Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Questions from Senator Murphy

Question 1: In the testimony you acknowledge this new provision (Section 258 of Division J of the 2018 Appropriation Act) and state that the "VA is working to implement this new authority. What progress has the VA made on implementing the law?

VA Response:

To implement this law, VA needs to issue implementing regulations, particularly to define certain terms in the law, and update applicable policies and protocols. We are drafting these regulations at this time. In addition, VA is preparing an education and communications campaign regarding the new authority. Implementation of this provision will take place in conjunction with current efforts to achieve the goals set forth in Executive Order 13822, Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life, including notifying transitioning Service members of the mental health care services that may be available to them under new section 1720I of title 38, U.S.C., and other VA authorities.

Question 2 : What is your timeline for fully completing the implementation of the law?

VA Response:

VA is already providing care for former Service members with Other Than Honorable (OTH) discharges and expects to fulfill the added requirements under section 1720I, particularly providing notice to individual Service members with OTH discharges, no later the end of calendar year 2018.

Question 3 : To date have any veterans received treatment under this new provision in the law?

VA Response:

As explained above, VA has not yet implemented new section 1720I. We note that VA has other authorities under which it currently furnishes mental health care to individuals with Other than Honorable (OTH) discharges. Since July 2017, more than 7,000 former Service members with OTH discharges have registered in VHA's enrollment system. In Fiscal Year 2018, 2,350 Veterans with OTH discharges received mental health care from VA healthcare facilities, the majority receiving outpatient services.

Question 4 : Per the testimony, as of December 30, 2017, VHA had received 3,241 requests for health care services under the previous 100-day emergent mental health

care program. What has the VA done in terms of notifying these newly eligible veterans under this new section in the law?

VA Response:

As noted in response to Question 1, VA has not yet implemented section 1720I. Part of implementation will include developing a plan to notify individuals with OTH discharges of their potential eligibility under the new provision. In the meantime, VA has consistently provided information about the availability of emergent mental health services for former Service members with OTH discharges as part of its suicide prevention communications since 2017. Information about the availability of these services has been communicated broadly within VA and outside of VA through Veterans Service Organizations, Veteran-to-Veteran contacts, and the media. Care and services under the OTH Mental Health Initiative remains available through VA health care facilities, Vet Centers, VA emergency departments, and the Veterans Crisis Line.

Concierge for Care (C4C) launched in October 2017 as a proactive outreach to Veterans shortly after military separation to inform them, in general, about the health care enrollment process.

The Transition Assistance Program (TAP) supports transitioning Service members with the VA health care enrollment process. TAP guides (Instructor and Participant) were updated to clearly articulate the health care application and enrollment process.

The "Easy Button", when completed in December 2018, will provide mental health resources and a straight path into mental health care for Veterans in need.

Question 5 : The VA has just over 130 days left to notify all eligible veterans of this treatment under the new law. Have you identified a contractor or vendor to notify the close to 500,000 eligible veterans?

VA Response:

Mechanisms to gather relevant information (names, phone numbers, addresses, etc.) and communicate are being finalized and the notifications will be sent in December 2018.

Questions from Senator Leahy

Question 1: White River Junction VA Medical Center- I remain concerned about the frequent and abrupt leadership changes at the White River Junction VA Medical Center in my home state of Vermont. While the acting leadership team is working hard to

maintain the highest possible quality of service for our veterans, the absence of a well-qualified permanent director will certainly hamper initiatives aimed at improving care. This is especially concerning to me at a time when the responsibility for the CHOICE program is transitioning back to the local medical centers.

What are your current and future efforts to recruit and hire a director?

VA Response:

The Department of Veterans Affairs (VA) is in a state of fundamental transformation not seen at this organization since the end of World War II. Such transformation will require substantial resources to meet the challenges of offering world-class customer service to Veterans and increase access to care through MISSION Act implementation. This organizational innovation and modernization cannot be successfully implemented without strong leadership at every level of the organization. The recruitment and hiring of a permanent Medical Center Director (MCD) at the White River Junction VA Medical Center is vital for such transformation to reach Veterans in Vermont.

To date we have recruited for the MCD position twice, but have not yet identified a candidate whom we are confident would be a strong, long-term leader for the facility, especially in this time of transformational change at VA. Most recently, we have posted again for the MCD position in Vermont on September 12, 2018.

We are hopeful that this most recent search will yield a strong, permanent person for the MCD position. In the event we are unable to identify a candidate, we will continue to leverage VA's comprehensive plan to identify, recruit, and hire highly qualified Medical Directors to include using:

- Current Legal Hiring Authority - VA is using existing legal authority to fill MCD positions, including the Senior Executive Service (SES) authority and Title 38 physician and direct hiring authorities. These appointment authorities incorporate a competitive selection process that required applicants to be rated and ranked, interviewed, and, in the case of those hired into the SES, certified by the Office of Personnel Management (OPM).

- National Recruitment Strategy - In FY 2016, VA elevated its focus on senior leader hiring through the Critical Staffing Initiative, a VA Secretary Priority Initiative. VA partnered with the Corporate Senior Executive Management Office (CSEMO) to fill MCD positions through a national recruitment strategy by posting national vacancy announcements for multiple locations across the country and leveraging social media outlets and other venues to increase the public's awareness of these leadership roles. Under this national recruitment strategy, VA instituted a corporate approach in making selections and obtaining approvals with the goal of filling MCD positions within 120 days of the vacancy.

- Critical Pay & Direct Hiring Authority - VA obtained approval from OPM in September 2016 to leverage Critical Pay Authority to adjust the rate of pay up to the Executive Level I ($210,700effective January 2018) for 39 Complexity Level 1A MCD positions. Additionally, VA utilizes the Direct Hiring Authority (DHA) authorized in the "Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017" that gave VA the flexibility to streamline the hiring process by allowing the Secretary to appoint qualified individuals without going through a lengthy recruitment process. However, candidates hired using the DHA authority have their salary capped at ($153,800).

Both our current and future efforts to recruit and hire a MCD are focused on identifying a leader than can offer world-class customer service and increase access to care to Veterans in Vermont – especially in the wake of VA's current state of fundamental transformation and modernization.

Question 1A: What obstacles are delaying or preventing you from moving forward to recruiting and hiring a director, and what initiatives will you undertake to encourage retention of that new director at the White River Junction VA Medical Center?

VA Response:

The White River Junction VA Medical Center experienced a significant system shock following allegations brought forth in a Boston Globe article. While an unfortunate event, it provided the organization an opportunity to re-examine its commitment to maintaining the highest possible quality of service for our Veterans in Vermont. Since that time, we have worked diligently for the leadership transitions to be as smooth as possible and focused on finding a well-qualified, permanent MCD capable of ushering the sweeping innovation and modernization efforts at VA into the White River Junction VA Medical Center.

Until a permeant MCD is recruited and hired, the facility is being well cared for by a strong Interim MCD. This position has been vital in helping overcome delays and barriers associated with addressing the scope of the partnership between the White River Junction (VT) and Manchester (NH) Medical Centers. While discussions ranged from collaborations to mergers, VA had to finalize a decision before the White River Junction VA Medical Center could move forward with significant hiring efforts. In the end, VA decided on a creating a partnership between the medical centers focused on close collaboration. We expect that the depth and breadth of services for each facility will inevitably be greater through the partnership than working independently.

VA has made positive progress in the recruitment of highly qualified candidates for MCD positions. Tactics to mitigate recruitment challenges, continue to be updated, such as

monthly national job announcements, eliminating extra steps in the hiring process, and reducing time to hire. However, one challenge to hiring is the Direct Hiring Authority (DHA) salary restriction cap at Exec Level V ($153,800). According to a 2014 publication in the Journal of the American Medical Association: Internal Medicine, the average compensation for private sector hospital executives is approximately $600,000 annually.[1]

VA has proposed a technical amendment to significantly increase MCD salary caps, authorizing VA to appoint MCDs at the Executive Level II ($189,600) and Executive Level I ($210,700) for Critical Pay Positions. Such pay reform efforts could go a long way in recruiting and retaining quality MCDs in VA Medical Centers in Vermont and across the country.

Question 2 : Vermont and New Hampshire VA Medical Services- I understand that the New Hampshire Task Force recommendations are currently under review by the VA Central Office. While thoughtful collaboration between the Vermont and New Hampshire medical centers may serve the veterans in both states, I have heard the perception from constituents that the discussion of a more integrated system appears to be driven by the problems at the Manchester VA, rather than by the leadership at the White River Junction VA Medical Center, which offers a higher level of care.

What measures will you pledge to have your office take to solicit and integrate the concerns and input of Vermont veterans and stakeholder groups prior to considering if this proposal should move forward?

VA Response:

VA's purpose is to serve those who served. As such, VA will ensure Vermont and New Hampshire Veterans alike have organizations keenly focused on their well-being. Preliminary planning efforts are now underway between the VISN senior leadership and the senior leadership teams at both Manchester and White River Junction. These efforts will focus on what meaningful collaboration could mean for each site. Two core principles of this work are that any collaboration should be of mutual benefit to patients of both facilities, and that there is frequent communication to Veterans and other stakeholders about our progress in this partnership.

During this planning process, Veterans' input will be of the utmost importance. Manchester VAMC hosted a series of open forums such as town hall meetings to

[1] Joynt, KE; etal. Compensation of Chief Executive Officers at Nonprofit US Hospitals. JAMA Intern Med. 2014;174(1):61-67.

specifically gain stakeholder feedback when formulating recommendations for the Manchester 2025 Task Force. These forums helped to inform the recommendations of that group. While White River Junction has not identified any specific service changes as a result of potential collaboration with Manchester, the relevant information such as WRJ providing interim leadership in Manchester and exploring future collaboration has been a topic at their regular Veteran town hall meetings throughout 2018. Communication with Vermont Veterans and stakeholder groups will continue as the Manchester and White River Junction VAMC partnership continues to develop.

Questions from Senator McConnell

Question 1 : Women's Health- It has been brought to my attention that some VA health care facilities lack the capability to provide care to meet the specific medical needs of women veterans. With this in mind, what efforts is the VA taking to ensure that all of its health care facilities are fully equipped to provide quality care to women veterans? What plans are being made to ensure that the new Louisville VA Medical Center is able to provide quality medical care to female veterans?

VA Response:

In order to ensure we meet the needs for the increasing numbers of women Veterans, VHA is rapidly increasing access to trained designated Women's Health providers through large scale educational initiatives and has now trained over 5,000 providers since 2008. Educational efforts include hosting national mini-residency programs at training conferences each year; local mini-residency programs, and the newest training at rural sites. In fiscal year 2018, in partnership with Office of Rural Health (ORH), Women's Health Services began providing a mini-residency for rural providers and nurses at 35 sites and up to 40 rural clinical sites per year going forward.

VHA is also enhancing access to Women's Health Services through telehealth. VHA Telehealth Services uses health informatics, disease management, and telehealth technologies to target care and case management to improve access to care, improving the health of Veterans. The Virtual Integrated Multisite Patient Aligned Care Team (V-IMPACT) is a nationwide initiative funded by ORH to provide virtual primary care coverage to facilities with provider shortages via primary care tele-hub sites. In addition to the telehealth hub sites, there are 62 active women's health telehealth programs across the system.

Not all VA health care systems have a gynecologist onsite, but all Veterans have access to gynecologic care as a basic component of high-quality care. As of FY 2017, 27 of the 160 medical facilities (17 percent) did not have a gynecologist on-site. Women

at sites without a gynecologist receive needed gynecologic care through care in the community. VA medical facilities do not provide on-site obstetric care to pregnant Veterans. However, many female Veterans receiving their routine or gender-specific care through VA have their pregnancies diagnosed at a VA medical facility and receive further maternity care through community health care providers. Once a pregnancy is diagnosed, the VA maternity care coordinator (MCC) contacts and educates the Veteran on maternity benefits and the process for accessing maternity care throughout the pregnancy. The MCC answers Veterans' questions and remains in communication with pregnant Veterans throughout their pregnancy and postpartum care.

Additionally, privacy and safety of women Veterans is a high priority for VA. VA is working to improve standards and maintain facilities to provide gender-specific healthcare delivery in a sensitive and safe environment. VHA's Women's Health Service updated VHA Directive 1330.01 to ensure clarity of environment of care requirements and VA's Office of Construction and Facilities Management (CFM) is developing facility design guide clarifications/revisions to reduce policy compliance variability at medical facilities.

As part of continuing efforts to improve VHA's culture concerning women Veterans, the Women's Health Service is promoting respect for women Veterans and raising awareness on the issue of harassment, specifically, harassment that women Veterans experience when visiting VHA sites of care. An internal education and awareness campaign launched in August 2017 includes targeted messaging to VHA staff and Veterans that communicates our responsibility to provide healthcare to women Veterans in environments that attend to their dignity, safety, and privacy.

VHA's Women's Health Service updated and published VHA Directive 1330.01 on July 24, 2018 to ensure clarity of requirements and their measures. VA's Office of Construction and Facilities Management has identified appropriate updates for Design Standards and released Design Alerts to the field in September 2018, which effectively updated the 2010 design standards to extend to all Veterans and clarify the standards to facilitate application in VHA facilities. The Design Alert will be followed by a systematic update of Design Guides, Equipment Lists, and related criteria. The VHA-chartered Improving Oversight of Care for Women Veterans Advisory Group (IOCWAG) will be meeting in October to formulate a multifaceted strategic implementation and compliance plan to include: communications, education, room assessments and tracking of corrective actions to ensure compliance by all medical facilities.

The new Louisville VAMC will incorporate extensive Women's Health Serives design standards to accommodate the growing population of Women Veterans utilizing VA medical services.

Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Question 2 : Opioids- As you may be aware, the opioid and heroin epidemics have hit Kentucky particularly hard and continue to be a challenge for many veterans. What programs have been implemented by the VA to treat substance use disorders, and particularly opioid abuse, by veterans? What programs have been most effective in providing successful treatment to veterans?

VA Response:

Overall, quick access to Medication Assisted Therapy (MAT) that spans across the continuum of care is critical in our effectiveness with opioid use disorder (OUD). Having all of these levels of care in one program allows for expedited access and increased communication among providers. To address the opioid epidemic, VISN 9 has implemented VA's National Opioid Safety Initiative. Through this initiative, VISN 9 has achieved the following (comparing fourth quarter FY 2017 data with third quarter FY 2018 data):

- Reduced the percentage of Veterans prescribed opioids from 12.5% to 8.9%;a 29% reduction.
- Reduced the percentage of Veterans prescribed opioids and benzodiazepines from 5.3% to 4.1%; a 23% reduction. VISN 9 is the best in the Nation on this metric.
- Increased the percentage of Veterans on long-term opioids who have had a urine drug screen from 89.2% to 91.1%; a 2% increase.
- Reduced the percentage of Veterans receiving opioids in doses greater than 100 MEDD from 4.7% to 4.04%; a 13% reduction.
- Increased the percentage of Veterans who have signed an opioid informed consent for long-term opioid therapy from 87.6% to 90%; a 3% increase.

Academic Detailing Clinical Pharmacy Specialists work in every VISN 9 facility to educate providers about OUD identification and treatment, opioid prescribing, and the risk of combination opioid and benzodiazepine prescribing.

Opioid Overdose Education and Naloxone Distribution (OEND) were implemented in every VISN 9 facility. This includes education and training for patients on how to prevent, recognize, and respond to an opioid overdose. Naloxone (Narcan) is available for outpatient dispensing. Over the past year, VISN 9 facilities dispensed 6,314 naloxone rescue kits to Veterans. VA Police carry naloxone while on duty to quickly respond to any opioid overdoses on site.

VISN 9 providers query State Prescription Drug Monitoring Programs (PDMP) to identify Veterans who may be receiving controlled substance prescriptions outside VA. VA submits VA prescription data to State PDMPs increasing awareness of what controlled substances Veterans receive from VA. Use of PDMP improves patient safety and reduces the risk of Veterans receiving duplicate treatment. We appreciate Congress'

enactment of section 134 of the VA MISSION Act of 2018, which created a new section 1730B in title 38, U.S.C., which should reduce barriers to VA clinicians' access to information from State PDMPs.

Providing medications such as buprenorphine/naloxone (Suboxone) allows the patient to focus more readily on recovery activities by preventing withdrawal and reducing cravings. These medications help Veterans achieve the long-term goal of reducing opioid use and the associated negative medical, legal, and social consequences, including death from overdose.

VISN 9 clinical providers reviewed the medical records of 2,349 Veterans with a diagnosis of OUD to identify candidates for medication assisted therapy. All VISN 9 facilities have buprenorphine/naloxone (Suboxone) and long-acting naltrexone (Vivitrol) available to patients to help manage their OUD, if clinically appropriate and desired by the Veteran. Methadone treatment is made available, if needed, through referrals to the community.

In the third quarter of FY 2018, 750 Veterans with OUD in VISN 9 received MAT, including Suboxone, methadone, and Vivitrol (LEX=174, LOU=99).

VISN 9 is also participating in the VA Buprenorphine Initiative. Buprenorphine has been shown to be a safe and effective treatment of opioid dependence in non-specialized, outpatient, office-based settings, including VA environments. Furthermore, buprenorphine's availability has encouraged opioid-dependent patients who would not otherwise present themselves to an opioid agonist therapy program to access treatment.

Lexington VAMC:

- Full evaluation for OUD, and, when appropriate, the initiation of MAT, was expanded to both the inpatient and residential treatment settings.

- Prescribing Vivitrol for alcohol use disorder as well as OUD was expanded to include Patient Aligned Care Team (PACT).

- Primary care providers are authorized to obtain the qualifications necessary to prescribe Suboxone while retaining Veterans in their clinic.

- Intensive outpatient therapy, which is for Veterans of higher acuity, is available within the Substance Abuse Treatment Program.

- Veterans with a documented diagnosis of opioid abuse where treatment is recommended also receive a direct-to-Veteran mailer outlining information about

OUD as well as treatment options. Veterans are also continuously re-reviewed and encouraged to participate in treatment.

The creation of programs allowing both inpatient teams as well as the residential teams to initiate MAT when appropriate has been the most effective method of providing successful treatment to Veterans at this point. Programs provide a more direct and effective continuum of care for Veterans which should lead to higher retention rates and improved outcomes for Veterans receiving MAT.

Robley Rex VAMC:

- Substance Use Disorder (SUD) treatment is offered in nearly all of the outpatient community-based outpatient clinics (CBOC) and at the main campus. This evidence-based treatment includes group and individual psychotherapy as well as medication assisted therapy for OUD (including Vivitrol and Suboxone).

- An Intensive Outpatient Program is offered at the main campus. The program involves two hours of evidence-based treatment daily for approximately eight weeks. Individual psychotherapy and MAT for OUD (including Vivitrol and Suboxone) are also offered at this level of care.

- A Substance Abuse Residential Rehabilitation Treatment Program is offered at the main campus. This is our highest level of care for substance abuse disorders and involves a 16-bed residential program that lasts for approximately one month. Included in this program are at least four daily evidence-based groups, intensive individual psychotherapy, and medication assisted therapy for OUD (Including Vivitrol and Suboxone).

- Methadone treatment is made available, if needed, through referrals to the community.

- The SUD treatment program also provides a consultation service for Veterans hospitalized in acute psychiatry or in medicine service. A psychiatrist is involved in this consultation service and medication assisted therapies can be started (if appropriate) while Veterans are still inpatients.

Question 3 : Louisville VA Medical Center- As you know, a new Louisville Department of Veterans Affairs Medical Center (VAMC) was announced in 2006. Kentucky veterans – who have served our country so bravely – have waited far too long to begin receiving care at this announced facility. While I have never endorsed a specific location, I was

encouraged when the VA signed a final Record of Decision for a new Louisville VAMC, indicating the long-delayed project would finally move forward. However, I was highly dismayed when I learned that the VA failed to request funds for this project in the President's FY19 budget. My expectation is that the VA will take all necessary steps to advance this project and ensure the new Louisville VAMC will be built expeditiously for the care and service of our veterans. Will you please provide an updated timeline for the design, construction, and completion of the facility and share what preliminary work can be accomplished during this interim period to expedite the project?

VA Response:

VA signed and published the Record of Decision in the Federal Register in October 2017 to conclude the National Environmental Policy Act (NEPA) process. VA had planned to advertise the currently appropriated Phase 1 construction in October 2018 with award for April 2019. However, the pending litigation by the City of Crossgate, challenging VA's adherence to NEPA requirements, has delayed solicitation and award of phase 1 construction. Resolution of the litigation is not anticipated before the end of FY 2019. VA is working with the Department of Justice and the US Army Corps of Engineers to determine the best options for moving forward with the solicitation and potential award of the phases.

Question 4 : Accountability- To assist the VA as it continues with reform efforts to improve and expedite care for our nation's veterans, Congress passed and the President signed into law the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017. This bill authorizes the creation of a new Office of Accountability and Whistleblower Protection and provides new authority for additional accountability measures. Will you please provide an update on the VA's implementation of these new authorities to ensure that veterans receive the quality care they deserve?

VA Response:

As discussed in the OAWP report of June 30, 2018, as of June 1, 2018, OAWP received nearly 2,000 submissions of alleged wrongdoing within the Department.

The nearly 2,000 submissions are further broken down by general category in the chart below:

Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Count of Disclosures by Type, by Month – Details

Disclosure Category	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18	APR 18	MAY 18	Grand Total
WB retaliation	11	50	48	31	25	28	22	24	19	28	20	13	**319**
Violation of any law, rule or regulation	7	36	33	32	41	27	38	31	48	47	22	31	**393**
Gross mismanagement	1	6	10	5	7	10	2	6	7	6	5	4	**69**
Gross waste of funds		1		2		4	2		1	1	1	2	**14**
Abuse of authority	3	6	20	7	7	15	12	10	17	15	19	6	**137**
Substantial and specific danger to public health		2	4	3	2			3	4	9	2		**29**
Substantial and specific danger to safety		1	2	3	6	3	1	1		1	1	1	**20**
Not a WB disclosure	8	110	107	80	61	66	42	89	102	105	101	147	**1018**
Grand Total	**30**	**212**	**224**	**163**	**149**	**153**	**119**	**164**	**198**	**212**	**171**	**204**	**1999**

OAWP completed 128 investigations involving 236 persons of interest (POIs). Seventy-four of those investigations did not substantiate misconduct by the POIs. OAWP recommended disciplinary or adverse actions in 54 cases involving 58 unique POIs. Twenty-three of the recommended disciplinary or adverse actions were against individuals occupying senior executive positions under 38 U.S.C., section 713.

VA created and published implementation guidance for the new authorities contained in the Accountability and Whistleblower Protection Act, PL 115-41, in the form of four Human Resources Management Letters (to implement 38 U.S.C., section 714 and the changes to title 38 employment in section 208 of the Act) and a Corporate Senior Executive Management Office Letter (to implement 38 U.S.C., section 713). VA's Office of Human Resources and Administration developed and delivered, in coordination with VA's Offie of General Counsel (OGC), immediate training to field activities and staff offices regarding implementing the new authorities. OAWP and OGC continue to deliver orientation and training sessions throughout VA to educate supervisors and senior leaders regarding the provisions of the Act.

Training to the workforce continues to be provided through the existing Notification and Federal Employee Antidiscrimination and Retaliation Act of 2002 (No-FEAR) mandated training while OAWP develops the expanded training directed in the Accountability and Whistleblower Protection Act (38 U.S.C., section 733).

These efforts demonstrate the Department's commitment to improving the stewardship of VA by holding senior leaders accountable by thorough, impartial investigations into allegations of senior leader misconduct or poor performance.

Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Questions from Senator Baldwin

Question 1 VHA: Opioid Rx Rates: Dr. Clancy, please provide the Committee with the latest prescription rates of opioids and benzodiazepines for all Wisconsin VA Medical Centers. In addition, please segregate these prescribing rates annually for 2015, 2016 and 2017, both nationally and for each Wisconsin VA Medical Center.

VA Response:

The most recent opioid and benzodiazepine prescribing rates available for Wisconsin VA Medical Centers (Table 1) is for the first three quarters of Fiscal Year 2018, from October 1, 2017 to June 30, 2018.

Table 1. Opioid and Benzodiazepine Prescribing Rates for Fiscal Year 2018 (October 1, 2017 to June 30, 2018)

VA Medical Center	Patients Dispensed An Opioid and Benzodiazepine Prescriptions (#)	Outpatient Pharmacy Patients (#)	Percentage
VISN 12 607 Madison, WI	404	29,948	1.35%
VISN 12 676 Tomah, WI	243	19,019	1.28%
VISN 12 695 Milwaukee, WI	728	45,951	1.58%

Table 2 represents the opioid and benzodiazepine prescribing rates nationally and for the Wisconsin VA Medical Centers from Fiscal Year 2015 to Fiscal Year 2017.

Table 2. Opioid and Benzodiazepine Prescribing Rates for Fiscal Year 2015 to Fiscal Year 2017

Fiscal Year	VA Medical Center	Patients Dispensed An Opioid and Benzodiazepine Prescriptions (#)	Outpatient Pharmacy Patients (#)	Percentage
FY2015	National	173,044	4,951,897	3.49%
FY2015	VISN 12 607 Madison, WI	906	31,076	2.92%
FY2015	VISN 12 676 Tomah, WI	869	21,168	4.11%
FY2015	VISN 12 695 Milwaukee, WI	1,886	49,263	3.83%
FY2016	National	141,628	4,993,889	2.84%
FY2016	VISN 12 607 Madison, WI	817	31,313	2.61%
FY2016	VISN 12 676 Tomah, WI	612	20,946	2.92%
FY2016	VISN 12 695 Milwaukee, WI	1,585	48,692	3.26%
FY2017	National	107,630	5,027,011	2.14%
FY2017	VISN 12 607 Madison, WI	701	31,339	2.24%
FY2017	VISN 12 676 Tomah, WI	420	20,155	2.08%
FY2017	VISN 12 695 Milwaukee, WI	1,143	48,247	2.37%

Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Question 2 VHA: Colorectal Cancer Screenings: Dr. Clancy, the FY18 Omnibus directed the VA to align with the more than 90 percent of U.S. health plans that utilize all seven colorectal cancer-screening strategies recommended by the United States Preventive Services Task Force. Can you tell me when the VA will come into compliance with this directive to offer all seven colorectal cancer-screening strategies for veterans?

VA Response:

The Department of Veterans Affairs (VA) recommends and provides access to evidence-based colorectal cancer screening strategies for enrolled Veterans. VA established policies that mandate providers to offer screening to Veterans aged 50-75 years and to provide timely diagnostic evaluation. Performance metrics provide feedback to clinicians. This work is accompanied by a significant investment in research to determine the best ways to screen for colorectal cancer, including a large-scale comparative effectiveness study of the fecal immunochemical test (FIT) and colonoscopy, to ultimately reduce colorectal cancer mortality. All seven United States Preventive Services Task Force recommended colorectal cancer screening strategies are recognized by VA. Clinicians are able to recommend any test that they deem appropriate for their patients.

Question 3 VHA: MASS Program: Dr. Clancy, during your testimony before the Committee on May 9th, Senator Tester shared a story and frustration of significant delays in scheduling appointments. He shared a story of it taking 10 minutes to simply sign into the system. You responded to Senator Tester that the delay was unacceptable and it reinforces the need to advance a new electronic health record (EHR) system. You additionally stated the VA needed a new scheduling system that was "much better - swifter" than is in place. I noticed in your response to Senator Tester you did not mention a current scheduling pilot project called the Medical Appointment Scheduling System (MASS) program could be deployed nationally by December 31, 2020. Please provide the status of the pilot and next steps. In addition, given that the VA EHR modernization project has been significantly delayed and a contract has not yet been signed, would you consider rolling out the MASS program to help address this pressing scheduling problem?

VA Response:

VA announced the Electronic Health Records Modernization (EHRM) Contract on May 17, 2018. In addition, VA is piloting a resource-based scheduling system (MASS) at the Columbus, OH VA Medical Center. This has been implemented, stabilized, and is under evaluation. VA is strongly considering rolling out a commercial resource-based scheduling system ahead of the full EHRM implementation. To that end, VA is gathering information from the MASS pilot and the MASS and Cerner contracting teams to inform next steps.

Question 4 VHA: Rare Cancers: Dr. Clancy, are you aware of the lack of therapeutics available for veterans diagnosed with rare cancers? If so, what action is the VA taking to ensure service members have access to the most effective cancer treatments for their service-connected cancers?

VA Response:

VA provides appropriate diagnostic testing and treatment for any cancer diagnosis, aligned with the most recent recommendations, regulations and clinical guidelines. Since rare cancers as a group are not rare in clinical practice, VA provides comprehensive care on a daily basis for Veterans with these cancer types including diagnosis and treatments (surgery, radiation, drug therapy). Remarkable progress in treatment has occurred for some rare cancers. For example, chronic myelogenous leukemia, a previously uniformly fatal disease, is now effectively treated with an oral medication resulting in more than 80 percent of patients being alive 10 years after diagnosis.

VA's National Precision Oncology Program provides molecular characterization of cancers, including rare cancers, to identify patient-specific therapies and clinical trial opportunities. VA is partnering with the National Cancer Institute and others to accelerate access to clinical trials. If VA cannot provide specialized treatment to a specific Veteran, that Veteran is appropriately referred to a treatment center that can provide the needed care, in accordance with VA policy.

Question 5 VHA: Medical Records: Dr. Clancy, on July 31, 2017 the VA Office of Inspector General released a report (No. 17-01846-316) on opioid prescribing in VA community care programs that found contract providers are not subject to many of the opioid safety reforms included in Jason's Law and implemented at VA. Furthermore, VA is not consistently tracking opioid prescriptions from community care programs due to significant information exchange gaps between VA and non-VA providers. Please provide the Committee with the updated status of all four recommendations made by the Inspector General in this report.

In response to this report, Senators Capito, Moran and Tester introduced legislation with me to close this gap and it is included in Section 131 of the MISSION Act working its way through the House as we speak. More than 1.9 million Veterans have received care through the Veterans Choice Program thus far, so Dr. Clancy, I have two questions:

Would you agree that since the VA is responsible for coordinating Veterans care, in the community and in-house, the VA's goal should be to have all medical records and prescription information for Veterans under their care?

VA Response:

We look forward to implementing this and all the provisions of the MISSION Act as passed into law in June. VA is actively working to meet all required deadlines as provided by the Act. VA continues its roll out of HealthShare Referral Manager (HSRM), which will enhance sharing of medical documentation between community care providers and VA partners, including documentation of opioid prescribing.

Question 6 VHA: With a new Electronic Health Records contract potentially years away from being deployed, what is the VA doing today to ensure that veterans medical records are shared with outside providers and the VA's own records are updated when those veterans receive care outside of the VA?

VA Response:

VA has multiple methods to send and receive medical records with community providers. These options include mail, fax, secure email, direct messaging and Health Information Exchange (HIE). If the Community Provider is part of an HIE network that VA has partnered with, VA will have access to that data real-time through HIE's supported capabilities to pull data as needed from a partner's EHR. However, if the Community Provider is not a member of a partnering HIE, a Provider may send documentation through VA's Community Provider portal, secure email, or electronic data interchange transaction, and VA will upload that documentation to Imaging and EHR viewer applications immediately upon receipt and approval of that documentation. In May 2017, VA deployed a new tool, Community Viewer, that allows community providers read only access to the VA medical record. In addition, VA has begun rolling out a portal capability that will allow for the medical records to be exchanged. The ability to attach medical records to the electronic claim submission will also be available at the beginning of FY19.

Questions from Senator Hoeven

Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Question 1 VHA: In response to North Dakota and western Minnesota Veterans concerns when scheduling appointments to receive VA community care, the VA implemented the Choice Program Care Coordination initiative at the Fargo VA Medical Center. This initiative allows Fargo VA staff to work directly with veterans and help them schedule and coordinate their community care appointments. The implementation of this initiative has significantly reduced waiting times for Veterans to have their primary care, specialty care, and mental health appointments scheduled. Recognizing its success in reducing scheduling times, the VA has extended this initiative to a VA facility in Montana. With the amount of success and impact this initiative has had on North Dakota and western Minnesota Veterans, as well as its extension into Montana, is the VA looking to further expand this initiative in other parts of the country?

VA Response:

The Choice Program Care Coordination initiative will not expand further as a separate pilot program. Instead, VA continues to improve care coordination for Veterans through implementation of multiple process and technology deployments, the development and implementation of the MISSION Act, and future award of the Community Care Network (CCN) contract.

Question 2 VHA: Since the implementation of the Veterans Choice Program, many Veterans have opted to seek care in their home communities. Many non-VA providers continue to have concerns about receiving prompt payments from third-party payers. These providers face a claims backlog, and may have long waiting times to speak with someone regarding payment issues. Congress has the potential to pass legislation that would consolidate and improve VA's community care programs. That being said, it is critical that the VA's third-party payers provide prompt and accurate payments so that these providers can better serve our Veterans. What actions has the Department taken in order to ensure that providers who are caring for our Veterans are being paid on time?

VA Response:

Since January 2018, VA has increased emphasis on working with community providers to improve timeliness of payments. VA has reached out to the top 20 providers based on billed charges. Rapid response teams are actively working reconciliation of inventory for top 20 providers, while concurrently educating providers through tailored training sessions and resolving underlying issues that lead to processing delays. VA has increased the numbers of claims processed through the use of vendors, as well as

working towards IT improvements to streamline the claims processing functions. Through this claims resolution process, VA has helped clean up providers' VA accounts receivables (AR) and curbed systemic issues that cause providers to keep claims on their AR or submit unclean claims.

VA continues to improve care coordination for Veterans through implementation of multiple process and technology deployments, the development and implementation of the MISSION Act, and future award of the Community Care Network (CCN) contract.

Question 3 VHA: As our Veteran population ages, many of our Veterans, particularly those with service connected disabilities, are seeking greater access to high quality long-term care services closer to their family and friends. While the current Veterans Choice Program offers limited authority for the VA to enter into provider agreements, it does not include skilled nursing facilities. The VA MISSION Act of 2018, which was recently reported favorably to the House of Representatives, contains language that I helped secure that would allow the VA to enter into agreements with non-VA extended care providers. Does the Department continue to support these agreements? Should this legislation be signed into law, will the Department work with me to ensure the legislation is implemented in a manner that will allow long-term care facilities, especially those located in rural areas, to serve our veterans without having to jump through unnecessary bureaucratic hoops?

VA Response:

The VA MISSION Act of 2018 has been signed by the President (Pub. L. 115-182). VA is developing regulations that will enhance access to certain long term care facilities, particularly in rural areas, and should reduce the administrative burden of these facilities.

Question 4 NCA: This year, the Department is expected to open North Dakota's first VA national cemetery, which will help to ensure that our state's Veterans receive the recognition they deserve for their service. With the groundbreaking of the cemetery occurring this spring, is the project still expected to be completed by the end of 2018?

VA Response:

Yes, construction of the Veterans cemetery in Fargo, ND is expected to be complete in the summer of 2019.

Questions for the Record
SAC MILCON/VA
FY 2019 Budget Hearing
May 9, 2018

Question 5 VHA: Congress recently provided an additional $2 billion in funding for VA infrastructure. Some of this funding will be directed toward the first 52 projects on the FY 2018 State Home Construction Grants Priority List. The VA State Home located in Lisbon, ND recently completed a renovation that will help them better serve our veterans. The project was ranked 42nd (31st in funding order) on Priority List Group 1. What is the expected timeline for this particular project to be reimbursed?

VA Response:

The North Dakota renovation project was awarded August 21, 2018. The Memorandum of Agreement has been mailed to the State. The reimbursement account takes 7-10 business days to set up and the state can request a reimbursement any time after the account has been established. After a reimbursement request has been made and approved by VHA staff, it takes about 5-7 business days for the funds transfer to be completed.

Questions from Senator Rubio

Question 1 VHA: I'm encouraged to learn about the work being done to open cancer clinical trials at neighboring VA facilities. In these partnerships, faculty from National Cancer Institute (NCI)-designated Comprehensive Cancer Centers engage with VA medical staff to offer clinical trials inside the VA to veterans battling cancer. With access to clinical trials, veterans can benefit from cutting-edge new technologies in cancer care without leaving the VA. These partnerships enable our veterans to receive more effective personalized cancer care, such as those offered at NCI sponsored facilities. It also enables VA physicians to work alongside the top oncologists at NCI-designated cancer centers.

- Besides the "Navigate" program, in which the National Cancer Institute provides funding for certain clinical trials at a handful of VA facilities, how is the VA making investments to build the necessary infrastructure to facilitate partnerships like this, which enhance the options available to veterans as well as their chances of defeating cancer?

VA Response:

To clarify, NAVIGATE does not provide funding for specific NCI clinical trials to VA facilities. VA facilities may participate in NCI trials without having received funding from NAVIGATE. In fact, there are VA facilities that continue to participate in NCI trials even though they were not selected for funding under the NAVIGATE program. VA has

supported activities to enhance site capabilities and best practices for conducting clinical trials through its Cooperative Studies Program's Network of Dedicated Enrollment Sites. Additionally, VA has been partnering with stakeholders including its VA affiliated non-profit corporations, industry and patient advocacy organizations to facilitate the ability to conduct industry-sponsored trials, including ones related to cancer. While participation in non-VA funded activities is often a local decision at the particular VA facility, VA is working with various groups at the national level to enhance its capabilities for innovating and adopting best practices as part of the national clinical trials enterprise.