am aware of a newspaper article that recently quoted a much higher number of VA employees that have been placed on administrative leave. I have not been able to have this data confirmed by the VA Department of Human Resources. I will continue to ask VA to provide me with the comprehensive data that would substantiate this number. The issue that I am told is difficult to do is that administrative leaves are recorded for many reasons other than disciplinary issues. Regardless of the difficulty in reporting this data, if confirmed as Secretary I would use my office to ensure that the practice of paid administrative leave is used as little as possible and only when absolutely required.

Finally, by way of context, at VA, as at other Federal agencies, administrative leave may be used to take an employee out of the workplace while agency management or another entity (such as the Office of Inspector General) investigates to determine whether the employee has engaged in misconduct warranting adverse action. Employees may also be placed on administrative leave during the time period between the delivery of a proposed removal or other adverse action and the issuance of a final decision on the proposal.

Factors	Mitigation Plan
Increasing Demand/Lack of Providers and Clinic Staff.	• Active recruitment of health care providers and clinic staff—VA increased provider and nursing staffing by approximately 12% over the past two years • Granting full practice authority for Advanced Practice Nurses • Increase use of telehealth for Primary Care and Mental Health • Use of community care resources when unable to recruit providers • Increased use of extended clinic hours

Factors	Mitigation Plan
Inefficiencies in clinic practices.	• Implemented Clinic Practice Management Program across VA—in this program all facilities have at least one group practice manager to oversee and optimize administrative clinic activities • Validating clinic grids to achieve optimal clinic capacity • Focus on improving productivity—increased productivity by 16% over past two years • Developed strategies for reducing "no show" rates, and redesigning clinic space • Implemented standardized face to face Clinic Clerk Training for optimal scheduling of patients • The above efforts have resulted in an increase in 12,000 appointments daily in 2016 when compared to 2014

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 50. Dr. Shulkin, you have rightly stated that the VA should stop doing the things the VA doesn't do well. I think many would agree that the VA does not have the strongest track record when it comes to VA led IT solutions, to include software development. Countless iterations of VISTA and a currently disjointed scheduling system are cases in point.

Yet, the VA is again pursuing what appears to be a VA solution to scheduling software with VSE. This is concerning, when there are many commercially available, proven and affordable off-the-shelf solutions. Even more concerning is at the hearing yesterday you also referenced an additional VA scheduling tool, called MASS. I am very concerned the VA is moving forward with multiple scheduling tools, at great cost, without giving adequate thought to commercially available solutions, interoperability and effectiveness. An even greater, overarching concern is the scheduling solutions you describe did not mention how they would integrate into an even larger EHR transition. Lack of preparation and the absence of a coordinated strategy are what led to the disjointed IT architecture VA has now.

a. Please describe how you have arrived at multiple software solutions, the respective capabilities and objectives of VSE and MASS, anticipated costs, as well as what consideration has been given to ensuring interoperability with existing platforms and needs.

Response. Improving the tools to support accurate and timely scheduling is a top priority for VA and critical to our ongoing efforts to expand and improve access. VA's current legacy scheduling application successfully schedules millions of appointments, but it is cumbersome to use, does not have a modern look-and-feel, and does not include functions that can drive improved operational efficiencies. VA is focused on providing our workforce with modern scheduling tools. Please find additional details below.

VSE

VistA Scheduling Enhancements (VSE) is a cost-effective, interim solution to bring an urgently needed modern interface to the antiquated VistA scheduling package. VSE is currently being piloted in multiple clinical settings at five VA facilities. If the pilot is successful, VSE will be implemented nationally until a permanent and complete solution is available. The "go /no go" decision related to VSE is anticipated by February 10, 2017 after feedback from the pilot sites. The costs for the pilot sites are less than 10 million. The anticipated spending on VSE through FY 2019 is $36 million, which includes development, enhancement and national deployment costs.

MASS

In addition to VSE, VA awarded a contract for the Medical Appointment Scheduling System (MASS). The Medical Appointment Scheduling Solution (MASS)is a best-in-class Commercial off the shelf (COTS) resource-based scheduling tool. MASS is being piloted in

Boise, Idaho as a potential long term solution to VA's scheduling needs. The future potential deployment costs and approach will be clarified through this MASS

pilot. As you note in your question, scheduling decisions must be made as part of a broader view of Health IT strategy at VA. The anticipated spending on MASS through FY 2017 is $19.5 million, with the total spending to be determined after completion of the pilot. However, if VSE is determined to meet the needs of our schedulers and a decision is made to proceed with a national rollout then the Mass pilot could be stopped and the cost of the pilot would be significantly less.

b. Please explain how these tools affect the self-scheduling pilot project required by the Faster Care for Veterans Act.

Response. The Faster Care for Veterans Act requires a full and open competition for a Commercial Off-the-Shelf Solution (COTS) self-scheduling application for use by Veterans. The Request for Proposal (RFP) to acquire that application is on-track for release by February 14, 2017 with an anticipated contract award date of April 17, 2017, as required by the Act. The Act stipulates that these self-scheduling solutions must integrate with VA's current scheduling platform, VistA, or any future scheduling platform.

Prior to the Faster Care for Veterans Act, VA developed the Veteran Appointment Request (VAR) self-scheduling application through a contract. VAR allows Veterans to self-schedule Primary Care appointments with their Patient-Aligned Care Team and to request assistance in booking both Primary Cary and Mental Health appointments at VA facilities where they receive care. As of February 3, 2017, VAR is operating in 42 VA medical centers and expansion to additional sites is planned.

c. Please provide specific details regarding the RFI that was recently issued regarding the Faster Care for Veterans Act pilot, to include justification as to why the VA has imposed such restrictive requirements which exceed congressional intent and may impede full consideration of available, commercial off-the-shelf solutions.

Response. The intent of the RFI is to conduct market research and ensure that VA is in a position to gather the best information on commercial-off-the-shelf (COTS) solutions that will meet the requirements specified in the legislation. In addition, the RFI provides VA with the information to determine if the procurement must be set aside for competition among Veteran-owned-small-businesses (VOSB) in compliance with the June 16, 2016, U.S. Supreme Court decision regarding *Kingdomware Technologies, Inc.* v. *United States* (Kingdomware) case.

In order to ensure the solution is scalable, reliable, and sustainable, the RFI questions sought to determine the range of options available. In addition, the RFI included questions that provided additional information to determine the stability of the recommended solution.

The questions on case studies allowed the supplier to demonstrate that the proposed solution is fully operational, and supports the intent of the legislation. It should be noted, that the VA has received 8 responses, several of which are not current VA contractors. This will provide excellent input to the next phase—the release of the RFP by February 14, 2017.

d. Will you ensure, as the Faster Care for Veterans Act requires, that the RFP is free and open and not limited to existing VA contractors? How will you ensure that a pilot is launched quickly and safely without unreasonable customization?

Response. Yes, we fully expect it will be a full and open competition as required by the Act. We expect the RFI market research will demonstrate that VA is not required to restrict the competition to SDVOSB or VOSB vendors in accordance with Public Law 109–461 (38 U.S.C. 8127 and 8128) "Kingdomware decision." There have been eight respondents to the RFI; several of which were not current VA contractors. It is in both VA's and the taxpayer's interest to select a partner that can offer a product that does not require extensive customization in order to meet the criteria set out in the law.

The RFP is not restricted to those who responded to the RFI, and VA expects many more suppliers can provide their solutions during the RFP solicitation process.

The requirements included in the RFP are being reviewed to ensure they are sufficient to meet critical VA needs, including security, privacy, VistA integration, and identification of patient eligibility without exceeding the capabilities specified in the Act. VA is prepared to move forward once a successful award is made, and the pilot is planned to begin shortly after contract award (on-target for April 17, 2017).

e. Finally, please describe how you are standardizing functions across the entire VA enterprise and leveraging other large EHR implementations to prepare for such a large transition to a fully functioning electronic health record.

Response. VA is currently reviewing options regarding long-term EHR modernization which include continuing to upgrade VistA, shift to a commercial EHR platform, some combination of both, among other alternatives.

In order to enhance our clinical practice standardization, VA will leverage the Enterprise Health Management Platform (eHMP), which is now deployed and in pilot

testing throughout the VA system. It provides a structured interface for standardization of clinical processes and can be utilized with our current legacy systems or a commercial EHR.

In addition, the VA has developed a Digital Health Platform concept that has a goal of standardizing functions across the entire VA, and provide a comprehensive end-to-end model for integrating healthcare across an individual's lifespan enabling interoperability among systems much more efficiently than traditional system integration efforts. VA is actively reviewing all of the above technology approaches and frameworks so as to make future-looking Health IT modernization decisions that provide cutting edge technology to VA medical providers serving Veterans in the most cost-effective manner.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

TOXIC EXPOSURE

Question 51. Dr Shulkin, in 2002 the VA stopped granting the presumption of Agent Orange exposure to those veterans who served in the bays, harbors and territorial seas of the Republic of Vietnam despite the fact that there is strong evidence of infiltration of toxins into those harbors and bays. In 2015, the Court of Appeals for Veterans Claims (GRAY v. *McDonald*) found that the VA had excluded the bays and harbors from the definition of "inland waters," and ordered that the VA rewrite the regulation based upon the probability of exposure due to river discharge.

The VA currently continues to exclude these bays and harbors from the definition of inland waters. We all agree the rivers were contaminated and rivers run into the harbors and bays. Maritime traffic and anchoring kept that area in a state of flux and the Institute of Medicine has also confirmed a plausible pathway for the dioxin to have entered the shipboard potable water system via the shipboard distillation system, which actually enriheds the dioxin. Will you be taking action to restore benefits to these veterans?"

Response. This case (GRAY v. *Acting Secretary*) remains under litigation. VA believes its revised policy, in response to this litigation, is consistent and fair, as it clearly delineates between inland waterways and offshore waters. In addition, this policy is consistent with evidence concerning the spraying of Agent Orange in Vietnam.

VA previously extended the presumption of exposure to herbicides to Veterans serving aboard U.S. Navy and other vessels that entered Qui Nhon Bay Harbor or Ganh Rai Bay. In the interest of maintaining equitable claim outcomes among shipmates, VA will continue to extend the presumption of exposure to Veterans who served aboard vessels that entered Qui Nhon Bay Harbor or Ganh Rai Bay during specified periods that are already on VA's "ships list." VA will no longer add new vessels to the ships list, or new dates for vessels currently on the list, based on entering Qui Nhon Bay Harbor or Ganh Rai Bay or any other offshore waters.

VA will continue to look at additional evidence and adjust policy as appropriate.

TELEMEDICINE

Question 52. Dr. Shulkin, do you view telemedicine as a platform that could improve access and quality for the critical health care needs of our Veterans? If so could you please elaborate on the role telemedicine might play in the future of the VA and care in the community.

Response. Telemedicine represents a key component of VA's strategy to enhance access to the highest quality medical services for our Telemedicine represents a key component of VA's strategy to enhance access to the highest quality medical services for our Veterans. VA completed 2.1 million telemedicine visits across 50 specialties last year, providing service to more than 700,000 Veterans. VA will continue to leverage and expand Telemedicine programs to share valuable clinical resources across the healthcare system, facilitating support from large and academically affiliated VA facilities to Veterans in rural and underserved areas. VA has initiated or expanded projects for 8 Primary Care and 10 tele-mental health hubs to serve Veterans in regions where demand exceeds capacity, and 45% of telemedicine visits last year were delivered to Veterans in rural areas. VA is also building its capacity to support Veteran access to specialized care that is in short supply in some areas of the country, including tele-genomics, tele-ICU, tele-dermatology and tele-rehabilitation services. In addition, VA delivered more than 39,000 clinical video visits to Veterans' homes last year, and home telehealth programs have produced a reduction

in hospital admissions. Continued expansion of mobile and home telehealth programs is planned.

Currently, telemedicine in Community Care is only in San Diego. VA hopes to expand in other markets once we get it up and going. VA completed 2.1 million telemedicine visits across 50 specialties last year, providing service to more than 700,000 Veterans. VA will continue to leverage and expand Telemedicine programs to share valuable clinical resources across the healthcare system, facilitating support from large and academically affiliated VA facilities to Veterans in rural and underserved areas. VA has initiated or expanded projects for 8 Primary Care and 10 tele-mental health hubs to serve Veterans in regions where demand exceeds capacity, and 45% of telemedicine visits last year were delivered to Veterans in rural areas. VA is also building its capacity to support Veteran access to specialized care that is in short supply in some areas of the country, including tele-genomics, tele-ICU, tele-dermatology and tele-rehabilitation services. In addition, VA delivered more than 39,000 clinical video visits to Veterans' homes last year, and home telehealth programs have produced a reduction in hospital admissions. Continued expansion of mobile and home telehealth programs is planned.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. THOM TILLIS TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

VA LEASES

Question 53. As you know, Congress has not, through a regular process, authorized Department of Veterans Affairs (VA) major medical facility leases since a 2012 change in budgetary scoring of these leases by the Congressional Budget Office (CBO). This change in budgetary scoring has resulted in VA major medical facility leases receiving large, up-front spending scores, despite the fact that actual spending would not increase. This issue has prevented Congress from authorizing two dozen major medical facility leases in 15 states, including in Virginia and North Carolina, states with some of the fastest growing populations in the Nation. If confirmed as Secretary of Veterans Affairs, what are your plans to address this problem? How can we, as elected officials, better assist VA in finding a solution to the lease authorization issue?

Response. If confirmed, I will work diligently with the Congressional Budget Office (CBO) and Congress to come to a resolution in order to move the 24 pending leases forward. These leases are critical to providing care to Veterans and represent 2.7 million annual clinic visits. Specifically, I will work with CBO to highlight the key changes VA is currently implementing to standardize our leasing process and requirements to further demonstrate that the leases are not similar to government purchases of facilities built specifically for VA's use. It is paramount that we all work together to find a solution.

COMMUNITY CARE NETWORK RFP

Question 54. When the VA put together its plan for the community care network, did the Department consider the disruption to veterans from these changes—including in the urgent and emergent pharmacy program? If so, what methodology did you use and most importantly, what are you planning to do to ensure veterans do not see a disruption in their access to critical medicines?

Response. Changes to prescription fulfillment processes for the Community Care Network (CCN) combine existing requirements for the PC3 program, the Choice program and the approximately 75 regional and local "first fill" pharmacy contracts. The changes were made considering the impact on Veterans and were specifically designed to improve services by:

a. Expanding the number of urgent/emergent drugs available.

b. In comparison to approximately 75 existing regional and local first fill contracts, the urgent/emergent drugs available under the CCN is in some cases a reduction but in many cases it is an expansion.

c. Eliminating the out-of-pocket costs Veterans must now pay for their PC3 and Choice urgent/emergent prescriptions.

d. Eliminating the need for Veterans to seek reimbursement from VA for PC3 and Choice urgent/emergent prescriptions.

e. Ensuring continuity of care by making urgently needed medications not listed on the CCN drug list to be available via a prior authorization process.

f. This feature is not currently available uniformly across the VA system.

g. The changes to non-VA prescription fulfillment processes were developed with significant input from field-based VA pharmacists who were charged with improving access, patient safety and the customer experience. VA's formulary management process is dynamic, updated continuously to meet the needs of Veterans and the evolving health system. In the unlikely event the changes result in disruption of services to Veterans, VA has the ability to modify the process to avoid the disruptions.

FASTER CARE FOR VETERANS ACT

Question 55. Late last year, the Faster Care for Veterans Act was signed into law by President Obama. As you may know, the legislation directs the VA to establish a pilot program to test commercial off-the-shelf scheduling solutions, such as cloud-based applications and services, to allow veterans to book their own appointments online or on a mobile device, in real-time, 24–7. The goal is to help the VA rebook the 18 percent of appointments that are generally wasted due to last minute cancellations, scheduling changes, and no-shows, enabling more veterans to access timely care.

As you know, the VA has a long history of trying to build scheduling solutions in-house. Will you prioritize solutions that are already proven to work at scale in the private sector?

Response. Yes, VA's OI&T has implemented a buy-first strategy, which is utilized whenever possible.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MIKE ROUNDS TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

THE VA AND CERTIFIED REGISTERED NURSE ANESTHETISTS

As you know, on December 14, 2016, VA issued the final rule providing full practice authority for advanced practice registered nurses with an effective date of Jan. 13, 2017, which excluded Certified Registered Nurse Anesthetists (CRNAs).

Question 56. What is the VA's rationale for excluding Certified Registered Nurse Anesthetists (CRNAs) in the final rule?

Response. Amending this regulation increases VA's capacity to provide timely, efficient, and effective primary care services, as well as other services. This increases Veteran access to needed VA health care, particularly in medically-underserved areas and decreases the amount of time Veterans spend waiting for patient appointments.

CRNAs play a critical role in providing care for our Veterans. We did not find that VA had immediate and broad access challenges in the area of anesthesia that would require including CRNAs in the final rule. If VA learns of access problems in the area of anesthesia care in specific facilities or more generally that would benefit from FPA, now or in the future, or if other relevant circumstances change, we will consider a follow-up rulemaking to address granting FPA to CRNAs. VA CRNAs that are granted full practice authority by their state license will continue to practice in VA in accordance with their state license and subject to credentialing and privileging by their VA medical facility's medical executive committee. VA will not restrict or eliminate these CRNAs' full practice authority.

Question 57. Would the VA experience cost savings by hiring CRNAs and thereby increasing the capacity of the VA to administer anesthesia instead of using non-VA anesthesia practitioners in some cases?

Response. VA believes a team-based approach to anesthesia care provides the best outcomes to Veterans. Cost is not the primary driver in making decisions on behalf of Veterans. We do employee CRNA's as part of the team and believe we are cost effective. Contracting cost is not necessarily more expensive than having VA paid Full-Time Employee Equivalents. This is complex and involves the use of anesthesia residents (allowed to work for 80 hours/week) in many locations, and is considerably cheaper than Physician Assistants and Nurse Practitioners in the ICUs, as an example. Additionally, some contracting is for specialty services that are not needed on a full-time basis (e.g., coverage of evoked potential surgery, coverage of liver transplants). Because of this complexity, it is very difficult to estimate the system-wide effect.

Question 58. Despite the VA assessing no anesthesia workforce shortage overall, would a local VA facility potentially benefit from more hiring flexibility to fill anesthesia workforce positions?

Response. There could always be some benefit in more hiring flexibility in order to improve access to care for Veterans. If VA learns of access problems in the area of anesthesia care in specific facilities or more generally in VHA facilities that would benefit from advanced practice authority, now or in the future, or if other relevant circumstances change, VA will consider a follow-up rulemaking to address granting FPA to CRNAs.

TRAUMATIC BRAIN INJURY AND POST-TRAUMATIC STRESS

Question 59. If confirmed, how will you work to prioritize research and the development of new treatments for PTS and TBI, two devastating and life-threatening conditions that disproportionately affect veterans long after they are in combat?

Response. If confirmed as Secretary, I would work toward advancing VA's core research mission. While there is much more to learn, VA is already a world leader in research on PTSD and TBI. VA was, in fact, established to take on the mission of studying and treating the health consequences of military service. No other health system has the mandate, the research portfolio or the clinical expertise to carry out this mission. VA researchers developed and fielded the gold standard tools in PTSD research and are pioneering new diagnostic and treatment approaches to TBI. As demonstrated in our recent Brain Trust Conference, VA knows that, as good as we are we cannot accomplish the mission alone. VA is highly focused in our research program to test, confirm and implement new treatments for PTSD and TBI, working closely with partners in other research agencies. A specific highlighted new activity is concentrating on launching studies of new medications and other therapies for PTSD where we will be establishing public private partners (PTSD Psychopharmacology Initiative). I stand committed to work with the best within VA and synergize our efforts with researchers across the country and around the world to meet the health needs of our Nation's Veterans.

Question 60. With public and private partners, studies on post-mortem brain tissue from the VA's National Center for PTSD Brain Bank, have improved our understanding of how TBI and PTS affect the brain and helped discover potential targets for new treatments. How can the VA continue to support these successful efforts and work to close research gaps?

Response. As you note, VA's National Center for PTSD Brain Bank, the first of its kind, was established to significantly advance our understanding of how the health effects of military service affect the brain and to develop new treatments to improve the lives of Veterans. I am committed to supporting the efforts of VA's world-class research and clinical teams and of integrating their efforts with those of public and private partnerships to identify and tackle the next breakthroughs in research and treatment. We will maintain VA's new Office of Public Private Partnerships and participate in engagement programs such as Stand Down on Suicide Prevention, VA Brain Trust Conference and meet with leaders of major pharmaceutical companies to ensure that the right people and the right teams are closing those gaps and identifying the next research horizons. VA Research has a long history of working in partnership to move evidence for new treatments forward. We are currently launching new treatment trials under our PTSD Psychopharmacology Initiative, however, efforts are ongoing to continue to improve understanding and advance treatment for TBI and PTSD in a robust portfolio of clinical trials, epidemiology, and health services.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DAN SULLIVAN TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 61. Do you believe the current hiring process within the VA is as timely and efficient as it could be? If not, what do you believe should done in order to improve the current system so that hiring high-quality personnel occurs as expeditiously as possible?

Response. There are a number of efforts that will need to continue in order to improve the hiring processes and lessening the time to fill jobs. The hiring metric established by the Office of Personnel Management for filling jobs open to the general public is 80 days. The VA hiring metric for filling jobs open to the current Federal workforce is more aggressive and is 60 days; I support this goal. VA's hiring managers and human resources offices take every opportunity to fill jobs quickly by using noncompetitive hiring authorities when there are qualified and eligible applicants, such as Veterans. In addition, I believe we will improve the timeliness and efficiency of the hiring process by:

• Ensuring better collaboration between the H.R. professional and the Hiring Manager when developing the position's requirements and the skills needs for the job that is to be filled;
• Sharing selection certificates between H.R. offices within VA and with other Federal agencies that may have posted job ads with similar job skills which minimizes the need to continually post jobs; and
• Establishing standing applicant files for mission critical occupations.

Question 62. I am asking this question on behalf of my constituent, Ross Bieling: "Dr. Shulkin, as Under Secretary to the VA during the Obama administration, during your tenure, please provide examples where you have implemented meaningful ideas resulting in positive change within the VA system that have directly or indirectly benefited all veterans. And if not, why not?"

Response. Mr. Bieling, thank you for your question. I would be glad to share several examples that started as ideas and moved into meaningful benefits for our Veterans. I will share four ideas here that all relate to improving access to care. They are: 1) reorganizing our approach to wait times to a clinically meaningful approach toward urgent care; 2) access stand downs; 3) same day services; and 4) best practice adoption.

When I came to VA 18 months ago, the biggest issue I believe we faced was access to care for our Veterans. However, from the way that VA was approaching access I did not believe that we could develop an effective solution to the problems we faced. I, therefore, instructed our team to reduce our clinicians' way of ordering consults from 31 different ways to just 2 ways: either routine or urgent. That allowed us to see which Veterans needed care the most. It also allowed us to focus our efforts on these urgent health care needs. Once we did that, we went to our second idea—that is to have national access stand downs. This was a mandatory event that occurred in every single medical center to focus the entire staff on reducing urgent care needs. This effort is described in an article I wrote, http://catalyst .nejm.org/va-stand-down-resolved-56000-plus-urgent-care-consults/.

After we reduced our urgent consults, we then implemented the next idea—same day access. We have implemented same day services for primary care and mental health in every one of our medical centers in the country. The final idea implemented is our Diffusion of Excellence initiative. In this initiative, we are taking the best practices in access from around the country and sharing them to adopt these practices. All of these ideas have led to a significant improvement in access for our Veterans.

Question 63. I am asking this question on behalf of my constituent, Capt. Bob Pawlowski: "Given the effort to revamp the VA and the important focus on health care and services for our veterans, what do you propose to improve the perception in our veterans minds that this is a 'new VA' and you are 'here to serve?'"

Response. Captain Pawlowski—thank you for your question. The design of the "new VA" as you stated is already underway. Since my arrival 18 months ago, we have been working to define a Veteran-centric experience. This is about changing the culture of VA, and setting new expectations for our employees. Our ICARE values define the "new VA:" Integrity, Commitment, Advocacy, Respect, and Excellence (ICARE).

We have asked all employees to sign a commitment pledge to upholding these values and we have now trained over 100,000 of our leaders in how to manage to these values. We are teaching a "principle" based management style rather than a "rules" based style that had begun to characterize much of VA in the past. If confirmed as Secretary, I will continue to lead through these values and make sure that all employees are working to honor our Veterans through the adoption of these principles. The ultimate judge of our success will be our Veterans.

Question 64. I am asking this question on behalf of my constituent, Charles Wilson: "I was told my entire military career that if I stay in and retire, I would be given medical benefits at no cost. I was actually shocked, when I retired, to learn that I had to pay for that benefit. Why? Is there any relief in sight to this tragedy, or are we going to be asked to suck it up once again?"

Response. Mr. Wilson, let me start by thanking you for your service. I am aware of a 2003 decision by the United States Court of Appeals for the Federal District held that promises of lifetime health care made decades ago by recruiters to entice people to serve in the military for at least 20 years were not valid and we have also learned that the recruiters did not have the authority to make them. I would also encourage you to call the following number to determine your eligibility for VA services 1–877–222–8387.

Question 65. I am asking this question on behalf of my constituent, Bejean Page: "Will you [as VA Secretary] seek out veterans and ask them what they need?"

Response. Mr. Page, if confirmed as Secretary I will absolutely do this. In fact, as Under Secretary for Health I can assure you that we have begun to do this now. We seek direct Veteran feedback about what they need in several ways.Let me name four of these ways. First, we speak to our Veterans all of the time. Whenever I do visits to our medical centers around the country I make sure I meet with Veterans to get their candid feedback. In addition, I actually practice medicine in the VA system and care for patients (who do not know I am the Under Secretary) so I hear it straight from them. Second, we ask our Veterans directly all the time. We do hundreds of thousands of satisfaction questionnaires and we pay attention to what we hear and we also ask our patients on our kiosks (we call it Vetlink) about their experience and how we can do better. Third, Veterans contact us every day with their issues and we not only listen, but we respond. I get dozens of these emails myself directly from Veterans and I can assure you I pay attention to what I am hearing. And remember, 33% of our employees are Veterans and many use our services so we listen to our employees as well. Finally, we have established a formal Veteran insights panel of a few thousand Veterans that we run ideas by and ask their thoughts. We also use our Veteran Service Organizations in a similar way and ask them what they think. As you know they represent collectively millions of Veterans.

Question 66. I am asking these questions on behalf of my constituent, D.A. Anderson: "What is your vision for the VA in going forward? How can the VA be run more like a business that has accountability for its actions and treats the veterans of this country with fairness and respect?"

Response. I have a background in business and in running leading healthcare organizations.My approach to running VA is similar to running these other organizations. Successful businesses must be responsive to their customers or they fail. My vision for VA is to be the system of choice in the country and to have healthcare and services that are second to none anywhere. VA must not only be responsive to Veterans (and their families and caregivers) but also be responsible to taxpayers. This means that both the quality of the services and the efficiency of the services must be competitive with private sector options. Accountability in my opinion is set by having clear expectation, clear metrics and feedback, and clear consequences. I am committed to do just this.

Question 67. I am asking this question on behalf of my constituent, Jason Nesslage: "There is discussion in our veterans ranks regarding concurrent receipt of retired pay and disability pay. There is not one veteran that wants this to return to the past, where a retired servicemember chose whether he/she wanted the VA offset pay or their retirement pay. These are clearly two different entitlements that should never be up for discussion again. What are your thoughts?"

Response. Mr. Nesslage, while I agree that Servicemembers and Veterans should be entitled to the maximum benefits allowable as established under law, by statute, VA is not able to pay both disability compensation benefits and military retirement payments in certain instances. Congress recently expanded entitlement to receive concurrent payment for individuals who have a disability rating of 50 percent or more. We will continue to implement any future legislation on this issue.

Question 68. I am asking this question on behalf of my constituent, Ross Bieling: "Do you believe that the current VA structure for purchasing, ensures that new products and equipment are considered for purchasing at the lowest competitive price possible ensuring that budget dollars are spent wisely and effectively? Please describe in detail the current system utilized within the VA for purchasing and if or how you would restructure it under your leadership ensuring that veterans will ultimately benefit within these important areas."

Response. Mr. Bieling, we need to look at all of our support systems and structures to ensure that what we are doing is actually supporting our Veterans while providing value for taxpayers. There is a current initiative underway to improve our supply chain which would not only leverage spending with the input of clinicians, but will also improve inventory management and business processes.

Five initiatives were set in place for the supply chain and purchasing modernization effort: standardize processes and data to establish enterprise-wide management practices; centralize purchasing for cost avoidance; establish a life-cycle management system to ensure consistent availability and correct usage of supplies and equipment; create a national supply chain formulary for improved ordering and recordkeeping; and standardize positions and work responsibilities of acquisition and logistics staff.

Central to the effort was establishing a new list of medical supplies and equipment to be purchased through a centralized system, using one of four regional "prime vendors." This list, or formulary, includes over seven thousand items and

continues to expand, as have the number of facilities using this list. The modernization effort centralizes purchasing authority, streamlines ordering, tracking and procurement of equipment and supplies by providing an efficient, just-in-time distribution process. It also enables VA to leverage its scale to order items at a negotiated rate to avoid costs.

By modernizing these processes, VA's supply chain is successfully reducing excess inventories and leveraging purchasing power, guaranteeing medical facilities have the right supplies, in the right amounts, at the right place, right when they are needed for Veterans' care.

Question 69. I am asking this question on behalf of my constituent, Tony Molina: "Would the VA consider establishing a special help desk for VSO's and Tribal Veteran Representatives, so when a family member asks for a copy of their DD214, we can receive it as quickly as possible? I have been given many answers but there is still no quick way for us to attain a DD214 with one phone call and online takes forever."

Response. Mr. Molina, currently, we allow authenticated VSOs to request DD Form 214s through our general benefits line without a written request, thus allowing the VSO to obtain the document as quickly as possible. Additionally, this service is also provided by chat agents to properly authenticated VSOs. Agents can provide the requested document via U.S. Mail or by fax. Additionally, on February 21, 2017, a new rule will take effect under 38 CFR 14.628 that will allow tribal nations to apply for VSO status in the same manner as if they were a state and once they are properly accredited, VA will be able to provide this same service to their organizations as well.

Question 70. I am asking this question on behalf of my constituents, Mike and Sandy Coons. "Why is it that retired veterans who have served 20+ years for our Nation are required to put up with waiting for an authorization for medical care for weeks, much less days? Retired military or vets with 100% disability have the retired military ID card. We have earned our free medical and dental that was promised to us, yet we have to pay into TRICARE, we have to get a 'mother may I?' for physical therapy, lab tests, radiological testing when all we should be doing is showing our ID to the doctor's office and the doctor's office bills the VA. All we want is for the government to honor the promises made that we fulfilled on our end!"

Response. For many of the VA community care programs, especially Choice, VA is following the criteria Congress set out in law. I recognize that it is not always easy for Veterans to move between programs or access certain types of care. This is exactly the reason why in the future streamlining is necessary to eliminate some of the bureaucracy. Veterans eligible for enrollment in VA's Health Care System are eligible to receive all medically necessary care available through VA health care programs. Veterans, who are eligible for health care from both VA and TRICARE, are free to choose whether they want to receive care from VA or TRICARE.

Question 71. I am asking this question on behalf of my constituents, Mike and Sandy Coons. "Why can't vets with 20+ years or 100% disability, get full dental coverage for all needs, routine cleanings, fillings, crowns, dentures, partials, etc.?"

Response. Veterans who have service-connected disabilities rated 100% disabled, or are unemployable and paid at the 100% rate due to service-connected conditions, are eligible for comprehensive dental care.

Question 72. I am asking this question on behalf a constituent. "My niece is a retired veteran with lupus and has to wait months for an appointment. In addition, the VA is not as familiar with this specific disease as other doctors. Therefore, I believe my niece does not receive the best care, even after serving our country. If a patient cannot receive prompt attention and appropriate care, will the VA pay for a doctor outside of the network?"

Response. If an enrolled Veteran is not able to receive care in a timely manner or requires specific care that is not available at VA, the Veteran can be seen in the community through the Veterans Choice Program (VCP) or other community care programs. The Veteran can speak with the Choice Champion at the facility she attends if she wants to talk someone in person to explain her options. She can also call the Choice Call Center at 1–866–606–8198, or visit the VCP internet site at: http://www.va.gov/opa/choiceact/.

Question 73. I am asking this question on behalf of my constituent, Ric Davidge. "The demand for mental health professionals in Alaska has been long and well known. We just need more. A suggestion is that the VA through the US Public Health Service focus on this highly needed professional group and then put them in Alaska for two years."

Response. Thank you for the suggestion. VA and HHS are exploring any and all possible avenues to fully staff our hospitals and clinics with an emphasis on Veterans Access. VA and HHS leadership are developing a partnership between our agencies for Public Health Service medical officers to serve as clinicians in VHA medical facilities, to include mental health professionals. The mental health needs of our Veterans are a priority and we will take your suggestion into consideration.

Question 74. I am asking this question on behalf a constituent. "I have observed three instances of what could be determined as HIPAA violations since 2014. My husband and I have received two pieces of unrelated medical correspondence for veterans who live somewhere else: one, a faxed a prescription for a VA pharmacy for a veteran who lives elsewhere, the second was a piece of correspondence pertaining to a medical appointment for a veteran who lives in Texas, (the appointment was set for a provider in Texas.) I made the VA and the Choice Program aware of these two instances.

"The third instance was revealed to have impacted my husbands' benefits claim directly. We received a copy of his Disability Benefits Questionnaires which contained medical history of another veteran that had been erroneously inserted into my husband's claim. This other veteran is older and had been seen at a VA for dizziness which my husband now suffers from as well. However, this medical appointment date was 1986 when my husband was just a freshman in high-school and did not suffer dizziness until his Traumatic Brain Injury (TBI) sustained while performing USAF work duties in Plattsburgh, NY in 1990. This 1986 VA visit was cited as the reason for denying his C & P rating increase claim in 2014. An appeal was filed in a timely manner and the second rating doctor reviewed this rating file and used the original rating doctor's decision as the reason to also deny the benefit rating increase claim. Neither of these doctors referred James for follow up evaluation of TBI related issues."

"How will the workflow processes be improved to end these potentially life-altering mistakes? Would Dr. Shulkin be open to having an audit of workflow processes in an effort to identify gaps and unnecessary duplicitous steps in order to streamline the process?"

Response. Yes, I am open to any improvements that could mitigate risks as well as streamline workflow processes. The inappropriate access of patient health records is unacceptable and in violation of privacy laws and regulations, VA policies and procedures, and our principles. We recognize that access to current health information is critical in order to support care coordination and delivery of high-quality care. Currently, each VAMC has unique processes and procedures for requesting, retrieving, and processing returned documentation as well as general workflows related to handling and uploading returned documentation and closing consults. Establishing standardized processes and responsibilities will improve the availability of clinical documentation for providers, enhance continuity of care, and streamline the approach to manage incoming documentation. We are committed to keeping our Veterans health information secure.

Question 75. I am asking this question on behalf a constituent. "I currently have a claim for service-connected Hepatitis C that has been denied twice at the local level and now it is under review at the national level. Will the VA acknowledge the transmission of HCV by jet injector?"

Response. We have heard feedback from Veterans regarding a possible relationship between the hepatitis C virus infection and immunization with jet injectors. Although we currently do not have a documented case of hepatitis C transmitted by a jet injector, it is biologically plausible. Any Veteran enrolled in the VA health care system who has concerns about hepatitis C infection, because of jet injectors or any other potential blood exposure during military service, is welcome and encouraged to request testing and evaluation for hepatitis C at the nearest VA hospital.

Question 76. I am asking this question on behalf a constituent. "My husband tried to get just medical assistance from the VA in 2004 for Hepatitis C. He believed he got HCV at boot camp, or Korea during the war from air guns. The VA turned him down for medical treatment and he died in 2008. He did not know much about it, like everyone else. I've have had an appeal since 2008. I have HCV that I believe I got from [XXXXX]. I'm pretty healthy, except I need treatment, like he did. He was proud to be in the Army. I am trying to get DIC benefits, but the VA is fighting it. I have letters from friends, doctors, etc. I have been fighting since 2008."

Response. Mrs. [XYZ]—After looking into your case, I was advised that the regional office did grant you entitlement to DIC benefits in September 2016. The regional office is in the process of awarding benefits pending recoupment of a previous overpayment and payment of attorney fees.

Question 77. I am asking these questions on behalf of my constituent, D.A. Anderson. "Because you have been a part of the VA system in the last administration, would you consider that a liability or an asset and why? Do you think that being a non-veteran will affect your effectiveness in any way?"

Response. I have been at VA for 18 months. I consider this an asset. Since I was new to the VA system, it took me several months to learn about the system, identify the ways of getting management initiatives accomplished, and developing relationships and trust with employees, Veteran groups, and community organizations. Eighteen months, however, is not long enough to have become engrained in the system about doing things the same way as we always have.My current knowledge of the system allows me, if confirmed, to have the ability to move the system forward without a new learning curve and with the ability to know how to implement these changes.

In terms of being a non-Veteran, I have spoken to dozens and dozens of Veterans about what they want in a new Secretary. What I have consistently heard is that the most important thing they want is a Secretary who knows how and who will make the system work better for them. I believe my experience will allow me to do this. Since I have worked in the system for the past 18 months, I do believe that I have developed a good understanding of the Veteran perspective. However, by not being a Veteran, I know that I will need to try even harder to make sure I am including the Veteran perspective in everything I do. I plan to accomplish this by building a strong management team that has strong representation from Veterans, and in constantly asking for feedback and input from Veterans.

Question 78. I am asking this question on behalf of my constituent, Carol [XYZ]. "When is the VA going to pay their bills? I had to find another podiatrist due to the VA being behind on paying the bills."

Response. As the relationship between VHA and the network contractors continues to mature, the timeliness and effectiveness of payments to community providers improves. The most recent reports indicate that over 90% of clean claims are processed within 30 days; a great step forward since program inception.

Simultaneously in traditional community care, claims staff members have worked tirelessly to reduce the overall backlog of overdue claims within the past 18 months. In July 2015, there was an overall claims inventory of nearly two million claims with prompt payment rate of 67%. These numbers have steadily been reduced to a total inventory of 660,000 with a prompt payment rate of nearly 80%.

We are keenly aware of some providers threatening to leave the Network. There is no more critical service we provide then to ensure timely and consistent care for our Veterans. To that end, in February 2016, the VHA Office of Community Care Provider Rapid Response Team (PRRT) was created to facilitate the expedited resolution of ongoing individual billing and payment cases. Since its creation, the PRRT has received a total of 263 cases, resolving 236. The average time to resolve an individual case is between 7 and 10 days.

Despite these successes, tremendous room for improvement still exists. VHA leaders engage in weekly meetings with Health Net and TriWest leadership reviewing key areas of performance. The Request for Proposal (RFP) for the new Community Care Network addresses incentives to encourage prompt payment by contractors to providers. This RFP was released on December 28, 2016, and will provide stronger oversight in ensuring timely payment to providers.

Question 79. I am asking this question on behalf a constituent. "Since those of us who qualify for boots on the ground, why do we have to go through so many hoops to share a buddy letter or to show through our experiences that we do have PTSD, no matter what our MOS was?"

Response. VA no longer requires that an in-service stressor be documented in personnel records—rather, if the stressor is related to combat or fear of hostile military or terrorist activity, then the stressor can be proved merely by lay testimony (a Veteran's statement) that the event occurred. Veterans may still submit buddy statements to show the current severity or existence of a disability and the statements can be considered in assigning an evaluation. For military sexual trauma (MST) leading to a diagnosis of PTSD, only corroborating evidence ("markers") is needed.

For stressors that do not fall under an exception to the evidentiary standard (i.e., they must be proven by the facts of the case) a buddy statement can be used to help show that the stressor occurred. However, even in those situations, a buddy statement is only one piece of evidence that can be submitted to prove that a stressor occurred.

Question 80. I am asking this question on behalf of my constituent, Capt. Trevor Sayer. "I am a USMC Captain retiring this summer. I am retiring from a joint command in Arizona, and begin my terminal leave in March. The VA pre-discharge

claims enrollment program (BDD) allows active duty to submit claims 120 days out. However, if you are leaving the state in which you file before the claim is processed and your appointment for your initial medical exams are not made in time then the claim has to start over in the new state. Now in my case, I am in Arizona and going home to Ketchikan. I could start my claim now in Arizona but I am told it could delay processing by months because the claim would need to be transferred to Alaska then arrangements for me to fly from Ketchikan to a VA med center in Anchorage would need to be made in order to do initial medical screenings. There simply isn't time within this 120 day window to do all the evaluations in AZ before I depart. The alternative being to forego terminal leave in order to do medical screening prior to going to Alaska or wait till I get home to Ketchikan and submit a fully developed claim once my retirement is effective thus eliminating the benefit of the predischarge program. What if the VA had a mobile outreach program in Alaska?"

Response. Servicemembers are highly encouraged to initiate their claims during the pre-discharge stage to afford the earliest effective date possible for any award of benefits. Currently, participation in the Benefits Delivery at Discharge (BDD) program requires being available for examination at the Servicemember's last duty station. However, if the Servicemember is not available for examination at their last duty station, the claim is transitioned to the Quick Start program. Quick Start claims are also considered priority VA claims. The VA examination for the claim would then be completed near the post-separation site where the Servicemember/Veteran resides and is available for examination.

Based on your specific scenario, it is recommended for you to file your claim as soon as possible and we can expedite the scheduling of your examination at the most appropriate location convenient to you.

Question 81. I am asking this question on behalf of a constituent. "We called one of the VA phone numbers and they said on the recording that if there was someone who was feeling suicidal, to call a hotline number or call 911. So why is it that the VA phone systems cannot give an immediate option to press a number to go immediately to the hotline or to the 911 services?"

Response. Earlier this year we implemented a feature that allows callers to VA medical centers to "press 7" to be directly connected to the Veterans Crisis Line. We are exploring expanding that feature to other VA entities. The option of direct connection to 911 services is more complex and we are studying it now. Due to its complexity, we do not have a timeline for when, or if, it will be implemented.

Question 82. I am asking this question on behalf of constituents. "Issues like the flu, sinus infections, migraines and items like that it is much easier for us to go to a local hospital and use our TriWest in the urgent care department and pay the co-pays. As far as we know, we can't go to urgent care at the local hospital and use our VA. Is this where Choice would come in? Also, going in for urgent care or emergency care in a regular hospital could they streamline the VA Choice like it is with the TRICARE (TriWest) so we don't have to call prior to treatment for authorizations?"

Response. The Veterans Choice Act expanded VA's ability to provide timely access to care for Veterans from sources in the community. While this much-welcomed expansion of authority provides VA with another means with which to provide routine care for Veterans who cannot otherwise be seen within a VA facility, the requirement for VA pre-authorization of care under this program does not lend itself to being an effective tool for management of medical care during instances of urgently or immediately-required medical attention. VA is seeking additional authority from Congress to consolidate its community care programs and to provide expanded urgent/emergency care coverage to eligible Veterans.

Question 83. I am asking this question on behalf of my constituents. "We travel out of Alaska to Florida for our winter time for three months. So when we arrive in Florida, we can use the urgent care or the emergency room at Bay Pines VA Medical Center in Seminole, Florida and those services are really pretty good. However, we have to go into module A and wait because we do not have a VA primary doctor down here in Florida. We have noticed that our records and annotations from Alaska and records and annotations here in Florida do not always make it into the same record files on My Health in a timely manner. Why is that? One example is the echocardiogram my husband had at the Bay Pines VA medical center on Friday a week later, it is still not on the My Health records. This was a specialist referral that was requested in Anchorage that we asked to be conducted in the VA Gainesville thoracic surgeon's office so we would be close to family in case a surgery was needed."

Response. For some data from the Electronic Health Record (e.g., lab test results), information becomes available within My Health*e*Vet three calendar days after is

has been verified. This delay enables the provider to communicate with the patient if needed, for example to discuss an abnormal test result. The example you provided of an echocardiogram is something that is not currently sent to My Health*e*Vet, but is something we are working on for the future.

Question 84. I am asking this question on behalf of my constituents. "We think every VA center, especially in Alaska, needs to have an emergency room or agreements need to be worked out with local hospitals to service-disabled veterans by using the VA Choice for emergency services at local hospitals."

Response. The Veterans Choice program was designed and implemented to expedite access to care for those Veterans who do not have a VA facility reasonably available to provide required treatment in a primary care or urgent care environment. Because of the nature of the administrative requirements included in the Choice Act, utilization of it as a means to provide emergency care is not feasible and would add confusion or delay to Veterans in seeking or receiving care during an emergency. As it pertains to emergency care, the primary consideration of VA is the safety and well-being of the Veteran.

As such, VA provides emergency treatment to Veterans via Community Care programs that remove administrative prerequisites, such as calling a third-party administrator or VA, and encourages Veterans to proceed directly to a source where they can receive the care and services required. VA agrees that all Veterans should be aware of actions to take during an emergency as well as the benefits available to them. As part of plan to improve and consolidate community care programs, the variation in emergency care would also be addressed.

Question 85. I am asking this question on behalf of my constituents. "It is extremely difficult to see the VA primary care doctors more than once a year face-to-face. A lot of our interaction takes place on phone calls with nursing staff. When dealing with specialized health issues, that once a year face-to-face is not sufficient. We need to be able to go into our primary care when we're dealing with being moved from specialty clinic to specialty clinic in order to discuss the next course of action."

Response. Primary care plays an important coordinating role for patient care, particularly for the patient with complex medical issues requiring involvement of one or more specialists. These Veterans may require frequent interactions with the primary care provider in addition to other health care team members. The kind of interaction will vary depending upon both the medical needs and preferences of the patient, and includes face-to-face visits as well as telephone care and secure messaging. Primary Care policy (VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook) provides flexibility for the team to decide with the patient both the type and frequency of these interactions. Patients are encouraged to discuss their preferences with their Patient Aligned Care Team (PACT) to ensure that they are accommodated in the treatment plan. In occasional instances, these discussions can be facilitated by the patient advocate if specific concerns of the patient remain unaddressed.

Question 86. I am asking this question on behalf of my constituents. "We have both have talked to several dependent wives whose spouses are suffering from PTSD that served in the war zone and that they are not able to get help while they're serving at their current assignment. They feel like they have to get out of the service and they need to cope with it on their own, as the upper supervision has impressed upon them that they don't have a problem and they don't need to go get help for it. There is still a high need for more treatment and education in the upper management levels for them to understand and to help their troops suffering with PTSD without taking away peoples jobs or the stigma of this. Especially special ops or infantry. Our military and our veterans have served well, they have fought well, but they are struggling because they're being told that they should not identify themselves with PTSD issues because they might lose their jobs. Also, a lot of the dependent wives are having to cope with PTSD with their husbands that they don't fully understand how they can handle it, how they can walk through it with them, and how they can encourage them. We suggest that there needs to be a PTSD assistance and education program for spouses of military members/veterans to help the families as well. Also, recommend offering co-counseling services for dependent spouses that have walk-through documented PTSD incidences with their veteran husbands or their wives."

Response. I agree that PTSD or any mental health issue is best addressed within the context of the family. Since 1979, VA's Readjustment Counseling Service (also known as the Vet Center Program) has been offering couples and family interventions as a core service. Unfortunately, there are currently legislative obstacles to involving family members in VA mental health services. If confirmed as Secretary, I will seek Congress' action in updating legislation in order to allow VA clinicians to

provide robust involvement of family members in the care of all Veterans seeking VA care.

Vet Centers provide readjustment counseling to any Veteran, active duty Servicemember, and those in the National Guard and Reserve Forces who served in a combat zone or area of hostility. The family members of these individuals are also eligible to receive counseling when it is found to aid in the readjustment of their loved one or to help the family cope with a deployment in the absence of their Servicemember. Services to family members can consist of individual, group, and family counseling and focus on psycho-education, reducing the symptoms associated with PTSD, or any other goal the Veteran or Servicemember has identified. All Vet Center services are provided regardless of the character of discharge, to include dishonorable discharge.

To help reduce the stigma associated with receiving counseling, Vet Centers maintain the highest levels of confidentiality. Vet Center Counseling Records are released only through the signed consent of the eligible individual or to avert a crisis such as serious suicide ideation or attempt.

Question 87. I am asking this question on behalf of my constituents. "There appears to be some pretty significant delays in the referral management office to get referral appointments. We believe that part of the problem is a lack of sufficient personal for referral management offices to handle and swiftly process those referrals outside of the VA to a specialist. If a specialist is seen (like a pulmonary doctor) and refers to another specialist (thoracic surgeon), we have to go back to the VA referral process system again into a holding pattern to get the request from the specialist that requested we see another specialist or series of tests that results in further delays. And we have to wait for the primary nurse practitioner to approve it before we can even get to the other specialist who is a doctor. We also find that we have to make routine phone calls to follow up on those actions, like the 'squeaky wheel gets greased first.'"

Response. We developed an operating model that improves efficiency in the referral process including direct communication with our community providers via our portal, the creation of standard episodes of care (EOC). This model is currently being rolled out and is now in use in Alaska. Many of these include the authority for a Veteran to see several providers or receive several tests as part of a complete EOC. For example, a complete EOC for a Veteran with a pulmonary nodule could allow a community pulmonologist to see the Veteran, diagnose a lung cancer and then send that veteran to a thoracic surgeon to perform a partial lobectomy. This should assist in getting Veterans access to specialty care more timely.

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

VA PUGET SOUND HEALTH CARE SYSTEM

Question 88. As you know, many Seattle area veterans receive their care through the VA Puget Sound Health Care System—specifically at the Seattle campus. Unfortunately, in meetings with individual veterans as well as Veteran Service Organizations in Washington state, we regularly hear of obstacles that veterans face in accessing care. My colleagues and I have worked to identify some of the root causes of these issues, which seem largely to stem from unfilled management positions, an overreliance on "acting" roles that lack decisionmaking authority, and frequent turnover in leadership.

On October 26, 2016, you spoke with my colleague Congressman Adam Smith, whose district includes the VA Puget Sound Healthcare Center in Seattle. During that call, Mr. Smith specifically noted the multiple leadership issues that plague the Seattle VA facility, including ongoing problems with open, unfilled positions. It is my understanding that both you and Congressman Smith agreed that sending a management improvement team was warranted, and would be beneficial to Seattle area veterans. Your staff in Washington, DC, confirmed this in an October 28, 2016 message.

Unfortunately, on November 14 last year, Congressman Smith's office was informed that this commitment was being rescinded, and VA officials have so far refused to explain why. The leadership problems continue, and have only worsened with President Trump's recent Executive Order directing a Federal hiring freeze. Clearly, the need for assistance remains.

• To that end, will you commit to sending a management improvement team to the VA Puget Sound Health Care System?

Response. I am disappointed to hear this and I was not aware of any decision to rescind a team from going to VA Puget Sound. I will commit that a team of Human Resources experts will be on site within 60 days to assist VA Puget Sound Health Care System hiring efforts and further instruct the team that no one but me would be allowed to rescind this commitment.

IMPACT OF HIRING FREEZE

Question 89. Dr. Shulkin, you said in your nomination hearing, "the most important thing to me is that we have the resources to hire the people that we need to take care of our veterans. We have requested that from the White House and we have gotten that." You further claimed that there are 45,000 positions open within VA, of which 37,000 are exempt, but that still leaves 7,000 positions vacant. Additionally, those numbers only apply to positions in the Veterans Health Administration. There are another 688 vacancies within the Veterans Benefits Administration, none of which are exempt. So the hiring freeze will clearly have a very real impact on veterans' access to services and care.

For example, data from VA Portland Health Care System, which provides benefits and treatment to veterans in Washington State, shows that on average they processed more than 500 claims for beneficiary travel program every business day in 2016. As a result of this high volume, the travel reimbursement claims processing time is backlogged to about six weeks for most claims and up to eight weeks or more for complex claims. Portland VA had hoped to address this backlog by hiring additional staff for their Veterans Transportation Program. Unfortunately, although the authorized number of staff for the VTP was raised to nine employees, the hiring freeze has blocked this VA from hiring the staff it needs to quickly provide this important benefit to our veterans.

• How can you say that you have received all the resources you need to take care of our veterans when close to 700 positions related to providing our veterans with benefits remain vacant and how are you going to address the delays in processing veterans' benefits with so many open positions at VBA?

Response. If confirmed as Secretary my focus would be to address any barrier that prevents us from delivering the services needed to our Veterans. At this point in time, my primary concern is to ensure the health and safety of our Veterans. I believe we have the exemption for hiring that allows us to do that. VBA continues to offer overtime on an optional basis to employees processing compensation rating claims. Additionally, VBA has authorized overtime for specific pension and non-rating work. VBA is considering all options, to include mandatory overtime, to ensure that Veterans are getting the best care and services possible while the hiring freeze is in effect.

• If confirmed, will you exempt VBA positions from the hiring freeze?

Response. I stated in my testimony that I had spoken to the current Acting Under Secretary for Benefits and asked him to closely monitor the situation with clear metrics to make sure that we are not seeing a significant deterioration of service levels. It is my understanding that VBA is in the process of submitting an exemption request to permit the hiring of direct labor occupations to ensure reduced impact on VBA's ability to serve Veterans. If I am confirmed as Secretary I would give full consideration to this request.

Question 90. As VA Secretary, it will be your job to advocate on behalf of all policies that affect veterans. That means that you must advocate not just for access to health care but also for veterans' ability to access all the benefits that have been provided to them in return for their service. One of those benefits is the hiring preference veterans receive when applying for Federal positions. I am very concerned that President Trump's hiring freeze will impact these veterans, who apply for Federal positions in disproportionate numbers compared to non-veterans.

• If confirmed, what work will you do with the Administration to make sure that veterans are not disadvantaged in their effort to seek Federal employment?

Response. VA provides first consideration to all qualified preference eligible Veterans when filling jobs open to the general public. When filling jobs that are only open to current Federal employees, VA also accepts applications from Veterans who are currently not part of the Federal workforce, but are eligible for hire using special hiring authorities. A large percentage of the Veteran workforce at VA, 32.57%, was hired using a variety of special hiring flexibilities, such as the Veterans Recruitment Act, Veterans Employment Opportunity Act, Schedule A Authority for People With Severe Physical Disabilities, Psychiatric Disabilities, and Intellectual Disabilities, and the 30% or More Disabled Veteran Public Law. To the maximum extent possible, if confirmed as Secretary, VA will continue to fill jobs with qualified Veterans.

The VA also has an established Veterans Employment Services Office to monitor our progress with regard to employment of Veterans and to advise me on Veteran recruiting and retention strategies. I am proud of the work we've done to assist Veterans seeking Federal employment, and I remain committed to those efforts. Over 120,000 of our employees are Veterans, including over 50,000 of whom are Disabled Veterans.

I look forward to the opportunity to serve as co-chair, with the Secretary of Labor, of the Veteran's Employment Council to ensure the Federal Government maintains its momentum in providing employment opportunities for Veterans both in the Federal Government and in the private sector.

UNDER OTHER THAN HONORABLE DISCHARGES

Question 91. I am concerned about the increasing number of servicemembers who leave the service not knowing their VA eligibility status. A 2016 report from Swords to Plowshares showed that under other than honorable (UOTH) discharges often result from minor infractions that relate to PTSD or other conditions that prevent them serving as expected. The report noted that Post-9/11 veterans in particular are three times more likely than Vietnam Era veterans to receive an under other than honorable discharge, and that veterans with an under other than honorable discharge are twice as likely to commit suicide, twice as likely to be homeless, and 50 percent more likely to get caught up in the criminal justice system.

The brave men and women who volunteer to serve in our military should not be left without healthcare or basic workers' compensation for injuries in service. Thankfully, the issues surrounding UOTH discharges have gained public and media attention, and increasing attention from this Committee, including a media event that the Chairman hosted last month.

Current law allows former servicemembers to get basic veteran services if their conduct was not dishonorable. However, it is often up to VA discretion when it comes to providing services to a veteran with an UOTH discharge. Over the past several years, VA has taken steps to address this problem, including preserving homeless housing eligibility while corrective legislation was prepared; improving the internal processes for deciding eligibility in these cases; improving internal communication to VA staff to make sure every veteran has an opportunity to access services; and making a commitment to this Committee last year that it would revise its regulations to better take mental health and other factors into account. These are great first steps, but there is much more that must be done to properly care for veterans with an UOTH discharge.

If confirmed, what specific steps do you plan to undertake to provide services and care to eligible veterans with UOTH discharges?

• In particular, will VA follow through on its commitment to issue new regulations this fiscal year amending the criteria for "under other than dishonorable" service, regardless of President Trump's executive order that would require agencies to revoke two regulations for every new rule they want to issue?

• If confirmed, will VHA revise its military sexual trauma program instructions to ensure that no veteran is denied access to military sexual trauma care, regardless of circumstances of discharge?

Response. If confirmed as Secretary, I would work to use the full regulatory authority available at VA to serve as many Veterans as possible including those with other than honorable (OTH) discharges. If there are statutory requirements that prevent us from doing this, I would come to you to ask for your assistance. Currently, an OTH discharge is not necessarily a bar to receiving MST-related health care. It is my understanding that Veterans with OTH discharges can currently receive VA care, including MST-related care, upon review of their discharge by the Veterans Benefits Administration (VBA). Following this review, VBA issues a decision as to whether or not the Veteran's discharge is a bar to receipt of health care benefits. VA has taken steps to ensure staff are aware that Veterans with OTH discharges are potentially eligible for MST-related services and that there have been no shifts in policy to tighten eligibility requirements. I am committed that no Veteran with MST would be denied access to care.

PAIN MANAGEMENT

Question 92. The VA, with Committee oversight and support, has taken important steps to improve pain management throughout the VA system. These include implementation of a "step care" model that matches appropriate therapies to the unique needs of individual patients, particularly for veterans with complex chronic pain problems of long, sometimes lifelong, duration. There has also been collaboration with the Department of Defense to allow servicemembers transitioning to VA care

to have their pain management coordinated across the systems. Furthermore, VA researchers have worked with the National Institute of Health and other research partners on new treatments, particularly those that could be alternatives to the use of opioids for chronic pain. Despite progress, a lot remains to be done.

a. What is your position on alternative methods of pain management?

Response. I have always been a strong believer in the importance of complementary and alternative methods in pain management. As the CEO of Beth Israel Medical Center in NYC we developed one of the largest private sector Complimentary Care Programs in the country.At VA, we have an extensive commitment to complementary care under the leadership of Dr. Tracy Gaudet. Dr. Gaudet prior to coming to VA led Duke University's programs in Complimentary Care.

b. If confirmed, how specifically will you continue prioritizing these efforts?

Response. In response to Section 932 of the Comprehensive Addiction and Recovery Act (CARA), passed in July 2016, the VHA has developed an ambitious plan to expand research, education, and clinical delivery of complementary and integrative health approaches for pain management as well as mental health and overall well-being over the coming three years. On the clinical side, the Integrative Health Coordinating Center in the Office of Patient Centered Care & Cultural Transformation is working to make the evidence-based CIH approaches—including acupuncture, chiropractic, yoga, tai chi, meditation, and massage—more widely available to Veterans nationally. Our commitment is that every medical center will offer at least two of these therapies routinely for Veterans with pain, and one "flagship" site in each VISN will offer the entire range of therapies. Our new Community Care contract will also make these complementary therapies available to Veterans in the community if they are not available through the medical center.

To support this increased access to CIH therapies for pain we are actively working to revise VA medical policies and regulations to facilitate delivery and evaluation of CIH approaches as part of the VA medical benefits package. We are also rolling out a large scale educational initiative through our Employee Education Service to increase awareness among clinical staff of the role of evidence-based CIH approaches for pain, so that our clinicians will begin to utilize these approaches more actively with Veterans. Finally, our Office of Research Development is collaborating with the National Center of Complementary and Integrative Health at NIH and the DOD to fund a large research initiative supporting demonstration projects developing the most effective ways to deliver CIH for pain in our military populations.

VETERANS ABILITY TO RAISE CONCERNS

Question 93. I have heard from many veterans in Washington state that it is very difficult to get a concern or complaint addressed that is not specifically related to an appeal or claim. I have also heard that former Secretary McDonald's open door policy, including the establishment of town halls, was well received by veterans. I understand that veteran advocates are intended to help veterans with complaints, but my office continues to receive complaints from veterans who do not feel their advocates are actually addressing their concerns, perhaps a consequence of the structure in which veterans advocates work with local VA but do not raise the concerns to the Department in D.C.

• If confirmed, can you assure me that you will continue the open-door policy established by former Secretary McDonald, and that you will create an avenue through which veterans can raise their concerns and complaints higher than a veterans advocate if they feel the complaint has not been addressed?

Response. Secretary McDonald and I share many of the same values in how to run organizations, but of course our styles are not identical. My record at VA shows that I have also been accessible to Veterans and many organizations as well. I hold town hall meetings, speak at numerous events where I interact with Veterans and organizations that represent them, and take advantage of as much interaction as I can. My career has been focused on allowing the voice of the patient to be heard as a primary means for improving healthcare. I've started companies that allow patients to be more empowered and I've written a book called "Questions Patients Need to Ask" to allow patients to be more informed about being a knowledgeable consumer of services. I would plan to continue with this philosophy of patient empowerment if confirmed as Secretary.

Question 94. While I have heard support for the VA town hall program, I have also received complaints from veterans in rural communities who have not been able to attend these meetings because they only take place in the greater Seattle area.

• If confirmed, can you assure me that you will keep the VA town hall program going, and that you will expand it to reach parts of the country outside major metropolitan cities?

Response. Yes.

BREMERTON CBOC

Question 95. I wanted to follow up on the conversation we had regarding the Bremerton CBOC. As I mentioned, for the last decade, my office has been working with VA, the local community, and the Navy to find an appropriate relocation site for the CBOC in Bremerton, Washington, which is significantly undersized. In your written response to questions you cited multiple tools to solve real estate problems, some of which were not effective in resolving the Bremerton CBOC issue. This facility has experienced two failed relocation efforts, the last of which means a new facility won't open until 2019 at the earliest. I understand it is VA's opinion that this location is not opening as a result of the building not being renovated in compliance with seismic regulations. However, this community has been without adequate care capacity for ten years, so I am less interested in what has gone wrong than how you intend to fix it.

a. What immediate steps will you take to provide additional outpatient resources to the growing veteran population in Bremerton?

Response. The VISN 20 Network Director during an update call with your staff on February 2, 2017, committed to seeking clinical space in a non-VHA healthcare facility into which could be placed an additional PACT Team to increase primary care while work to relocate the Bremerton CBOC is completed. VA has already identified two possible locations: one at the new Harrison Hospital in Silverdale; a second in the Franciscan Medical Building in Port Orchard. Opening an additional PACT team at a satellite location in the Bremerton area is contingent on our ability to timely recruit the PACT medical team professionals required to provide this service. In the meantime, all new Veterans seeking enrollment for Primary Care Services in the Kitsap County area are offered the option to enroll with a Choice primary care provider. There are approximately 153 Primary Care Choice providers in Kitsap County—sufficient to provide the primary care needs of our Veterans in the Bremerton area.

b. What changes will you make to prevent this from happening again?

Response. The delays associated with moving the Bremerton CBOC to a new and larger location were related to the contractor that was selected for this project. This raises the issue of Federal contracting law and the ability to select the best contractor for the job to ensure that this type of issue does not arise again. If confirmed as Secretary I would undertake a review of our contracting rules and make recommendations on how we can improve and prevent issues like this from recurring. In the meantime, please be assured that the Bremerton CBOC relocation project has the personal attention of the VISN 20 Network Director and VA Deputy Under Secretary for Health for Operations and Management.

ACCESS TO WOMEN'S HEALTH IN RURAL AREAS

Question 96. Dr. Shulkin, women make up the fastest growing veterans population in the United States. In response to pre-hearing questions, you noted that since 2014, 100 percent of medical centers and 90 percent of CBOCs have Designated Women's Health Providers (DWHP). Those are commendable numbers, but I would like to see 100 percent of CBOCs have a DWHP, especially since so many veterans live in rural areas where their only access to VA care is through their local CBOC. In fact, a report released this January by the U.S. Census Bureau found that roughly half of all veterans live in rural areas. In my home state of Washington, more veterans lived in rural areas than non-veterans.

a. With VA projections showing that the number of women veterans is expected to rise to 15 percent of the entire living veteran population, how will you, if confirmed, ensure that 100 percent of CBOC's have a Designated Women's Health Provider?

Response. VA recognizes that the population of women Veterans has grown dramatically and will continue to rapidly expand. For FY 2017, VA has set a Secretary's Management Initiative focus on women Veterans' access, trust and satisfaction. Specifically with regard to access in CBOC's we will conduct additional trainings this year gaining an additional 500 providers through our Mini Residency trainings. The attendees are selected specifically targeted to gaps in providers, particularly for CBOCs. In addition, we are launching a new traveling education for rural sites to deliver the curriculum to CBOC providers. VA has identified where the gaps in providers exist, we strive to have Designated Women's health Providers at every facility and CBOC.VA, just as for all of health care, continues to be challenged in hiring Primary Care Providers. To assist with recruitment, Workforce

Management and Consulting (WMC) is developing new recruitment tools to entice more women's health providers into VA employment.

b. What else will you do, specifically, to care for the growing population of women veterans?

Response. With regard to ongoing access, VA Office of Community Care has recently added analysis of referrals for women and provider availability. Approximately 33% of women go out into community care each year, thus an important focus had been adequacy of referral networks. In house, we have expanded Mammography to 52 sites and will continue to add locations that reach the critical minimum number of women at that site. VA Office of Women's Veterans Health has developed IT tools for management of breast cancer cases. Also added is a tracking system that allows follow up of tests ordered for women, whether seen in the VA or in the community.

VA recognizes ongoing challenges for women Veterans using VA care and benefits. Despite many gains in culture change, women Veterans report feeling less welcome at VA than men, and overall do not report high trust in VA. We have launched a new campaign to enhance respect of Veterans and to end harassment of women Veterans by other Veterans. The full campaign will roll out it waves throughout this year.

CAREGIVERS

Question 97. As I have long believe, you stated in your meeting with me on Tuesday that the Caregivers program may actually be cost effective. However, you also stated that it would cost $3 billion annually in your answer to my pre-hearing questions. When we discussed this further you said that you would be interested in doing a cost-benefit analysis of the Caregivers program, or something similar, to determine if it is a cost effective program for VA to utilize, which could result in the actual cost of the program being much less than $3 billion.

• Do I have your assurance that you will conduct a cost benefit analysis of the Caregivers program to determine if it is actually cost effect? Once this analysis is complete will you work with CBO to update the estimated costs associated with the Caregivers program?

Response. You have captured our conversation correctly. I do believe that support of additional Caregivers, particularly to older Veterans, may be cost-effective. This may be especially true in the area of cost avoidance of institutional care. I would be very interested in seeing the results of a study that would allow us to make a decision regarding the value of expanding the program. Rather than committing to a study right now, I would first want to make sure that such a study has not already been done for us to learn from. If not, I would want to speak to our researchers in VA to see if we have the ability to do such a study and if not I would want to speak to an outside group to determine the cost, time required and scope of such a study. Finally, I would want to confer first with CBO to make sure that we are asking the right questions up front to ensure that the results of the study would be meaningful to them.

IMPACT OF INCREASED MILITARY

Question 98. President Trump has said he wants to substantially increase the size of the U.S. military, with an addition of 60,000 active duty soldiers, an unspecified number of additional sailors to man the 78 naval vessels he would like to build, another 12,000 Marines, and additional personnel to man at least another 100 combat aircraft for the Air Force. These servicemembers will one day become veterans who will rely on VA to provide them timely access to the benefits and care they earned through their military services. A Brown University study showed that the cost of caring for veterans peaks 30 to 40 years after a conflict has ended, and that future costs associated with the Iraq and Afghanistan veterans will likely be between $600 billion and $1 trillion. If President Trump is serious about increasing the size of our military, he must also be serious about providing resource to VA to ensure that all veterans can access the services and benefits they have earned in a timely matter.

a. How are you preparing VA so it can afford the impending influx of veterans from the Iraq and Afghanistan wars?

Response. As Secretary McDonald stated in testimony from FY 2017 budget hearings, forty years after the Vietnam War ended, the number of Vietnam Era Veterans receiving disability compensation has not yet peaked. VA anticipates a similar trend for Gulf War Era Veterans, only 27 percent of whom have been awarded disability compensation. As the demand for benefits and services from Veterans of all eras continues to increase, VA will ensure budget requests to Congress reflect the necessary resources to handle influxes in workload and benefit payments.

b. Have you had conversation with President Trump about the possibility of increased funding for VA concurrent with the increase in the number of servicemembers? If not, do I have your assurance that you will have periodic conversations with President Trump if funding shortfalls continue to impact VA's ability to provide benefits?

Response. I have not had this conversation with President Trump. VA will continue to coordinate with the White House as well as DOD leadership to ensure workload forecasts and funding requests reflect the latest information available regarding separating Servicemembers. This ongoing coordination will ensure VA and Veterans are not impacted by a funding shortfall. If confirmed as Secretary, I would commit to raising issues to the President that impact on our ability to deliver necessary services to our veterans.

HOMELESSNESS

Question 99. You stated in your response to a pre-hearing question that you believe the current spending levels for key programs that combat homelessness among our veterans, particularly HUD-VASH and Supportive Services for Veterans and Families, are sufficient to address this serious issue.

However, the Department of Housing and Urban Development estimates that nearly 40,000 veterans are homeless on any given night.

• Can you please explain how there is no need for additional resources to address veteran homelessness with so many of our veterans sleeping in the streets each night?

Response. The 2017 President's Budget includes $1.6 billion for VA programs that prevent or end homelessness among Veterans including funding for case management support for the nearly 80,000 existing Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers, grant funding for community-based prevention and rapid rehousing services provided through the Supportive Services for Veteran Families (SSVF) program, clinical outreach and treatment services through Health Care for Homeless Veterans (HCHV), service intensive transitional housing through the Grant and Per Diem (GPD) and prevention services to justice involved Veterans in the Veteran Justice Program (VJP); and employment supports in Homeless Veterans Community Employment Services (HVCES).

We believe that through prevention and housing retention efforts that our current capacity allows us to provide we will be able to continue to reduce the inflow of veterans becoming homeless or returning to homelessness. Those Veterans who are currently homeless often require enhanced efforts at engagement and support to help them achieve housing. The reduction in the overall number of homeless Veterans allows us to re-direct the services and programming to those more complex Veterans with greater needs. We believe we have the capacity to do this within our current programming while continuing to decrease the number of Veterans identified in our PIT counts. We do, however, need to ensure that funding levels are sustained so that communities can meet the goal of ending Veterans homelessness, and once there, they will be able to sustain it and not jeopardize the progress to date or recreate the levels of homelessness among Veterans prior to the investment.

EDUCATION

Question 100. Throughout my time in the Senate, protecting our servicemembers and veterans enrolled in higher education has been one of my top priorities. Unfortunately, our military students and their families have not always been treated well by their colleges and student loan servicers. One such company was ITT Educational Services, Inc., ("ITT") which closed last September after enforcement actions by the Department of Education. ITT had been subject to investigations by numerous state attorneys general, the Securities and Exchange Commission, the Department of Justice, and the Consumer Financial Protection Bureau for illegal recruitment practices, scamming students into taking out expensive private loans, and other misconduct. According to data provided to my office by the Workforce Training & Education Coordinating Board, there were approximately 215 veteran students in Washington State enrolled in ITT programs at the time the school abruptly closed. I want to make sure that we do everything we can to avoid putting our veterans at risk for future abuses by unscrupulous actors. Do you commit to withdrawing program approval for GI Bill Benefits when an institution of higher education is found by any other Federal or state entity to have committed fraud, including deceptive or misleading recruitment?

• If confirmed, will you commit to working with other Federal agencies to crack down on "bad actor" colleges that deceive veterans?

Response. Yes. We have already forged and continue to strengthen relationships focused on enforcement with the FTC, DOD, Dept of Education, Consumer Financial Protection Bureau, and DoJ. Additionally we are collaborating on these issues with the State Approving Agencies.

Question 101. As you may know, our financial aid rules permit for-profit colleges to receive up to 90 percent of their total revenue from Federal aid, which is known as the "90/10" rule. However, a loophole in Federal law does not technically "count" educational programs for veterans and servicemembers, including Post-9/11 GI Bill benefits and Military Tuition Assistance, as "Federal aid." These benefits are therefore excluded from the 90 percent cap. I am very concerned that this loophole drives unnecessarily aggressive marketing and recruitment of our military students and their families. But regardless of whether you share my opinion on whether Congress should close this loophole, I hope we can agree on the facts.

• Do you consider Department of Veterans Affairs Post-9/11 GI Bill, and Department of Defense Tuition Assistance benefits, both of which are paid for by American taxpayers, to be Federal aid?

Response. Yes

Question 102. Last year, the Department of Education worked with the Department of Veterans Affairs to publish full estimates on the amount and percentage of VA and DOD funding that is received by institutions of higher education from each Federal educational program, including Post-9/11 GI Bill benefits and Military Tuition Assistance. I had been pressing for some time for this data to become publicly available as a useful tool to know which institutions have a healthy level of outside, non-Federal investment.

• Do you believe this is important consumer information for the U.S. Department of Education to continue making available to our veterans and servicemembers?

Response. Yes as it provides quantifiable impact of any proposed changes to the 90/10 rule.

Question 103. I believe it is essential to ensure that student veterans have the resources they need to succeed in their educational pursuits.

a. Do you believe that veterans who were attending a school that closed before they could complete their education deserve to have their eligibility for GI Bill benefits restored, just like students who receive Pell Grants and student loans?

Response. VA has supported proposed legislation (S. 2253) that would reduce the negative impact on student Veterans and their dependents of abrupt school closure to include some amount of entitlement restoral.

b. Additionally, do you believe that student veterans who are using their GI Bill benefits when their school closes should see their living stipends extended for at least a short period?

Response. VA has supported legislation (S. 2253) that would provide a limited continuation of the housing stipend in cases of abrupt school closure.

Question 104. The conflicts in Iraq and Afghanistan have led to a tremendous number of veterans returning home to get an education using their Post-9/11 GI Bill benefits. But unfortunately, as noted by former Consumer Financial Protection Bureau official Holly Petraeus, many colleges see these veterans as nothing more than a "dollar sign in uniform."

In the last few years, the Department of Veterans Affairs, Defense, Education, and the Consumer Financial Protection Bureau have begun to implement Executive Order 13607, Establishing Principles of Excellence for Educational Institutions Serving Servicemembers, Veterans, Spouses, and Other Family Members. The "Principles of Excellence" allow the VA to make law enforcement referrals to crack down on bad actors, particularly for-profit colleges, like Corinthian and ITT.

• If confirmed as VA Secretary, will you support the law enforcement community by following the Principles of Excellence and actively making referrals to other agencies in order to protect veterans and curb waste and abuse of education benefits provided by taxpayers?

Response. Yes, VA already has and will continue to refer schools and incidents to other Federal agencies to ensure compliance with all applicable laws and regulations.

LGBTQ

Question 105. When Vice President Mike Pence was running for Congress in 2000, his website included multiple statements that are shamefully discriminatory against the LGBTQ community. In addition to opposing gay marriage and anti-discrimination laws that protect LGBTQ individuals, a section of his website included a statement that has been interpreted as an endorsement of conversion therapy, a discred-

ited practice that falsely purports to change a person's sexual orientation or gender identity. While Vice President Pence has denied this accusation, I remain deeply concerned about this Administration's treatment of LGBTQ individuals.

• If confirmed as VA Secretary, can you assure me that you will never deny care to any veteran on the basis of his or her sexual orientation or gender identity?

• Can you further assure me that you will continue to protect LGBTQ employees from discrimination based on their sexual orientation or gender identity?

Response. I am committed to diversity and inclusion in both patient care and the VA workforce. In fact, VA is among the leaders in the Federal Government in the area of LGBT protections. With respect to Veteran patient care, on July 1, 2014, VHA issued a policy memorandum ensuring that all our LGBT Veteran patients receive quality and respectful patient care, "in an environment and culture that is informed, welcoming, and empowering for the LGBT Veterans and families whom we serve." The specific guidance on care for transgender Veterans can be found in VHA Directive 2013–003: Providing Health Care for Transgender and Intersex Veterans. VHA also established an Office of Health Equity to address the different and specific health care needs of diverse populations, including the LGBT community. To ensure that these services are delivered by culturally competent health care providers, VA has had a longstanding commitment and explicit policy protecting all of its employees from discrimination and harassment on the basis of gender identity and sexual orientation, long before these protections became embedded in Federal policy or law. We complement these policy protections with mandatory and elective EEO, cultural competency and unconscious bias training in the area of LGBT awareness for all our employees, including health care providers and supervisors. The VA is close to issuing a Transgender Employee Workplace Transition Guidance as a resource for our employees to address these issues appropriately and sensitively in the VA workplace; I will ensure this gets published. I commit to you that VA will continue to support these and other protections for our LGBTQ Veterans and employees.

ACA

Question 106. Dr. Shulkin, I am deeply concerned about the impact that dismantling the Affordable Care Act may have on our veterans. A study released last September by the Urban Institute found that the ACA's combined coverage expansions reduced the uninsured rate among non-elderly veterans by 42 percent. The number of non-elderly veterans without health insurance has declined from 12 percent in 2013 to 8.6 percent in 2014 as a result of the ACA. If ACA is repealed without a comprehensive replacement plan the most likely scenario at this time is that many veterans currently insured through the ACA will turn to VA for health care.

• As Republicans rush to rip apart the civilian healthcare system by repeal, increase uncompensated care at rural hospitals, threaten to gut Medicaid and take away the guarantee of full coverage under Medicare, what conversations have you been a part of to ensure no veterans lose health insurance?

• During your confirmation hearing you said that VA will do all it can to care for all veterans; could you provide specific answers to how, if confirmed, you will handle a possible increase in the number of veterans seeking VA care if they lose coverage through ACA repeal?

Response. The Urban Institute's analysis of 2011–2015 American Community Survey data that noted a decline in the number of uninsured Veterans between 2013 and 2014 is encouraging news for efforts to promote Veteran's access to care. Within this context, it is possible that both the ACA and VA's outreach to encourage enrollment in the VA health care system contributed to this reported decline in uninsured Veterans. Regardless of future national health reform policies, the VA will continue to plan for providing high quality health care to our Nation's Veterans that are eligible for VA health care services. If more Veterans seek care in VHA as a result of an ACA repeal or any other reason, as Secretary I would seek the resources necessary to make sure we honor our commitment to serve these Veterans.

SEXUAL ASSAULT

Question 107. Sexual assault continues to be a pervasive issue in our military. Reports suggest that as many as 1 in 10 servicemembers experience sexual assault or harassment. In 2014, 62 percent of those who reported they were assaulted also said they experienced retaliation. While the Department of Defense has undergone commendable efforts to tackle this distressing problem, we have a long way to go to ensure that the brave men and women in our military are provided the resources they need, and VA plays an integral role in supporting survivors of sexual assault.

• If confirmed as VA Secretary, what specific steps will you take to ensure that survivors of sexual assault and harassment receive the specialized care they need and are entitled to?

Response. All Veterans seen for health care services are screened for experiences of MST (sexual assault or repeated threatening sexual harassment). This is an important way to ensure that Veterans are aware of and offered the free MST-related care available through VHA. Every VA medical center provides MST-related services including evidence-based psychotherapies that target the mental health diagnoses that are associated with MST. MST is an experience, not a diagnosis or a condition in and of itself. Every VA medical center has a designated MST Coordinator who can assist Veterans with accessing MST-related health care. Beginning in FY 2012, VHA mental health and physical care providers must complete a one-time mandatory training that is accredited for continuing education. The MST Support Team in Mental Health Services coordinates a wide range of other national specialized MST-related training initiatives for VHA clinicians.

Question 108. During your time as President of Morristown Medical Center you withdrew counselors from Morris County Sexual Assault Center, which provided important resources to survivors. In an Op-Ed concerning this decision you suggested that ER services would be adequate.

• If confirmed, will you commit to putting all the resources necessary to support survivors of sexual assault in the military, including ensuring that survivors have access to counseling services to treat long-term trauma?

Response. Your statement about what happened at Morristown is not accurate. I would be glad to discuss the specific circumstances with you at the appropriate time, but the facts show that when I learned about this I restored these services. In regards to your question, the MST Support Team in Mental Health Services completes an annual report to determine whether each VA health care system (HCS) has adequate capacity to provide MST-related care. The most recent report found that 100 percent of VA HCS were at or above the established benchmark for MST-related mental health staffing capacity. All Veterans seen for health care services are screened for experiences of MST (sexual assault or repeated threatening sexual harassment). This is an important way to ensure that Veterans are aware of and offered the free MST-related care available through VHA. Every VA medical center provides MST-related services including evidence-based psychotherapies that target the mental health diagnoses that are associated with MST. The VA offers a continuum of MST-related care that ranges from outpatient to mental health rehabilitation and treatment programs (MH RRTPs) and inpatient programs for Veterans who need more intense treatment and support.

MEDICAL LEGAL PARTNERSHIPS

Question 109. Research indicates that genetics, medical care, and personal choices account for 40 percent of an individual's health outcomes while 60 percent of health outcomes are determined by social and environmental factors. This is particularly true for veterans who often face barriers to safe housing, benefits appeals, and employment that negatively affect their health. The VA's annual CHALENG survey of homeless veterans has shown that four of homeless veteran's top 10 unmet needs are legal needs including eviction and foreclosure issues, child support and family law, outstanding warranties and fines, and restoring drivers' licenses. Medical-legal partnerships ("MLPs") between legal services and medical providers can help to address these issues by integrating legal solutions into medical settings.

• In recognition of the importance of MLPs, the VA recently launched the MLP Expansion Initiative to expand the number of MLPs in VA sites in order to identify and identify veterans' legal needs that effect health outcomes and to improve physician quality of care. If confirmed as VA Secretary, will you commit to continuing the MLP Expansion Initiative to increase veterans' access to legal services in VA facilities?

Response. Medical-legal partnerships (MLPs) allow VA to help Veterans address not only their health-related needs but also their health-harming legal needs, by providing access to legal services that VA itself cannot offer. There are now 13 MLPs in VA facilities, and I am committed to fostering such partnerships elsewhere in our health care system. The VA MLP Expansion Initiative will therefore continue its work on this important issue.

• VHA Directive 2011–034 encourages VA medical centers to make space available for legal services providers to assist veterans. Approximately 120 legal pro bono clinics staffed by outside legal providers are currently given space to operate in VA centers. Do you commit to keeping VHA Directive 2011–034 in place? What additional steps will you take to ensure veterans have access to legal services, to support

existing MLPs, and to create new partnerships between health facilities and legal service providers?

Response. VHA will soon issue a new directive to replace the expiring VHA Directive 2011–034. This new directive will restate VHA's commitment to facilitating Veterans' access to legal services, and provide expanded operational guidance to VA facilities. It is in the final stages of pre-publication review in VHA, and once released it will guide VHA's continued efforts to assist Veterans with unmet legal needs. Although VA does not have the authority to provide or fund legal services, we will continue to seek out and develop new partnerships to improve Veterans' access to needed legal services.

CERTIFIED REGISTERED NURSE ANESTHETISTS

Question 110. In your response to pre-hearing questions, you recognized workforce shortages at VA and promised to continue pursuing strategies to meet such gaps, which included expanding the scope of practice for advanced practice registered nurses. On December 14, 2016, VA issued the final rule providing full practice authority for advanced practice registered nurses with an effective date of January 13, 2017. However, the final rule excluded Certified Registered Nurse Anesthetists (CRNAs) from receiving full practice authority, which the draft rule did not. This is despite supportive evidence in favor of full practice authority for CRNAs in research journals and recommendations from numerous independent entities, including the Commission on Care. Additionally, the exclusion of CRNAs from the VA final rule is inconsistent with the full practice authorities that exist in other Federal health care systems in the military and the Indian Health Service. I understand that VA's rationale behind excluding CRNAs from the final rule was that there is no shortage of anesthesia providers in the VA system. However, a RAND study commissioned by this Committee published in 2015 found that a lack of anesthesia services and support directly affects VA's ability to provide care. It seems like the research evidence, recommendations from independent entities, and policies of Federal health systems outside VA should have been sufficient to include CRNAs in the final rule, which I fully support.

- Can you please provide a comprehensive explanation as to how you came to the conclusion you did, including fully identifying and explaining the criteria you used for providing APRN full practice authority and how this criteria was applied equitably across the four APRN categories?
- Will you commit to revisiting VA's rule on nursing full practice authority to further assess whether CRNAs should be included if confirmed?

Response. I appreciate your point of view on this issue. VA first began to look at changing its' policy on advanced practice nurses over 9 years ago. As Under Secretary I committed to making a decision and I did so. We have received hundreds of thousands of comments and I have personally taken dozens of meetings and sessions to hear people thoughts and input on this topic. I tried to make the best decision I could at the time, with the information I had available.

The truth is that I believe CRNAs play a critical role in providing care for our Veterans. In fact we hire at VA many more CRNA's than we do anesthesiologists. We also believe that it is a team based approach to anesthesia care that serves our Veterans best, with the best outcomes. A team based approach to care includes CRNA's working with anesthesiologists. In making our final rule, we did not find that VA had immediate and broad access challenges in the area of anesthesia that would require a change to our current approach to anesthesia care, that is a team based approach. If VA learns of access problems in the area of anesthesia care in specific facilities or more generally that would benefit from FPA for CRNA's, now or in the future, or if other relevant circumstances change, we will consider a follow-up rulemaking to address granting FPA to CRNAs. VA CRNAs that are granted full practice authority by their state license will continue to practice in VA in accordance with their state license and subject to credentialing and privileging by their VA medical facility's medical executive committee. VA will not restrict or eliminate these CRNAs' full practice authority. Amending this regulation increases VA's capacity to provide timely, efficient, and effective primary care services, as well as other services. This increases Veteran access to needed VA health care, particularly in medically-underserved areas and decreases the amount of time Veterans spend waiting for patient appointments.

SMOKING

Question 111. As a physician, I'm sure you know that smoking poses a significant threat to the health of our veterans, in addition to costing the VA healthcare system billions of dollars every year. You may also be aware that over half of current smok-

ers (57%) report that they had tried quitting within the past year and, according to the Centers for Disease Control and Prevention, as of 2010 nearly 70% of adult smokers wanted to quit.

• If confirmed as VA Secretary, what policies and practices will you put in place to ensure that all veterans have affordable and comprehensive access to the help they need when they want to quit?

Response. VA is a leader in smoking and tobacco use cessation treatment with a range of evidence-based interventions. Today, the smoking rate of Veterans in VA care is 16.8%, the lowest ever and a 49% decrease from fiscal year 1999. VA is committed to maintaining current programs and to build on their success through the development and implementation of new innovative treatment models that will ensure that any Veterans who want assistance with quitting smoking will receive comprehensive and effective care.

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

Question 112. For-profit colleges are able to leverage the Higher Education Act's 90/10 loophole to go after veterans with GI Bill benefits, using those funds to compensate for the gap these institutions face due to a lack of Federal fund.

a. Do you support closing the 90/10 loophole?

Response. While VA defers to the Department of Education on the 90/10 calculation, I am supportive of including the Post-9/11 GI Bill in the 90 percent limit on Federal funding or related proposals. Under the present structure, some institutions may be targeting Veterans because the Federal education benefits they receive are treated the same way as private funds in the 90/10 calculation.

Modifications to the 90/10 rule could provide additional tools to assist in this area. However, it is understood that such a change could cause some schools to exceed the 90 percent threshold and be at risk of losing eligibility to receive Federal student aid. Therefore, in order to ensure that Veterans are not adversely affected, the manner in which such a change would be implemented is important. VA would welcome the opportunity to work collaboratively with the Department of Education and Congress as it considers changes in this area.

b. What actions are you prepared to take to ensure VA's compliance with 38 U.S.C. 3969?

Response. The VA Education Service is postured to formally request the Secretary to leverage his authorities outlined in the public law when an institute of higher learning (IHL) is in violation of the law.VA has recently made two referrals to FTC for potential violations of section 3696.

c. What is your plan to hold colleges accountable to properly using the GI Bill benefits veterans sacrificed for?

Response. VA will continue to work with all State Approving Agencies and our Federal partners to ensure compliance and enforcement of all GI Bill statutory and regulatory requirements.

d. What is your strategy for communicating to colleges the standards for compliance with the VA Advisory Committee on Education's VA Principles of Excellence initiative?

Response. Since the inception of the Principles of Excellence (POE) in 2012, the standards for compliance with POE are communicated to the institutes of higher learning via the VA GI Bill web site and reviewed during the over 5000 annual compliance visits with schools.

e. Please outline your plan to collaborate with other Federal entities to address colleges that take advantage of veterans and their benefits.

Response. We have developed strong relationships with the Department of Education, Federal Trade Commission, Department of Justice, Department of Defense, Consumer Financial Protection Bureau and VA's Office of Inspector General. Regular meetings are ongoing and as needed virtual communications are leveraged as warranted. In 2017, VA will further strengthen these collaborations in order to ensure schools that engage in any activities that negatively impact our student veterans are addressed appropriately and in accordance with applicable laws and regulations. These include but are not limited to deceptive marketing, deceptive recruiting, and accreditation of IHL programs and schools.

Question 113. How will you implement the Career Ready Student Veterans Act, legislation aimed at blocking GI Bill benefits going to programs that, due to low-

quality or lack of accreditation, do not result in veteran-graduates earning state certifications and licenses?

Response. The State Approving Agencies, who are charged with enforcing the requirements for initial and continued GI Bill program approval, will be at the forefront of the implementation effort, as they have expertise in GI Bill approval requirements and state licensure and certification requirements. VA has had a number of discussions with the State Approving Agencies (SAAs) on these new provisions and we are currently in the process of drafting guidance. Both VA and the SAAs strongly believe that vocational and occupational programs should meet the requirements in the state in which the educational institution is located so that GI Bill beneficiaries are well-prepared upon completion of these programs.

Question 114. As Governor of Indiana, Vice President Pence wrote to VA officials, including Secretary McDonald, urging the Department to compensate student veterans for lost GI Bill benefits used at shuttered ITT Tech and Corinthian College locations. These student veterans were taken advantage of by institutions looking to profit from their sacrifice.

a. How will you ensure that these veterans' GI Bill benefits are restored?

Response. Currently, VA does not have the statutory authority to restore a student's GI Bill benefits due to a school closure. VA has provided technical assistance to Congress on draft legislative language that would allow for such benefit restoration and will continue to provide any additional assistance that may be needed.

b. Do you believe that when VA and other Federal entities designate that an institution of higher education displays signs of instability? If so, what is your plan to communicate to student veterans when an institution shows such potential, as ITT Tech and Corinthian Colleges did prior to their closing?

Response. VA uses a web based Comparison Tool with an appropriate Caution Flag to make student Veterans aware of indicators VA or other Federal agencies have determined potential students should pay attention to and consider before enrolling in a program of education. The VA is also very proactive in sending emails to individual students attending such institutions which explain the potential impact to their education benefits. For example VA has sent six different email communications to ITT students providing information and resources to assist them.

Question 115. Knowing the risks posed by colon cancer, the second-most common cause of death from cancer for men and women collectively, and the opportunities for patients through early screening and detection, will you ensure that all available colorectal cancer screening methods endorsed by the U.S. Preventative Services Task Force are employed to serve the healthcare needs of veterans?

Response. Yes I will. The VHA is proud to have just received an achievement award from the National Colorectal Cancer Roundtable for surpassing an 80% screening rate for colorectal cancer (http://nccrt.org/tools/2017–80-by–2018-national-achievement-awards/). However, we are continuing efforts to further expand screening and to ensure appropriate and rapid follow up of every Veteran. Specifically, we have developed and are deploying an IT tool to automate the reminder for the appropriate screening and tracking of every veteran. VA is currently updating its recommendations for colorectal cancer screening and is carefully considering the recommendations of the U.S. Preventive Services Task Force.

Question 116. In your testimony you said that VA needs to be able to hold its employees accountable. What did you mean by that, and what metrics would you use to hold employees accountable?

Response. I know that the vast majority of the VA workforce is highly professional and motivated to take care of our Veterans. There are times when employees get off track and need help in either getting back on track or moving out of the VA. While we already have and leverage existing laws to help move off track employees out of the workforce, additional legislation is needed. More specifically:

- The Choice Act VA needs to be modified, specific to SES removal procedures, to ensure constitutionality.
- The Merit Systems Protection Board needs to be directed to a lower burden of proof and deference to the agency's choice of penalty.
- We need the authority to use indefinite suspensions where there is reasonable cause to believe an employee has done something to harm or endanger a patient or a coworker.
- 5 U.S.C. 7511(a)(1)(A), (B), and (C) and 5 CFR 752.401(2), (3) and (5) need to be modified to allow those individuals serving a probationary period or on a temporary appointment to be separated without full due process and appeal rights.

Question 117. Last December, ProPublica and The Virginian-Pilot issued a report, based on data gathered from VA's Agent Orange Registry, which assess that chil-

dren born to servicemembers who had self-reported Agent Orange exposure during or after the Vietnam War were 34 percent more likely to have a birth defect than children born to servicemembers who had not self-reported exposure.

a. On Tuesday I received a response from VA-that you signed and your letter said VA recommended to ProPublica that the report be peer reviewed, but my question to you is if VA had been collecting this information for over 40 years, why didn't VA initiate its own study?

Response. As was mentioned in the letter "a voluntary registry such as the Agent Orange Registry, may have bias, or a systematic deviation, that results if those who volunteer are not representative of the entire population of concern." Any research based on or conclusions drawn from this flawed dataset are immediately suspect for this reason. Desiring quality data and study design, VA has initiated the Vietnam Era Health Retrospective Observational Study (VE-HEROeS).

b. Why did it take a FOIA request to produce a study on data that VA already had at its finger tips?

Response. As stated above, the voluntary Agent Orange Registry did not provide a quality data set for research. VA has initiated the Vietnam Era Health Retrospective Observational Study with the aim to aim to develop scientific, peer-reviewed evidence that will inform policy decisions.

c. What is the timeline for VA's Agent Orange working group to review whether to include bladder cancer, hypothyroidism, Parkinson's-like symptoms, and hypertension to the list of presumptive conditions?

Response. A VA Technical Working Group has reviewed the National Academy of Medicine's Veterans and Agent Orange, Update 2014 and is in the process of drafting recommendations for the Secretary of Veterans Affairs.

d. I know VA has had the information from the Agent Orange Registry for years, yet VA says more research is needed, particularly from male servicemembers. These veterans and their families have waited too long for VA to do the right thing. Is the only reason VA isn't acting because of funding?

Response. VA relies on scientific, peer-reviewed evidence to inform policy decisions, and such evidence for transgenerational effects due to Agent Orange exposure does not currently exist, as reported in the most recent Veterans & Agent Orange Report issued by the National Academy of Medicine. However, VA continuously monitors the development of new scientific approaches that may provide additional insight.

Question 118. Many of the issues veterans face as they transition from active duty into the community is because of a lack of connectivity and collaboration between the Department of Defense and VA.

a. What steps would you take as Secretary to fix this?

Response. The Departments of Veterans Affairs (VA) and Defense (DOD) partner with other agencies to administer the Transition Assistance Program. This interagency cooperation provides coordinated information, counseling, and support to transitioning Servicemembers. This includes one-on-one counseling with military service representatives experienced in the transition process, enhanced VA benefits briefings that are designed to provide individuals with information about education and employment programs; training vehicles on VA benefits and services that can improve a transitioning Servicemembers' overall quality of life, as well as, overviews of other benefits to assist in building and maintaining a stable home environment.

VA and DOD have developed a robust relationship to improve the experience for separating Servicemembers as they transition into civilian life. Under the auspices of the Joint Executive Committee, which provides senior leadership a forum for collaboration and resource sharing, both departments have worked closely to remove barriers and challenges that impede collaborative efforts, assert and support mutually beneficial opportunities to improve business practices, ensure high quality cost-effective services for VA and DOD beneficiaries, and facilitate opportunities to improve resource utilization. As Secretary, I will work to strengthen the role of the Joint Executive Committee as it provides the strategic direction for the joint coordination and sharing efforts between the two Departments and oversees the implementation of those efforts.

b. Will you make the single electronic health record from active duty to VA a priority?

Response. Yes, we continue to make this a priority. We are actively exploring a few ways to accomplish this. The recent development of a prototype of the Digital Health record has created a new opportunity to make this a cost-effective mechanism to accomplish this.

Question 119. In 2010, the Federal Government adopted Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness. Opening Doors set out goals for ending homelessness for families and youth, the chronically homeless, and veterans. Through a combination of increased Federal investment—in both HUD-VASH vouchers and VA programs—and better practices, the Federal Government has made significant progress toward that goal. Since 2010, we've reduced homelessness among veterans by 47 percent.

But more needs to be done to ensure that no veteran is homeless. Last year, Congress enacted key provisions from the Veterans Housing Stability Act of 2015, which I cosponsored, to keep moving us toward this goal. Among other things, the bill would increase veterans' access to permanent housing options by increasing outreach to landlords to encourage renting to veterans and expand the definition of "homeless veteran," so more veterans, including those facing domestic abuse, can access housing assistance.

If confirmed, will you work expeditiously to implement these provisions?

Response. Yes. The Jeff Miller and Richard Blumenthal Veterans Health Care Act and Benefits Improvement Act of 2016, Public Law 114–315, was signed into law on December 16, 2016. Section 701 of this Act expands the eligibility to participate in the GPD program to persons fleeing domestic violence and interpersonal violence. VHA is working to incorporate the statutory changes as they relate to eligibility under the GPD program as quickly as possible following the standard agency protocols for inclusion of new statutory elements and notification to the field. Additionally, Our HUD-VASH regulations further define homeless as any individual or family who is fleeing or is attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children is jeopardized and who have no other residence and lack the resources or support networks to obtain other permanent housing.

Regarding outreach to landlords, VA in partnership with HUD and the United States Interagency Council on Homelessness (USICH) have embarked on a coordinated outreach effort to engage and recruit landlords, and the trade and professional associations to which they belong to provide affordable housing for Veterans exiting homelessness. The goal is an increased willingness to work with government and community providers to help these Veterans locate and maintain permanent and permanent supportive housing.

Question 120. Are you familiar with Opening Doors? If confirmed, will you commit to requesting the resources and pursuing policies necessary to achieving the goal of ending veterans' homelessness?

Response. Yes, Opening Doors is the Federal Strategic Plan to Prevent and End Homelessness among all populations—Veterans being a priority sub-population. I am proud to say that since its inception in 2010, Veteran homelessness has decreased by nearly fifty percent—far more than any other sub-population. One reason for this significant decrease has been the targeted resources that have been appropriated to combat Veteran homelessness. The 2017 President's Budget includes $1.6 billion for VA programs that prevent or end homelessness among Veterans. These funds are critical to ensure that once communities meet the goal of ending Veterans homelessness they will be able to sustain it and not jeopardize the progress to date or recreate the levels of homelessness among Veterans prior to the investment. I will continue to request appropriate levels of funding to ensure that Veteran homelessness is rare, brief, and nonrecurring.

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

Question 121. Improper Accreditation of schools and use of regulations in VA. During the hearing, I asked about implementation of the unanimously passed Career-Ready Student veterans Act and you committed to implementing that law.

a. To the extent that such implementation requires the use of regulations, how will you comply with President Trump's recent executive order requiring the elimination of two regulations for every new regulation that is promulgated?

Response. The Career-Ready Student Veterans Act as enacted is now Section 409 of the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016. There are many elements of this part of the law that can be implemented without regulations. However, where regulations are needed, we will work with the Director of the Office of Management and Budget to navigate

the process. I am committed to implementing the Career Ready Student Veterans Act.

b. Do you believe that Executive Order will impact your ability to run VA, which has used the regulatory process to provide care to veterans?

Response. The Department of Veterans Affairs will certainly have to adjust the way we have historically managed our programs through the use of regulations. However, I am confident that the VA will continue to accomplish its mission. I also look forward to the opportunity to remove some of the outdated and unnecessary regulations that do not allow us to best target our resources to those areas that benefit Veterans most.

Jerry Falwell Jr. has announced that President Trump has asked him to lead a White House Task Force on higher education reform. Falwell has been very critical of accreditation standards and gainful employment rules that have been required by the Obama Administration for schools receiving Federal dollars, including GI bill benefits.

c. If confirmed, will you commit to ensuring GI Bill benefits are used to help veterans attend high-quality schools and then get good jobs or start their own businesses, consistent with recently passed legislation, regardless of what Falwell or others might recommend?

Response. Yes. VA will continue to faithfully enforce the laws applicable to the GI Bill benefits.

PATIENT SAFETY

Question 122. The Veterans Health Administration has historically been a leader in patient safety making its current place on the U.S. Government Accountability Office (GAO) High Risk Report as a result of "risks to timeliness, cost-effectiveness, quality and safety of veterans' health care" particularly concerning. Under previous leadership, the National Center of Patient Safety reported directly to the Undersecretary for Health, but now it resides in the Office of Quality, Safety and Value. I believe it is important that patient safety remains a top priority for the entire Department of Veterans Affairs.

If confirmed, will you commit to aggressively working to get VA off of the High Risk List including resolving all of the issues regarding patient safety at VA that GAO identified?

Response. Yes, as a former chief medical officer and an executive who has always focused on quality and safety, I have always prioritized patient safety as the foundation of health care delivery. I feel the same way about care for our Veterans. As you know, numerous external assessments, including a report by the RAND Corporation, have reported that VA care matches or exceeds patient safety and quality in the private sector. Regardless, patient safety is a pursuit that should always be prioritized, and you have my utmost commitment to this.

One goal that I have in continuing to enhance patient safety is to create a system for quality and safety governance that ensures the right resources and policies are in place that directly impact front-line clinicians and improvement teams. Regarding the placement of the National Center for Patient Safety (NCPS)—which is a support structure for leadership and front line teams in facilities—I believe its effectiveness is enhanced under a structure that directly connects identified risks for preventable harm (the focus of NCPS) with parts of the organization that focus on quality improvement. The Office of Quality, Safety and Value does just that, and you have my commitment to support and enhance the structure of this office to meet our needs over time. This is consistent with the contemporary approach to patient safety and quality in private sector organizations.

I am committed to addressing all underlying risks (ambiguous policies; fragmented oversight; inadequate information technology; siloed training; and the need to enhance allocation of resources to meet Veterans' needs) identified by the GAO when they placed VA Health Care on the High Risk List because this work is imperative to complete the transformation of the Veterans Health Administration. You have my full commitment that we will continue our work to remove VHA from the high-risk list as quickly as possible.

INFORMATION TECHNOLOGY AND INTEROPERABILITY

Question 123. If you are confirmed as VA Secretary, you will be responsible for both VHA and OI&T. Just yesterday, a VA Office of the Inspector General Report released a report on the $2 million that OI&T spent on a cloud brokerage service contract that was supposed to all VA employees to access computing resources over the Internet on a pay-for-use basis.

The project, however, provided limited functionality for providing computing resources over the Internet for and the Inspector General also found that VA did not have adequate project management controls in place to ensure the contract met VA's IT needs and provided an adequate return on investment.

a. If confirmed, what will you do to improve return on investment for VA's IT purchases?

Response. I have not yet had a chance to review this IG report, but I would agree that this is concerning and if confirmed as Secretary I would be looking to see what recommendations the IG has made to ensure that issues like this do not occur again. It is important that we do better.

OI&T, through its Strategic Sourcing function, has consolidated its IT purchasing power to obtain and deliver solutions to our Veterans from industry at the best price. Strategic Sourcing will provide access to best-in-class suppliers; ensure strong contractual performance through continuous monitoring; improve our speed to market, product compliance, and quality; ensure our compliance with Federal Information Technology Acquisition Reform Act (FITARA); provide greater technical capabilities for VA and our Veterans; and foster the most responsible allocation of taxpayer dollars.

b. Do you believe that the Veterans Health Administration and the Office of Information and Technology have made adequate progress in addressing the IT challenges at VHA?

Response. I believe that progress has been made but we need to do much better. The Veterans Health Administration and the Office of Information & Technology continue to collaborate as partners in improving the Health Information Technology (HIT) at VA. Through this partnership, VHA has received a number of critical improvements to HIT at VA while recognizing that our work together is ongoing so as to keep pace with the needs of VA's medical providers serving Veterans as well as putting modern HIT tools in the hands of Veterans.

As Secretary, I would be looking for faster decisionmaking and more meaningful outcomes for our Veterans. The Commission on Care and the Independent Assessment have made a number of recommendations that require changes in the way that we currently operate. I would support an aggressive plan to ensure the necessary changes are implemented.

c. Are you satisfied with the degree of health record interoperability between DOD and VA?

Response. A Veteran's complete health history is critical to providing seamless, high quality integrated care and benefits. Our interoperability work with DOD and the private sector has made great strides and we are working daily to expand on our capabilities. On April 2016, VA and DOD were proud to certify to Congress, including this Committee, that VA had met the FY 2014 National Defense Authorization Act (NDAA) interoperability standards. Using the VA/DOD Joint Legacy Viewer (JLV), more than 220,000 VA health care and benefits professionals have access to real-time electronic health record information on a single screen from all VA, DOD and VA external partner facilities where a patient has received care. More than 2.5 Million records have been viewed in JLV by VA staff. Overall, 1.5 million data elements are currently being shared daily between the DOD and VA. These tools help those VA employees delivering health care and as well as those who process disability benefits claims who also need access to a patient's health record. The VA's Enterprise Health Management Platform (eHMP) incorporates JLV's capabilities and provides even greater interoperability and clinical tools.

While we did achieve interoperability and we are working on tools that will provide even better integration with DOD, today I am not fully satisfied. We have obtained a read only interoperability and that is not enough in my opinion.

BAD PAPER DISCHARGES

Question 124. I am also concerned that the warm hand-off between DOD and VA that is essential for veterans to get off on the right foot is failing for too many individuals with so called 'bad paper discharges.'

a. If confirmed, will you commit to working with Secretary Mattis to ensure that no Veteran falls through the cracks?

Response. I agree this is very important and yes, I will meet with Secretary Mattis on this matter.

VA has regularly met with the Department of Defense (DOD) to better understand each other's processes and collaborate to make certain that any proposed changes will not have negative unintended consequences for DOD's discharge process and will continue to do so moving forward.

I also understand that there was a commitment last year by Sloan Gibson to conduct a rulemaking process regarding VBA's processes and procedures for character of discharge determinations to update the definitions regarding "moral turpitude" and "willful and persistent misconduct." I think taking this step will help things greatly for veterans who would otherwise be unable to access VA health care and benefits.

b. Is VA still committed to updating that regulation and if confirmed, will you commit to updating the regulation as rapidly as possible?

Response. VA remains committed to pursuing policy changes to character of discharge (COD) determinations. VA is actively working to update 38 CFR 3.12, the regulation governing determinations of former servicemembers' COD for individuals with other than honorable (OTH) and punitive discharges. These changes will address ill-defined terms in the existing regulation, such as "moral turpitude" and "willful and persistent misconduct," as well as provide guidance on consideration of mitigating circumstances that relate to Veteran status. Given that this proposed regulatory update will impact basic eligibility requirements for Veterans benefits, VA wants to ensure any proposed rulemaking reflects adequate research and deliberation. VA has already met with the Department of Defense (DOD) to better understand each other's processes and collaborate to make certain that any proposed changes will not have negative unintended consequences for DOD's discharge process and will continue to do so moving forward.

Pursuant to the Administrative Procedure Act, rulemaking requires time for public notice and comment, as well as Office of Management and Budget (OMB) review. VA anticipates publishing a proposed rule to update 38 CFR 3.12 by the end of calendar year 2017.

LONG-TERM CARE

Question 125. Recognizing that VA provides a continuum of care that is unmatched in the private sector, and an increasing number of older and disabled veterans are coming to VA for care. In Connecticut, VA projects the number of veterans age 65 or older will be nearly 100,000 this fiscal year. As you know Medicaid is the largest single payer of long-term care in the United States and almost half of all state Medicaid spending goes to home and community-based services. However, VA's spending for home and community-based services has remained at about 30 percent and is perhaps reflective of an intuitional bias toward nursing home care. Aging Veterans want the option of living at home with appropriate supports and services.

a. What will you do as VA Secretary to meet the increasing long-term care needs for veterans with serious chronic diseases and disabling conditions?

Response. I will continue the Department's focus on optimizing the health, function, and well-being of Veterans facing the challenges of aging, disability, or serious illness by honoring their preferences for care by increasing access to home and community based services (HCBS). Since FY 2010, VHA has grown total spending for HCBS by 190%, from $810 million in FY 2010 to $2.3 billion in FY 2015. Furthermore, total HCBS spending as a ratio of total Long Term Services and Supports (LTSS) spending has almost doubled from FY 2010–2015, from 16% in FY 2010 to 31% in FY 2015, with commensurate decreases noted in the proportion of the LTSS budget spent on nursing home care going from 84% to 69%.

VA's efforts to provide long term care in home and community based settings will reduce nursing home admissions and preventable hospitalizations. However, we also want to ensure access to high quality nursing home care for Veterans when it is required through our community living centers, contract community nursing homes, and State Veteran Homes. In order to achieve these goals, VA needs Congressional support for VA authority to purchase care using provider agreements.

VA is poised to lead the Nation in the care of older Americans. VHA will continue to use data to support efficient and effective growth for home and community based services. VHA has recently completed a study that found many additional VHA users would benefit from VA's Home Based Primary Care (HBPC). This program has been shown to reduce total VA and Medicare costs by 12%. As a result, VHA has initiated efforts to expand HBPC access to meet the additional need for this program. VHA is also committed to expanding the Medical Foster Home Program as an alternative to institutional placement. Previous studies have shown that Medical Foster Homes can reduce Veteran total health care costs by 40%. In addition, VHA is conducting a national study to quantify long term care demand among Veterans, with an emphasis on measuring nursing home and HCBS demand and identifying rural and highly rural areas in most need of additional access. Findings from this study will be available in early 2018 and will be used to guide expansion of home and community based services to Veterans in most need of additional supports.

VHA expanded access to the Veterans-Directed Home & Community Based Services (VD-HCBS) Program in FY 2016. The goal is to make the program available at every VA medical center within the next three years. Through VD-HCBS, the Veteran has the opportunity to manage a monthly budget based on functional and clinical need, hire family members or friends to provide personal care services in the home, and purchase goods and services that will allow him or her to remain in the home. VD-HCBS is administered through a partnership with Health and Human Services Administration for Community Living (ACL) and has proven to be a program that can meet the needs of some of VA's most vulnerable populations, including many who would likely be placed in nursing home without this option. The number of Veterans served increased from 1,281 to 1,751 in FY 2016, a 37% increase.

VHA's ability to enhance and grow access to VD-HCBS has been greatly enhanced by changes in the Veterans Choice Program. In FY 2016, 81 VD-HCBS Providers have entered into VA Choice Provider Agreements with VAMCs offering VD-HCBS. Additionally, 30 new VD-HCBS Providers have been approved to deliver VD-HCBS services to Veterans, which has expanded access to HCBS for Veterans in over 130 rural and highly rural counties. VHA plans to focus on increasing VD-HCBS access in rural and highly rural areas where there is limited supply of traditional home care agencies that meet VA requirements to participate in the Veterans Choice Program.

VHA will continue to implement effective strategies based on measuring Veteran need for increased access to HCBS, creating an appropriate balance of HCBS and nursing home care, ensuring Veterans needing long term care are able to stay in the own homes for as long as possible. VHA will monitor progress of VISNs toward meeting performance measures that focus on rebalancing long term care. VHA will also continue to increase access to HCBS, primarily through expansion of HBPC and VD-HCBS, while leveraging opportunities under the Veterans Choice Program.

b. Have you considered how any efforts to restrict Medicaid, either through block granting or increasing requirements for eligibility, would impact veterans who may rely on Medicaid for long-term care or other health care needs?

Response. It is unclear what impact any such changes would have on Veterans needing long term care or other health care needs. As reforms are pursued, VA will need to evaluate the implications carefully and keep Congress informed of our findings.

c. Do you believe VA is prepared to step in and provide care that would not be available to veterans if Medicaid is block granted? If so, what is currently being done with that excess capacity?

Response. If policy changes at the national level occur that result in a new influx of Veterans that seek care, VA would do its' best to meet these needs. As has been our approach over the past 18 months, we would prioritize urgent care needs. However, if such a new influx of Veterans were to come to VA I would seek additional funding to be able to adequately care for all of our Veterans. I do not believe that VA has current significant unused capacity at this time.

CAREGIVERS SUPPORTS

Question 126. All the VSOs are advocating for caregivers of severely ill and injured veterans of all eras to be eligible for comprehensive caregiver services and supports. I'm very supportive of Senator Murray's bill to expand program for caregivers of veterans from all eras, but paying for that expansion proved problematic last Congress. I do hope that this Committee and Congress will find a way to get around the previous roadblocks to passing that bill in the very near future.

In the meantime, one program that could help address part of this inequity is the Veteran Directed Care program that allows all severely ill and injured veterans to support their family caregiver and continue living in their community. However, this program is not available at all VA facilities. In Connecticut for example, this program is only available at one (West Haven) of the two VA medical centers.

• What will you do to improve VA's support for family caregivers of veterans from all eras in the absence of expansion legislation?

Response. VSOs have been advocating for caregivers of severely ill and injured Veterans of all eras to be eligible for comprehensive caregiver services and supports. I'm supportive of Senator Murray's bill to expand program for caregivers of Veterans from all eras, but paying for that expansion proved problematic last Congress. I do hope that this Committee and Congress will find a way to support that bill in the very near future. We are looking into further study that may help us gain a better understanding of the true costs associated with caregivers.

In the meantime, one program that could help address part of this inequity is the Veteran Directed Care program that allows all severely ill and injured Veterans to support their family caregiver and continue living in their community. However, this program is not currently available at all VA facilities.

APPEALS LEGISLATION

Question 127. You expressed support to reforming the appeals process and the new framework that was developed by VA and stakeholders in 2016. As you mentioned, there is a wide spectrum of support for the new framework among stakeholders.

Do believe that the stand-alone appeals reform legislation that was introduced in the Senate in the 114th Congress (S. 3328) should be modified? If you do, please discuss your views.

Response. No. Among the bills introduced in the 114th Congress, VA preferred S. 3328 because it was a standalone bill, contained an effective date provision that allowed for an 18-month implementation period, included our clarification of the options available to Veterans after an initial decision on a claim, and had the support of VSOs and other stakeholders.

AGENT ORANGE AND THE DMZ

Question 128. In March 2016, I wrote to then Secretary Bob McDonald regarding the qualifying period for the presumption policy related to Agent Orange Exposure to all veterans who served in the Korean Demilitarized Zone (DMZ). In May 2016, Secretary McDonald responded indicating that VA would consult with the Department of Defense (DOD) about whether veterans were exposed to a herbicide agent in or near the DMZ prior to April 1, 1968.

If that consultation has not yet happened, will you commit to doing so if confirmed, and to following up with me as to whether VA will expand the qualifying period per my initial request?

Response. VA has reached out to DOD to make sure there are no records of usage of Agent Orange (AO) before April 1, 1968. Current records available to VA indicate no AO was sprayed before that date. VA is committed to having the most accurate records possible. If as Secretary I was to learn of new information that is different from what we know now, then I would act upon this information to make the right decisions on behalf of Veterans.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 129. Dr. Shulkin, the Veterans Choice and Accountability Act of 2014 provided the VA with $2.5 billion to add critically needed physicians and other medical staff. However, there have been recent reports that there has been no bump in VA hiring that would indicate staffing had increased beyond normal hiring and there has been priority given to those VA hospitals with the largest wait times. Please answer the following questions:

a. Has the $2.5 billion been used to increase staffing beyond normal hiring patterns?

Response. Yes, the Choice Act funding increased staffing. Choice Act funding increased the rate of hiring in VHA and resulted in a 6.3% net increase of more than 18,800 additional onboard staff. During the 17 months of the Choice Act hiring initiative (August 1, 2014–December 31, 2015), VHA hired 56,965 employees, of which 11,287 (20%) were hired using Choice Act funding. The total hires in this timeframe represented a 13% increase over the level of hiring in the previous 17-month period (March 2013–July 2014).

b. Was there any priority given to those VA facilities that had the longest wait times?

Response. This decision predates my arrival at VA, it was shared with me that VHA requested input from that each of our Medical Center Directors. Medical Directors submitted their needs based upon wait times and need for personnel. VHA collected this information and matched it against data showing where need was greatest. The VACAA 801 funds were distributed to 33 VAMCs that were experiencing the greatest challenges with Veterans access. While this was not a direct match to wait times there was an attempt to try to make sure that the funds distributed were appropriate. Since access remained a critical priority across the entire VA Health

Care System, the remaining funds were distributed proportionally across all sites, based upon the Veterans population to be served.

c. Did the hiring reflect critical needs, for example in areas that had acute provider shortages in their Cardiology departments was there an emphasis on increasing cardiology staffing or was hiring done without consideration of targeted need?

Response. There was a special emphasis on hiring Primary Care, Mental Health, and Specialty Care providers. In addition, each local facility targeted recruitment efforts toward their hardest to fill positions.

d. What plans are there to hire in the VA in a way that reflects need-prioritizing not only locations with shortages but particular specialties that are the highest priority.

Response. Each Medical Center is responsible to determining their needs for personnel that is required to meet the needs of the Veterans that they serve. This data is then reviewed by the VISN before being submitted for approval. Medical Centers must also consider the availability of services in the community as many Veterans are able to access care in the community when these specialties are not available at the VA.

The National Recruitment Program (NRP) provides a centralized in-house team of skilled professional recruiters employing private sector best practices to fill the agency's most critical clinical and executive positions. The national recruiters, all of whom are Veterans, work directly with executives, clinical leaders, and local human resources departments in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs. At facility request, NRP targets hard-to-fill recruitments in their regions.

VHA markets directly to direct patient care providers through partnerships such as National Rural Recruitment & Retention Network (3RNet), a national network of non-profit organizations devoted to health care recruitment and retention for underserved and rural locations, as just one example. Through these partnerships, VHA has access to a robust database of candidates interested in working for VHA. National Recruiters routinely post VHA practice opportunities on career sites such as www.vacareers.gov.

e. How much of the $2.5 billion has been used and how has it been used?

Response. The VACAA 801 Spending Plan, submitted to Congress on December 3, 2014 provided the breakdown of funding for hiring, leases and other purposes. Of the $5B provided by VACAA, $2.213B was dedicated to the hiring of clinicians and medical support staff by the end of FY 2016.

Question 130. Dr. Shulkin, following up from the question on the Palo Alto pilot which allows veterans to access care at pharmacy clinics, what is the timeline and path forward on expansion of the program? What additional requirements would improve the program's accessibility for veterans?

Response. The Veterans Health Information Exchange (VLER) is connected to all CVS Minute Clinics across the Nation for bidirectional exchange via the eHealth Exchange. The technical capability to roll this out nationally is in place. Further rollout for access to these clinics will be determined by the local need of each facility. Many VA medical centers now have same day access to primary care which would make the need for these services much less. However in areas where there is not a Medical Center nearby these clinics may be an important way to ensure timely access. The Office of Community Care is working with VA contracting partners to allow for access to care at community pharmacy clinics, with initiation of this pilot under the Choice program at the Phoenix VAMC in the next quarter. Different from the Palo Alto pilot which does not use Choice funding, the eligibility criteria under Choice does limit its usage; however with the assistance of triage nurses at the facility level, Veterans will be able to be directed to these clinics with wider hours of operation for their immediate needs and therefore allow for diversion of care from VAMC emergency rooms and primary care clinics. We expect the rollout beyond the Palo Alto and Phoenix pilot sites later this year.

Question 131. Dr. Shulkin, telehealth services are an important part of the VA's health care delivery system. What additional resources are required to expand the existing system and how can the program be used to fill the gaps in care for veterans who live in rural communities?

Response. The VA is currently leveraging Telemedicine to share clinical resources across VA facilities and states, providing the opportunity for large or academically affiliated VA facilities to fill Veteran clinical service needs in rural and underserved areas.

The development and maintenance of successful Telemedicine services rely on the coordinated efforts of information technology, telehealth, engineering, and clinical

provider staff as well as the availability of a robust information technology network, modern equipment, and a supportive legal and policy environment.

From a legislative perspective, express authority for a VA provider to care for a Veteran, using a state license, irrespective of the location of the provider or patient in would, itself, help accelerate Telehealth expansion.

Expansion of Telemedicine is dependent on the investment in these key areas, with limits defined primarily by the level of investment.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN, III TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 132. As of February 1, 2017, per the VA's website, there are 388,364 pending claims in VA's queue waiting for a decision. Of those, there are 97,119 backlogged rating-related claims backlogged. Please elaborate on your plan to:

a. Get these backlogged claims processed within the next 60 days,
b. Reduce the backlog to zero?
c. Ensure all new and pending claims are processed within 125 days?

Response. VBA makes every effort to work claims in a timely manner. We recognize that some pending claims require additional time to process to ensure VA meets its legal obligations to assist Veterans in the development of their claims. Complex claims (involving multiple body systems or a high number of claimed contentions) do tend to take longer as VA considers additional evidence and/or new medical conditions throughout the claims process. Additionally, late evidence or new contentions stop the momentum made in processing the claim, since they usually require a new round of evidence-gathering, medical examinations, and analysis, thus prolonging the determination of a decision. VBA is focused on resolving specific rating claims—our oldest claims, fully developed claims, and special interest claims (homeless, extreme financial hardship, former prisoners of war, terminally ill, etc.). Based on claim characteristics that make a claim more complex as well as VA's responsibility to help Veterans develop their claims, VA expects some claims to take longer than 125 days. One of VBA's published strategic targets is to reduce the disability rating claims backlog to less than 10 percent of the total rating inventory by FY 2021.

Question 133. Mandatory overtime of Veterans Benefit Administration employees has previously been used to reduce claims. While the current "hiring freeze" executive order is in effect, is the Department allowed to institute mandatory overtime if the claims backlog reaches a certain threshold? Do you anticipate that you will need to require mandatory overtime in the next 90 days?

Response. VBA continues to use overtime for employees processing compensation rating claims. Additionally, VBA has authorized overtime for specific pension and non-rating work. VBA is considering all options, to include mandatory overtime, to ensure that Veterans are getting the best care and services possible.

Question 134. Is there ever a reason why a veteran would be taken off the Agent Orange Registry? If so, what are the parameters that the Department of Veterans Affairs uses to make such a judgment?

Response. There is no reason that a Veteran should be taken off the Agent Orange Registry.

Question 135. You have mentioned in previous public statements that eradicating veterans homelessness is not a single event; it requires a long term commitment. Now that the number of homeless veterans has diminished, how do you plan to reach the remaining population of homeless veterans who are so difficult to reach? Additionally, are there specific initiatives in place to handle female veteran homelessness?

Response. VA will continue until the goal of all Veterans having permanent, sustainable housing with access to high quality health care and other supportive services is met. While significant advances have been made in reducing Veteran homelessness, there are sub-populations of homeless Veterans who are hard to reach and engage in services (e.g., chronically homeless, those with serious mental illness, and justice involved, and those not eligible for VHA health care services). The 2017 President's Budget includes $1.6 billion for VA programs that prevent or end homelessness among Veterans including funding for case management support for the nearly 80,000 existing Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers, grant funding for community-based prevention and rapid rehousing services provided through the Supportive Services for Veteran Families (SSVF) program, clinical outreach and treatment services through Health Care for

Homeless Veterans (HCHV), service intensive transitional housing through the Grant and Per Diem (GPD) and prevention services to justice involved Veterans in the Veteran Justice Program (VJP); and employment supports in Homeless Veterans Community Employment Services (HVCES).

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

Question 136. The pernicious nature of post-traumatic stress is especially traumatic for rural veterans who do not always have access to high quality mental health and/or cannot receive care in a timely manner. Please elaborate on you plan to improve treatment, wait times, and increase options for rural Veterans with PTSD to ensure their safety and health.

Response. VA's Office of Rural Health has collaborated with VA Connected Care and Mental Health to establish a regional telemental health hub network to enhance access to care for Veterans residing in rural areas and/or in areas with identified access challenges. These regional hubs leverage VA's established and successful use of telemental health to provide staffing solutions to facilities that are particularly access challenged. Four hubs were initiated in June 2016 and are located in South Carolina, Utah, Pennsylvania, and the Washington-Oregon area. Six additional hubs were approved to come online in 2017. Regardless of their location, the hubs are available to provide services to Veterans and VA clinics throughout the country. The regional hubs provide a variety of services to include consistent, timely access to a full episode of treatment (e.g., evidence-based psychotherapy, pharmacotherapy, and primary care mental health integration services) for commonly seen conditions including Post Traumatic Stress Disorder, depression, and substance use disorders.

VA's National Center for PTSD also offers a variety of resources to improve the treatment of PTSD, including a Consultation Program to build competency for treating PTSD among Community Providers. Consultation is available free of charge, and it offers education, training, and other information to non-VA health professionals who treat Veterans with PTSD. The services are consistent with evidence-based practices for PTSD and VA consensus statements such as the VA/DOD Clinical Practice Guidelines for PTSD. The goal is to improve the care available to all Veterans with PTSD regardless of where they receive services.

Question 137. How is the Department of Veterans Affairs currently differentiating treatment options, as well as facilities, for female victims of Military Sexual Trauma? Are there policy alternatives regarding treatment and facility structure being considered now that are different than the status quo?

Response. VHA policy requires that mental health services be provided in a manner that recognizes that gender-sensitive issues can be important components of care. VA recognizes that some Veterans will benefit from treatment in an environment where all the Veterans are of one gender. This may help address a Veteran's concern about safety and may improve a Veteran's ability to disclose, address gender-specific concerns, and engage fully in treatment; however, VA also recognizes that mixed-gender programs have advantages. This may help Veterans challenge assumptions and confront fears about the opposite sex in a protected environment and may provide an emotionally corrective experience. Given these considerations, VA does not promote one model as universally appropriate for all Veterans; the needs of a specific Veteran dictates which model is clinically most appropriate. Gender-sensitive mental health care contains these key components:

- *Comprehensiveness:* Includes full continuum of service availability for women;
- *Choice:* Considers treatment modality (e.g., mixed-gender, women-only service options);
- *Competency (of clinician):* Addresses women's unique treatment needs; and

• *Innovation:* Provides creative options and settings for subgroups of women, especially when caseloads of women are small.

Question 138. Will you continue to advance the *MyVA* concepts and programs put into place under Secretary McDonald's leadership? Are there components of *MyVA* that you will differ from?

Response. *MyVA* is an initiative to drive continuous improvement across the entire VA enterprise-as opposed to driving change from within each of the three administrations (Cemeteries, Benefits and Health). I believe this is important to continue as Veterans view VA as one organization and not three separate organizations. The *MyVA* initiative set organizational priorities, established metrics and timelines, and assigned accountable managers. With this approach, VA has improved numerous processes that have resulted in meaningful differences to Veterans. If confirmed as Secretary, I would continue with efforts for continuous improvement and accelerate our efforts to make meaningful changes on behalf of Veterans. Almost certainly VA's organizational priorities will change and evolve under a new Secretary. It would be my hope that we would have goals that were bold and would be realized through our transformational change that we plan to undertake within VA.

Question 139. You have previously stated that you do not and will not support a whole sale privatization of the Veterans Health Administration, and rather, you support an "integrated" model. Please elaborate on what you mean by "integrated" model.

Response. By an "integrated" model, I am referring to a system that integrates the best of what the VA offers Veterans and the best of what the private sector can offer together. A successful VA system would be more than just the intersection of VA and the private sector but it would have additional value added for Veterans. By using VA's considerable capabilities in care coordination, case management, and quality oversight, VA can make sure that Veterans receive an integrated experience and do not have the gaps in care that too many Americans experience in the our health care system. I believe such an integrated model of care can provide our Veterans with healthcare outcomes that will be the best care available anywhere. Please see my article that I published in the New England Journal of Medicine where I described this model for the country. www. nejm.org.doi/full.10.1056/NEJMp160

Question 140. What statutory authorities do you need to remove employees who are low-performing and/or not working in the best interest of America's veterans?

Response. I know that the vast majority of the VA workforce is highly professional, motivated to taking care of our Veterans and the cream of the crop. There are times when employees get off track and need help in either getting back on track or moving out of the VA. While we already have and leverage existing laws to help move off track employees out of the workforce, additional legislation is needed. More specifically:

• The Choice Act VA needs to be modified specific to SES removal procedures to ensure constitutionality.

• The Merit Systems Protection Board need to be directed to a lower burden of proof and deference to the agency's choice of penalty.

• We need the authority to use indefinite suspensions where there is reasonable cause to believe an employee has done something to harm or endanger a patient or a coworker.

• 5 U.S.C. 7511(a)(1)(A), (B), and (C) and 5 CFR 752.401(2), (3) and (5) need modified to allow those individuals serving a probationary period or on a temporary appointment to be separated without full due process and appeal rights.

Question 141. The Veteran Success on Campus (VSOC) program has been widely successful and there are many campuses, like West Virginia University, that meet the requirements for VSOC, but still are on the wait list. Will you commit to supporting additional funding in The President's FY 2018 budget that will make it so more of our Nation's veterans have access to this program?

Response. Vocational Rehabilitation and Employment (VR&E) Service currently maintains a list of 175 schools that have expressed an interest in becoming a VetSuccess on Campus (VSOC) site. We are looking at opportunities to fill select additional VSOC positions if this approved in the FY 2018 budget.

Question 142. Both Healthnet and TriWest have a footprint in West Virginia and my office has received complaints about the inability to reach a representative by phone and the lengthy approval process. Lengthy approval times often lead to a financial burden on the veteran and their family. Please elaborate on what VA is cur-

rently doing and what you envision VA will do when contracting with third party administrators in the future?

Response. VA recognizes that there have been issues with customer service and timeliness of authorizations for care into the community. VA is actively engaged with both Third Party Administrators (TPAs) to improve service and reach our united goal of providing the best health care experience for our Veterans and the providers who care for them. In October 2016, VA and Health Net agreed to an expedited payment plan to assure community providers can continue serving our Nation's Veterans. VA has also formed a provider rapid response team to address provider issues brought to the attention of Community Care. The team's goal is to respond to providers within 72 hours, and the team engages individually with each provider to resolve problems and works with the TPAs to complete payments where appropriate. VA is also offering more Provider education on how the billing and payment processes work to help reduce problems. Since late 2016, all correctly submitted/clean provider claims are being paid timely (within 30 days). Claims that are rejected and denied due to errors require additional interaction on both sides and result in delays and reprocessing of claims.

VA has partnered with the TPAs to embed staff in over 40 VA medical centers to improve the communication and coordination of care for veterans. We continue to grow that number and we will certainly look into creating this type of service in West Virginia.

Daily monitoring of the contract via VA contract officer representatives and the TPA operations staff occurs to resolve issue and ensure Veterans are receiving timely access to health services. VA representatives are engaging in weekly correspondence with each contractor on issues of performance not meeting contract specifications. VA will also continue to issue letters of corrections in areas where performance is subpar.

The future Community Care Network returns the Veteran communications, scheduling, customer service, and care coordination to the VAMCs. Based on lessons learned with the current contracts, VA will utilize the new contracted networks to assure that Veterans receive care in the community while not relying on other parties for these very important functions.

Question 143. What do you believe are the factors that create appointment wait times and how do you plan on mitigating those factors to ensure timely, quality care for our Nation's veterans?

Response. Contributing factors to appointment wait times include increasing patient requirement for care, staffing levels of providers, nurses and schedulers unable to keep up with the demand for care, and inefficiencies in clinic practices.

VA has been working mitigate these factors to ensure timely, quality care for the Veterans we serve. VA's greatest effort is to focus on ensuring timely care for Veterans with the most urgent needs. In July 2015, when I joined the VA as Under Secretary of Health, I identified the first challenge to be the inability to identify patients with the highest and most urgent clinical needs. I tasked senior leadership to take on different tactics to simplify our clinical processes. This included consolidation of the over 30 different ways of scheduling a specialist consult to two ways, classifying the appointment as either stat or routine. This resulted in identifying around 57,000 urgent consult referrals to specialists waiting over 30 days for an appointment. VHA executed an emergent call to action with national Stand Downs in November 2015 and in February 2016. During these endeavors, staff from each medical center contacted targeted Veterans waiting for care, triaged them for clinical care needs and connected them with the appropriate services. Around the time of the stand-downs, VA also implemented a standardized process for facility staff to review in real-time, referrals to specialists with more urgent needs. These efforts have led to an ongoing reduction of Veterans waiting over 30 days to see a specialist from the 57,000 in November 2015 to about 200 as of February 2017.

Other Elements in Mitigation Plan

Factors	Mitigation Plan
Increasing Demand/Lack of Providers and Clinic Staff.	• Active recruitment of health care providers and clinic staff—VA increased provider and nursing staffing by approximately 12% over the past two years • Granting full practice authority for Advanced Practice Nurses • Increase use of telehealth for Primary Care and Mental Health • Use of community care resources when unable to recruit providers • Increased use of extended clinic hours
Inefficiencies in clinic practices.	• Implemented Clinic Practice Management Program across VA—in this program all facilities have at least one group practice manager to oversee and optimize administrative clinic activities • Validating clinic grids to achieve optimal clinic capacity • Focus on improving productivity—increased productivity by 16% over past two years • Developed strategies for reducing "no show" rates, and redesigning clinic space • Implemented standardized face to face Clinic Clerk Training for optimal scheduling of patients • The above efforts have resulted in an increase in 12,000 appointments daily in 2016 when compared to 2014

Question 144. Will you commit to ensuring that VA continues to invest in the veteran transportation program?

Response. Yes, I commit to continuing the Veterans Transportation Service that transports Veterans to and from their appointments, especially, in rural areas where both community care and VA care are less available. This is an area in which we have been able to partner with our VSO groups.

Question 145. With VA's expertise on substance abuse and the Department's robust Office of Research and Development, I believe that you are well equipped to be on the forefront of alterative pain therapy research for the entire country. Please elaborate on how you will increase the number of alternative treatments for pain management. What investments will you make and are there authorities you need from Congress?

Response. In response to Section 932 of the Comprehensive Addiction and Recovery Act (CARA), VA developed an ambitious plan to expand research, education, and clinical delivery of complementary and integrative health (CIH) approaches for pain management as well as mental health. The Integrative Health Coordinating Center in the Office of Patient Centered Care & Cultural Transformation is working to make the evidence-based CIH approaches—including acupuncture, chiropractic, yoga, tai chi, meditation, and massage—more widely available to veterans nationally. Our commitment is that every medical center will offer at least two of these therapies routinely for Veterans with pain. In addition, the Office of Research and Development is collaborating with the National Center of Complementary and Integrative Health at NIH and the DOD to fund a large research initiative supporting demonstration projects developing the most effective ways to deliver CIH for pain in our military populations.

Question 146. The Department of Veterans Affairs is often charged with having a corrosive culture that breeds unethical, and sometimes unlawful, behavior that is not veteran-centric. While there have been improvements under Secretary McDonald's leadership, there is still work to be done. What are specific actions that you will implement to ensure that the culture of VA will continue to improve?

Response. Employees want to work in an environment where they have the tools and resources they need to be able to serve their patients. As a health care executive this is what the type of environment I strive to have for our staff and their patients. Employees want a place that has systems that work, co-workers that are well trained and supported, and a culture of respect. If confirmed as Secretary, I would work hard to have a work environment that supports our staff and allows them to do their best for our Veterans. Part of what is needed is to be able to support, retain, and recognize those employees that share the organization's values and

are high performers and to be able to remove those that have strayed from these values. When people are allowed to remain in the workplace, despite poor performance or bad behavior, it is demoralizing to all employees.

Question 147. Please elaborate on specific ways the Department of Veterans Affairs and Congress can work together to improve the claims backlog.

Response. We appreciate Congress's ongoing support for our budget for staffing, and information technology advancements and sustainment. We fully expect that as the needs arise for legislative intervention that we will be able to collaborate with Members of Congress to ensure that the needs of our Nation's Veterans and their families are met with the highest level of care and compassion.

Question 148. Do you support an expansion of the Caregivers programs beyond post-9/11 veteran era?

Response. I support programming for all caregivers of all Veterans, regardless of the Veteran's era of service or the reason why the Veteran needs the assistance of a caregiver. I cannot, however, support the expansion of the current Program of Comprehensive Assistance for Family Caregivers without considerable concern for how the cost will impact other services and supports to Veterans. VA welcomes collaboration with Congress to establish a sustainable program that provides assistance and support to all caregivers. I am exploring the option of a study to determine the cost avoidance that may be seen with the expansion of Caregivers to give us a better understanding of the true costs involved in expanding the program.

Question 149. Do you believe there are improvements or changes that need to be made in the way VA determines service-connected disabilities? Would you be open to reexamining the compensation and pension exam process?

Response. VA agrees, in principle, that there is a need for revision of the 1945 regulations that are found in 38 CFR Part 4, the VA Schedule for Rating Disabilities (VASRD). While VA has undertaken several changes, in the past, to update and clarify regulations for individual sections of 38 CFR Part 4, VA has not had major revision of VASRD that can be viewed as a complete modernization of its evaluative criteria.

In 2009, the Veterans Benefits Administration (VBA) Under Secretary for Benefits (USB), on behalf of the Secretary for Veterans Affairs (VA), directed the revision and update of the 15 body systems that are contained in the VASRD, under the authority of 38 U.S.C. § 1155. To date, VA has published for notice and commented on six of the VASRD regulations, which are currently under review for final publication. VA is working to publish proposed updates to the *Federal Register* for the remaining body systems. VA plans to complete these regulations by the end of 2018. Additionally, VBA continues to work to modernize efforts related to the disability evaluation process, to include accessibility to Veteran's benefits and system and procedural enhancements to improve the timeliness and quality of rating decisions.

We have consistently taken steps to improve the compensation and pension examination process. We now receive disability benefit questionnaires (DBQs) from Veterans seen by their private providers. We have increased the type of examinations that can be done by medical disability examination contract providers as well as by VHA clinicians. And we are working to implement system enhancements that more efficiently and quickly process evidence through automation. Finally, in FY 2016, VBA and VHA collaborated on a multi-prong Breakthrough Initiative to Improve the C&P Exam Process, and these efforts are ongoing. This included providing training to individuals involved in the C&P exam process in VBA and VHA as well as educating Veterans on what to expect before, during, and after their C&P examination.

Question 150. The difficulty veterans face in scheduling appointments is a frequent complaint to my office. Please elaborate on ways to improve scheduling to make it easier both for VA scheduling staff and the veteran.

Response. VistA Scheduling Enhancements (VSE) is a cost-effective, interim solution built in partnership with the private sector to bring an urgently needed modern interface to the antiquated VistA scheduling package. VSE makes it easier for schedulers to schedule and coordinate follow up appointments with other Veteran appointments, keep track of Veteran appointment preferences, and reduce scheduling errors all via a simplified point and click process. VSE is currently being piloted in multiple clinical settings at five VA facilities. If the pilot is successful, VSE will be implemented nationally until a permanent and complete solution is available.

VA provides uniform face to face training that teaches all schedulers how to optimally meet all of the scheduling needs of Veterans. This training includes simulation using VA's computerized system, working through real life challenge scenarios and focusing on optimization of customer service.

Based upon Veteran feedback, VA is implementing "patient centered scheduling," whereby Veterans are offered the option to schedule follow-up appointments upon leaving clinic even when appointment needs are a year or more into the future—this replaces the "recall system" that constrained Veterans to only schedule their appointment as it got closer to their appointment date.

VA also implemented call centers for Veterans to more easily request and cancel appointments by phone.

The Veteran Appointment Request (VAR) Mobile App enables Veterans to self-schedule appointments or request someone call them to make an appointment via either a smart phone or desktop computer. The system is currently being utilized at 21 sites and is being evaluated for possible expansion.

Finally, VA has awarded a contract for a commercial scheduling package, called MASS. Mass is now being implemented in a pilot site within VA to determine how it functions and compares to the alternatives detailed above.A off the shelf system, while more costly, might be the best solution to VA's long standing scheduling issues.

Question 151. What are ways that you would like to see access to Mental Health improve? What is being done to help prevent the overprescribing of opioids and benzodiazepines?

Response. Timely access to high-quality mental health care is an imperative for VHA. As of December 31, 2016, every VA Medical Center endorsed their capability to provide same-day mental health services to Veterans in urgent need. This represents a critical first step in our MH access plans but it is only the beginning. Veterans do not only need access to an appointment, they need access to a full episode of care which may require a succession of appointments over a short period of time. VHA is already the Nation's leader in integrating mental health services in primary care teams, an effort we continue to expand. In addition, we are rapidly expanding telemental health care across the system to expand capacity as well as making improvements in the CHOICE program when community providers are the best match to a Veteran's needs. Such demands can be a major obstacle to seeking care for many Veterans and can be overcome by delivering telemental health services directly to their homes, offices, or even to their parked cars. Finally, we are ensuring that expanded access means high quality, evidence-based, compassionate care which ensures a steady increase in trust, compliance, continuity, satisfaction and clinical outcomes. This will require additional hires, expansion of available Mental Health disciplines (including the current 'mission critical occupations' of psychologists and psychiatrists, as well as Licensed Professional Mental Health Counselors, Marriage and Family Therapists, Social Workers, Vocational Rehabilitation Specialists, Addictions Specialists, Advance Practice Mental Health Nurses, Psychiatric Physician Assistants, and Clinical Pharmacists). Full staffing, a full array of services, and enhanced availability across the Nation are key components of VA's Mental Health Access improvement plan.

The Opioid Safety Initiative was instituted nationally in the VA in 2013. Since then there has been a decrease in patients receiving opioids (27% reduction), a decline in the use of long term opioids (33% reduction), an increase in the use of safe prescribing practices such as patient signed consents, prescription drug monitoring program (PDMP) checks, use of urine drug screens (increased 48%) , and avoidance of unsafe combination therapies. The combined use of opioids and benzodiazepines has decreased by 51% from 2012 to 2017. There is a need to treat Veterans with pain, and the VA is focused on using conventional and alternative therapies to address pain and enable a reduction in opioid use.

Question 152. In the past, you have stated that you would not have used the "40 mile" and "30 day" rule if you had designed the Choice program. Please elaborate on how you would like to see Choice fixed and what measures you would use in considering eligibility for referral to care in the community?

Response. I know of no health system that has designed a system around mileage and wait times. The reason I believe we must look at alternatives to these criteria is that mileage and wait times do not differentiate between Veterans that need urgent care and Veterans that desire elective care. Such a system also does not differentiate between those that have other healthcare options available to them and those that have none. We are embarking upon an exploration of a number of different models that would propose alternative criteria and then we would need to get Veteran input into these models. We also need to do economic modeling of these models to determine the cost of new options. Once we have completed this initial work we would begin to socialize our ideas with Veterans, Veteran Service Organizations, Members of Congress and the Administration, and our staff.

Question 153. A frustration that many veterans have is that even though there is a VA regional office in their community, they have to contact a call-center to get an update on the status of their claim or to ask questions. How can the Veterans Benefits Administration be more accessible to veterans directly? Furthermore, have you considered embedding VBA counselors in VA medical centers to help veterans and their families understand their benefits during a hospitalization?

Response. Besides our national call centers; every regional office has a public contact team that can assist Veterans and claimants with submitting claims for benefits or getting a status on their claim. VA continues to look for ways to increase access to Veterans. Many of the VA medical centers do have VBA personnel onsite on an ad hoc basis to assist with claims related questions. Any expansion would require balancing of available resources. Finally, VA cultivates close partnerships with Veterans Service Organizations, which help Veterans and their families understand and navigate VA benefit programs.