

**Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Oversight Hearing**

September 26, 2018

Questions for the Record from Senator Tester

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

VA Response: The Veterans Health Administration (VHA) is responsible for 14 of the 26 High Priority recommendations; 2 are closed, 4 are pending a closure decision from the Government Accountability Office (GAO), 5 have target completion dates within the next 60 days, 3 have target completion dates in the future and are on track for completion.

Question 1b: Since GAO wrote to you in April, VA has only implemented 3 of GAO's 26 priority recommendations. These are just the priority recommendations. VA also has about 100 other open GAO recommendations that remain unaddressed. GAO tells me that VA has yet to submit a satisfactory action plan to address its high risk status in the almost 4 years that have passed since GAO put them on the list. What specific progress has been made during your tenure as Secretary?

VA Response:

- VA Actions on GAO's high risk listing titled "Managing Risks and Improving Veterans Health Care":
 - **FY 2015:** Established VA's GAO High Risk List (HRL) Area Task Force (Task Force) and provided GAO with an initial Strategy for Health Care High Risk Management that linked actions to the MyVA Initiative. Conducted listening sessions to gain field insights and potential solutions. GAO found this information interesting but not sufficient for an action plan.
 - **FY 2016:** Conducted root cause analyses for each of the five areas of concern and enterprise root causes. GAO found the root cause analyses acceptable and a good start to an action plan.
 - **FY 2017:** Work groups developed action plans for each of the five risk areas, and continued work to resolve the risk areas.
 - **FY 2018:** Work groups completed action plans and presented them to GAO on March 15, 2018. GAO considered the action plan to be a good start, and requested more clarification on metrics, and integration with modernization efforts.
 - **FY 2019:** VHA merged GAO high risk work with its Management Review Service to leverage strong liaison functions with GAO, improve communications, and build routine operations into management of the GAO HRL. VHA partnered with the

Office of Strategic Integration to apply robust project management discipline to all GAO HRL projects. VHA partnered with the National Center for Organizational Development to apply robust change management to GAO High Risk List. VHA partnered with Office of Enterprise Integration to incorporate modernization efforts into the GAO High risk plan.

- Status of Open GAO recommendations to VHA:
 - At the close of Fiscal Year (FY) 2018, VHA has 113 open GAO recommendations; 61 are new recommendations made in FY 2018; 47 were closed this fiscal year. VHA has completed work on 26 recommendations and awaits GAO's decision regarding closure.
 - Over the past 3 years, GAO averaged 50 new recommendations per year and averaged 51 closures per year – essentially no net decrease in recommendations despite constant actions toward completing actions.

Question 2: At your confirmation hearing, you affirmed the statutory independence of the Inspector General, after Acting VA leadership claimed that the IG is the Secretary's subordinate. It's essential that all VA employees know that you will continue to support and uphold this independence. It's also critical for veterans and taxpayers to know that an independent body exists to conduct oversight and help improve VA. Can you tell the Committee what you have done since taking the job to help reinforce and uphold the IG's independence?

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

Question 3: The Committee continues to receive concerns from whistleblowers and other employees about the implementation of the Accountability Act. Do you find it appropriate that facilities are investigating whistleblower complaints against themselves? Do you believe this can be done fairly? Do you believe that whistleblowers should have access to the findings of the reports and investigations conducted into their inquiries? What are the timelines given to OAWP, or by OAWP to administrations, within which they need to conduct investigations into reports of whistleblowers?

VA Response: The Department has developed a robust system of checks and balances related to the receipt, review, and reporting regarding whistleblower disclosures. The process ensures each disclosure is investigated thoroughly, timely, and impartially. The Office of

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

The definition of "whistleblower disclosure" is found in *38 U.S.C. §323(c)(1)(G)(3)*:
The term 'whistleblower disclosure' means any disclosure of information by an employee of the Department or individual applying to become an employee of the Department which the employee or individual reasonably believes evidences—

- (A) a violation of a law, rule, or regulation; or
- (B) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

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

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

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

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

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

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

Once the completed report is submitted by the Administration or Staff Office to the OAWP Case Manager who reviews the report for technical adequacy based on the instruction memo and reasonableness of the response. If the Case Manager accepts the report, it is reviewed by the Case Manager's supervisor for concurrence and, if satisfactory, the disclosure is closed. A closure notice is provided to the disclosing party. The notice explains that the disclosure was investigated and is now closed. If the disclosing party has further questions, the closure notice directs them to the Administration or Staff Office point-of-contact. If a disclosing party seeks a copy of any of the investigatory materials or report, they are referred to the appropriate Freedom of Information Act Office.

Question 4: Please provide the committee with the PowerPoint Slide deck titled, "Next Steps for Agent Orange Benefits, including Navy Veterans in Territorial Water", which was produced by VBA on November 24, 2017.

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

Questions for the Record from Senator Moran

Question 1: There's been much discussion about the poor implementation of the Choice program in terms of delays in scheduling, lack of robust provider network, and inability for participating community providers to get paid. In the midst of this bad news, I want to recognize and applaud VA's direct contracts with dialysis providers. This is a good example of VA's successful engagement of dialysis providers where Veterans receive high quality, timely dialysis care and 23 dialysis vendors are paid in a timely manner to provide a robust dialysis provider network with coast-to-coast coverage.

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

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

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

Questions for the Record from Senator Heller

Question 1: Secretary Wilkie—during your confirmation, we talked about getting a full-time doctor in a clinic in Pahrump. It was a great day two years ago to be there for the opening of this clinic—but we need to make sure it has the staff the veterans need. Can you provide a status update on getting a full-time doctor out to the Pahrump clinic?

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

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

- a. One full-time Nurse Practitioner (Monday through Friday);
- b. One full-time Physician Assistant (Monday through Friday);
- c. VA Southern Nevada Healthcare System Primary Care has collaborated with San Francisco's V-IMPACT program to provide one full-time physician via Telehealth, which started September 4, 2018. This program also provides an additional one week of face-to-face physician coverage each quarter; and
- d. If San Francisco is unable to see patients due to illness we have back up available via telehealth.

Question 2: Secretary Wilkie—As part of the VA MISSION Act, I secured a provision that requires the VA to implement a pilot program for the use of medical scribes. I believe Las Vegas would be a great location for this pilot program given we have a busy Emergency Department where scribes could be very helpful. Do you have a

status update on when that pilot program will be implemented? Can you provide a timeline for implementation?

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

Questions for the Record from Senator Murray

Question 1: HUD-VASH: Data from the Department of Housing and Urban Development showed that there was an increase in veteran homelessness in 2017, and a significant increase in my home state of Washington. Secretary Shulkin stated before the Committee that VA will be implementing a new plan to address this issue in Seattle. Please provide a full description of what additional resources have been made available, any proposed programmatic changes, and a timeline for implementation.

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

- New HUD-VA Supportive Housing (HUD-VASH) voucher allocations to increase permanent supportive housing resources:
 - FY 2017 award: 362 to Puget Sound (150 to Seattle/King County).
 - FY 2018 award (Round 1): 134 to Puget Sound (69 to Seattle/King County).
 - FY 2018 award (Round 2) not yet announced but expected to be: 54 to Puget Sound (44 to Seattle/King County).
- New lease signed for expanded, centrally-located Community Resource and Referral Center in Seattle (anticipated opening Spring 2019), to enhance homeless Veteran access to services.
- Two new Grant Per Diem (GPD) programs (Orting State Soldier's Home: 40 beds; expansion of Salvation Army William Booth Center by 14 beds).
- Expansion of Health Care for Homeless Veterans (HCHV) Contract beds (Seattle/King County) from 20 to 30 beds (Sept. 2018).
- Supportive Services for Veteran Families (SSVF) Rapid Resolution/Diversion Pilot (Seattle/King County).
- Continued, innovative collaboration with non-profit, local governmental, and Continuum of Care (CoC) partners to streamline services for homeless Veterans

across the region, including King County to ensure a targeted utilization of King County Senior, Veterans, and Human Services Levy (VSHSL) funds to complement services provided through VA and fill identified gaps in care.

- Close collaboration with all CoCs to create and maintain “By Name” or “Master Lists” of homeless Veterans across our region to better ensure that resources are optimally targeted based on need and availability.
- To help fill vacant case manager positions, VA assigned staff from VA Central Office Workforce Management and Consulting to assist in recruitment efforts, reducing the lag time associated with filling vacant positions.
- In terms of timeline for implementation, unless otherwise indicated, all resources and technical assistance listed above are ongoing.
- These efforts resulted in a 31-percent reduction in Veteran homelessness as identified by the 2018 PIT Count. This result provides concrete evidence of the effectiveness of the resources and technical assistance listed above.

Question 2a: Unfilled case manager positions and un-used vouchers throughout Washington state continue to hamper efforts to help veterans. From discussions with local staff in the VA, housing authorities, and non-profit providers, it seems that the hiring process remains tedious and inefficient. Also, HUD and VA tracking systems are not able to communicate with one another, slowing down the rapid-rehousing process and potentially resulting in some veterans falling through the cracks. What will you do to ensure a streamlined hiring process and the filling of critical case manager positions?

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

Question 2b: What will you do to ensure HUD and VA are able to coordinate more effectively?

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

Over the past 2 years, VA has also taken many steps to enhance the ability to share data across HUD and VA systems at the local level. These steps include but are not limited to the following:

- VA adopted HUD’s Universal Data Elements into its data collection system and matching data elements related to housing outcomes wherever possible
- VA established a process by which staff may share protected health information across VA and HUD systems through an encrypted email system which complies with all privacy and security requirements.

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

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

Question 2c: What is the long-term VA plan to get ahead of increasing rates of veterans experiencing homelessness in areas with fast increasing populations?

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

Question 2d: Please provide a national by-facility breakdown of:

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

VA Response: Please see the enclosed excel spreadsheet and the responses below:

VA Response i: Tab 1 (VA Staff) column D of the enclosure shows the total number of case manager positions in HUD-VASH.

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

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

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

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

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

Question 3: **Yakima CBOC - The Yakima CBOC funds were allocated in 2016. After a delay on construction due to a contested bid, we do not have a current estimate for date of construction beyond a vague assertion of 18 months to two years. Please provide a more detailed account of projected construction timeline.**

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

Question 4: **Bremerton CBOC - The Bremerton CBOC was slated to be updated nine years ago. A month ago the notice to proceed was finally obtained and construction has begun on a new facility in neighboring Silverdale. The timeline for construction is now 18 months. Since the authorization of funding, the needs of the community have changed and the slated construction of a site that can serve 7,200 veterans will not meet the needs of the area given the rate of growth in the veteran population, the number of beds being added to the new facility, and the expected return of veterans who have gone to the Choice program due to backups at the current facility.**

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

VA Response 4a: The lease was awarded on July 7, 2017, and in August 2018, VA issued the lessor a Notice to Proceed with construction per VA-approved clinic design. The lessor is currently scheduled to complete construction of the building by October 2019.

VA Response 4b: Currently, Market Assessments are being planned for all facilities nationwide. A contract was let to accomplish this starting this fiscal year. These assessments will analyze both in-house workload and complete a comprehensive review of community capacity and needs.

VA Response 4c: Newly-approved CBOC leases in Auburn and Olympia, Washington are similarly sized at approximately 25,272 and 25,179 net usable square feet respectively. Both sites intend to provide Patient-Aligned Care Team (PACT) Primary Care, Primary Care Mental Health Integration (PCMHI), and Specialty Mental Health services, along with basic laboratory and diagnostic imaging services. Differences in programming space can occur based on the number of staff, number of rooms, or the size of a room.

VA Response 4d: The current Bremerton CBOC has four designated Women's Health (WH) Providers. Two of them have been WH providers since 2016. The most recent ones have been on station since August 2017. The New Silverdale CBOC has space designated for WH.

Question 5: Tonasket Rural Medical Clinic - As of May 2017, the VA intended to close the Tonasket Rural Health Clinic, located within the North Valley Hospital, and roughly a year ago they did. More than 850 veterans relied on that clinic to receive care from the VA. Without the clinic, they are forced to travel either two hours each way to Wenatchee, or three hours each way to the Mann-Grandstaff VA Medical Center (MGVAMC) in Spokane. The medical center has been unable to provide an accurate picture of the status of the replacement clinic and previously told my office an award was expected in February 2018. As of last week, medical center had no update or information on this extended delay due to a lack of transparency in contracting.

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

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

Question 6: Puget Sound VA - During his confirmation hearing in 2017, Secretary Shulkin committed to following up on concerns I raised about the condition of the VA Puget Sound Health Care System and obstacles Washington veterans faced in accessing care. The problem then seemed to stem from unfilled management positions and frequent turnover in leadership. A management improvement team was sent to the facility, and measures have been taken to ensure physician and nurse positions are filled, but many problems persist. The problems again seem to center on unfilled rolls and overburdened existing staff. I am very concerned with low levels of support staffing

overall, specifically in the maintenance and human resources departments and the effects this understaffing is having on patient care.

- I ask that you investigate these issues and take action expeditiously to resolve these problems. In particular, if additional staff or resources are necessary for patient care or for human resources in order to expedite hiring of providers, I ask that you take all necessary actions to meet those needs, including temporarily detailing staff to the facility.
- I also ask that you undertake a review of the long-term feasibility of hiring in this region. With increasing costs of living and significant competition for employees among hospitals in the Seattle area, VA will have to be sure it can recruit and retain the top talent. Please describe whether and how VA can keep pace with the market and any additional authorities that are necessary.

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

- Please investigate these concerns and take appropriate corrective action.

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

- Utilization of Recruitment and Retention flexibilities (recruitment, relocation, and retention incentives, student loan repayment, education debt reduction, accelerated leave accrual) for hard-to-fill occupations for the facility, including human resources.
- Pay authorities such as above-minimum entry and highest previous rate are also applied, as appropriate, to assist in achieving and offering salaries commensurate with an applicant's qualifications and/or in recognition of prior Federal service.
- Telework options have been leveraged in an effort to recruit and retain HR staff while maintaining a customer service focus to support medical center operational needs.
- In January 2018, the Office of Personnel Management (OPM) authorized direct hire authority to VA for 15 critical occupations to include HR Specialists and HR Assistants, which we are actively using as a flexibility to hire.

- HR consolidation to the Veterans Integrated Service Network (VISN) is actively moving forward to create a more efficient, effective, and standardized means to deliver HR services in VHA.
- Adjusted salary rates or new special salary rates established for numerous occupations to create more competitive wages. VISN 20's compensation team has been providing assistance in this area and will continue to support the facilities, including Puget Sound.
- Utilizing non-competitive hiring authorities available to fill positions, appropriately, with qualified quality candidates (trainees, VRA, schedule A, 30 percent+ Veterans)
- Policy changes are creating greater efficiencies and flexibilities (i.e., physician market pay review, title 38 hybrid conversions, elimination of professional standards boards, etc.)

Continued Barriers/Challenges:

- OPM issued General Schedule (GS) rates of pay for the Seattle-Tacoma area is low compared to other areas of the country and cost of living. Although special salary rates are being utilized as appropriate, it should not be the norm and is reflective of the disparity between salaries in the market area. Minimum wage for the Seattle area is \$15.00 per hour which is slightly below the GS-4, Step 1 on the Seattle-Tacoma locality scale. This per hour rate is above that of a GS-3 for our area, a grade that we utilize and hire. The greater Seattle area was minimally affected by the economic downturn and for the last decade has been a major hub for growth in both technology and health care. This has further exacerbated a tight construction labor market due to the corresponding boom in construction increasing the difficult to hire trades and engineers.
- VA Puget Sound, Seattle campus, is in a prime location and property with a high-growth rate and cost of living. Competition is not only with private sector hospitals but also with other Federal agencies, as the area is saturated with other agencies.
- Available flexibilities are not available to recruit and retain personnel at VA, if they are existing Federal employees or taking an opportunity with another agency. There is also limited funding for education reimbursement.
- Length of job posting - 15 business days as negotiated by the union is often too long to leave a position open if you have a viable pool of applicants.
- Professional Standards Boarding timeliness presents a delay with some title 38 and title 38-hybrid occupations, with emphasis on those at a regional or national level.
- Required use of multiple systems for same or similar purposes that do not talk to each other causing additional administrative work for the HR team and users.
- Downgrading of positions such as HR Specialists, Engineers, Radiation Safety Officer, Credentialing Assistants, Administrative Officers of the Day (AOD), and other occupations.

- While there have been positive regulatory and policy changes occurring to support a more effective and efficient hiring process, it frequently increases the workload required of the local HR team members to enact.
 - Impact of OPM classification requirements and standards on grading of positions is not conducive to VA being competitive.
- **I have also received troubling reports about insufficient staffing and operations in the emergency department.**
 - **Please provide an update on staffing levels and vacancies, by position type, and describe any barriers to achieving full staffing and retaining ED staff.**

VA Response: As of September 26, 2018, there are 570.7 approved, budgeted vacancies for VA Puget Sound HCS. Of these, there are 185 selections to fill positions ranging from administrative support to direct patient care, 40 percent of these selectees have a firm Entry on Duty between October – December while the others pending are undergoing the pre-employment process.

The ED currently has the following vacancies:

- 4 Physicians
 - 1 Physician Assistant
 - 1 Advanced Registered Nurse Practitioner
 - 6 Registered Nurses
 - 6 Nursing Assistants
 - 2 Medical Support Assistants
- **Please describe wait times at the ED over the year to date, and any instances of bed shortages. What impacts are projected as flu season begins, and what mitigation steps are being taken?**

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

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

Risk mitigation steps include:

- We have hired additional staff in the Emergency Department, with approved and

budgeted additional increases in process.

- We have hired additional staff in the inpatient medical units, with approved and budgeted additional increases in process.
- We have a contract with a nurse staffing agency for short-term nurse staffing increases.
- We have improved processes around timely discharges to increase available isolation beds for patients with influenza.
- We have designed a process for continual and proactive assessment of bed availability that raises awareness and shares resources across units at times of high hospital census.
- We have met with local area hospitals (Madigan Army Medical Center) to improve collaboration around patient transfer at times of high hospital census.
- We have coordinated a robust staff influenza vaccination campaign.

Question 6: IVF - It has been two years since Congress gave VA the authority to provide IVF and other necessary fertility treatments for ill or injured veterans and their spouses. These treatments can help veterans realize their dream of starting a family, but access to this care promised to our veterans is still limited. We should not cut corners when it comes to our veterans and their families. Consistent and nationwide access to this program is essential to meet the commitments we have made, and the dreams for which these veterans fought so hard.

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

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

Question 7: Electronic Health Records - According to the reports from this spring, the Defense Department's \$4.3 billion Cerner medical record system failed to achieve many of its initial goals at the first hospitals that went online and transition systems seamlessly. Technical problems and poor training resulted in numerous errors and reduced the number of patients who can be treated, according to interviews with more than 25 military and VA health IT specialists and doctors, including six who work at the four Pacific Northwest military medical facilities that rolled out the software over the last year. Recently, DoD has added a \$1.1 billion contract to extend Leidos' work order to include EHR standardization since the VA had hired Cerner as its prime contractor. This is in addition to the original \$4.3 billion Leidos- Cerner contract. A recent briefing to Congressional staff by VA Puget Sound cited Madigan Army Medical Center experiencing a 50 percent drop in clinician productivity during the transition. Clearly, already overburdened VA hospitals cannot afford to see this same effect.

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

VA Response: To mitigate possible impacts to the deployment of VA's new Electronic Health Record (EHR) in VA hospitals, VA is leveraging DoD's lessons learned from their Initial Operating Capability (IOC) sites. Several examples of efficiencies VA is leveraging include revised contract language to improve trouble ticket resolution based on DoD challenges; optimal VA EHR Modernization governance structure; fully resourced Program Management Office with highly-qualified clinical and technical oversight expertise; effective change management strategy; and utilizing Cerner Corporation as a developer and integrator consistent with commercial best practices.

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

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

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

Hearing Deliverables 1:

Senator Murray. And I need to get this done.

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

inappropriate influence over the VA.

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

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

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

I agree with you about outside influences.

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

Senator Murray. Right. I know.

Secretary Wilkie. And I am committed to making sure that I am the sole person responsible to you.

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

Secretary Wilkie. Not that--

Senator Murray. Have you met with them?

Secretary Wilkie. Not that I know of.

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

Senator Murray. Okay. So the question is, Can you assure this Committee that there will be no inappropriate interference?

Secretary Wilkie. Absolutely.

Senator Murray. Okay. That is important to all of us.

And if you can response to my letter--

Secretary Wilkie. Yes.

Senator Murray. --I am looking to the data and records on that as well.

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

Hearing Deliverables 2:

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

We have seen the VA now try to divert funding away from homeless programs. Program providers actually in my home State are losing funding, and despite some of the VA's promises to help target Seattle by surging resources to the

area, we are not seeing that come through on the ground.

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

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

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

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

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

Senator Murray. Okay. Can you get back to me on that?
Secretary Wilkie. Yeah.

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

Questions for the Record from Senator Sanders

Question 1: Mr. Secretary, as you stated in your testimony provided ahead of the hearing, one of your priorities is to address the 45,000 vacancies at the VA. One of the ways I proposed to address this issue was to increase the maximum amount the VA will provide to participants in the Education Debt Reduction Program, a measure I was proud to have included in the VA MISSION Act. Can you expand upon the measures you mentioned in your testimony on how you and your staff are addressing this crisis, and how you hope to recruit and retain the best candidates to these positions?

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

Question 2: Mr. Secretary, I'm sure you know that today, veterans with no service connected disabilities who have higher incomes are not able to get care from the VA. My office gets calls from Vermont veterans who know they don't qualify for VA health care, but want to get their care there. Many have even suggested that they'd be willing to pay to access VA health care. I think this idea makes a lot of sense. Do you think that all veterans – regardless of income – should be able to choose VA if they want?

Are you willing to work with me on figuring out what it would take to give these veterans the choice of VA health care?

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

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

Question 2: Mr. Secretary, I know we've had a lot of conversations around choice and privatization. VA remaining strong is central to the whole idea of "choice" – that veterans should have the choice of where they go for care because VA must be one of the choices given to the veteran. I am worried, however, that right now – even with the changes from the MISSION Act – the VA is set up to fail as an organization, and fail our veterans, because of the current bureaucracy we've set up. Let me walk you through what I mean by that.

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

veteran but knowing it will mess up their numbers, or doing the wrong thing for the veteran but what looks better administratively for them.

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

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

Question 4: Mr. Secretary, last month VA testified on my legislation to expand access to dental care for veterans. I want to thank you for supporting the idea of expanding access to veterans for dental care. I'm glad this is something the VA supports. Now, I understand you're worried about the cost. First, this committee doesn't get to make the decisions about how much money the VA gets – that is the job of the appropriations committee. But let me promise you that I will do everything I can to make sure the VA gets the money needed to accomplish any expansion that this committee approves. And I hope we can work together on that. Will you work with me on that?

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

financial impact in both the short term and long term, and we would be happy to discuss any such options with you.

Question 5: Mr. Secretary, to my mind, VA is already spending this money on dental care – it’s just that you’re spending it on the back end, when costly health care problems have already occurred rather than on the front end, preventing these problems in the first place. Let me give you some data, which you might find helpful. UnitedHealthCare – a private insurance company, which you probably won’t hear me cite very often – did a study where they found that – and I quote: “individuals with chronic conditions who regularly received recommended dental care...had medical claims that averaged nearly \$1,500 lower annually than those with chronic conditions who received....no dental care at all.” Given the especially high rates of veterans with chronic conditions, I think it’s reasonable to assume this same cost savings of \$1,500 per person would easily translate to the veteran population. That is to say, by providing dental care to veterans, we’d actually have the opportunity to save money, not spend more. So, Mr. Secretary – can you tell me that if we can show that providing dental care wouldn’t actually cost the VA more money, that you’d support it?

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

Question 6: Mr. Secretary, I have always believed that the cost of war must also include taking care of our veterans when they return home. To my mind, this includes providing benefits to those who may have been exposed to dangerous chemicals in service to our country, such as Agent Orange. While the VA provides benefits to these veterans, the burden of proof is much higher for those who served in Vietnam’s territorial waters compared to their counterparts who served on the ground. I have heard from many Vermonters that this increased burden of proof has negatively impacted their ability to receive the care they need. Mr. Secretary, will you work with me and the overwhelming majority of Congress who want to create a more lenient burden of proof for our Blue Water Navy veterans, and ensure they receive the care they need due to their service?

VA Response: VA stands ready to work with Congress to ensure the equitable administration of disability compensation for all Veterans including Blue Water Navy Veterans. VA’s current regulatory definition of service in Vietnam excludes service in the offshore waters of Vietnam unless the conditions of service involved duty or visitation in the Republic of Vietnam. This is

because there is no valid scientific evidence showing that individuals who served in the offshore waters were subjected to the same risk of Agent Orange exposure as those who served on land in Vietnam. However, VA has developed procedures for Veterans who served in the offshore waters to ensure that each case is reviewed individually on a facts-found basis. This procedure allows adjudicators to grant benefits for presumptive service-connected conditions when the evidence demonstrates that a ship operating in the offshore waters:

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

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

Question 7: Mr. Secretary, as you know, the White River Junction VA Medical Center has been without a permanent director for some time now. Now that we have a new VISN 1 Director, will you commit to working with me and Mr. Lily to quickly fill the White River Junction director role with someone who will be there for the foreseeable future?

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

Questions for the Record from Senator Brown

Question 1: Agent Orange - Your letter to the Committee neglects to mention several sections of the "Blue Water Navy Vietnam Veterans and Agent Orange" report issued by IOM in 2011, which corroborates the Australian report finding "that in experiments simulating the water-distillation systems used on Navy Ships the systems had the potential to enrich TCDD concentrations." You also ignore IOM's Veterans and Agent Orange 2008 Update, published in 2009 that states, "a presumption of exposure of military personnel serving on those vessels is not unreasonable." The effort to cherry-pick details from the report undercuts your opposition to extending presumption of service connection to Blue Water Navy veterans. Does the Department dispute the science behind the IOM and Australian studies related to distillation? Why does VA refuse to act when IOM presents the Department with scientific evidence linking health conditions, such as bladder cancer, Parkinson's like conditions, etc. to herbicide exposure, as was clear in the 2016 release report?

VA Response: VA recognizes this is a complex exposure issue that is important to our Veterans, and we have been working diligently over the years to gain as much understanding as possible and to recommend policies that are facts-based. Senator Brown has noted that he finds both the Australian study (Muller et al., 2002) and the Veteran's testimony to be strong evidence in support of concluding that Blue Water Navy Veterans were exposed to Agent Orange and other tactical herbicides during the Vietnam War. However, the statements and conclusions made in both of these, in terms of the consumption of water distilled aboard ships while at sea, are contingent upon the assumption and requirement that tactical herbicides and the contaminant tetrachlorodibenzoparadioxin (TCDD) were present in the water. VA's understanding of the science related to that issue, including the policies regarding the spray missions, the properties of the herbicides, the environmental fate of the herbicide components and the expected behavior of the components in bodies of water off the coast of Vietnam, is that it is unlikely that this was a significant pathway of exposure to tactical herbicides for most Blue Water Navy Veterans.

Researchers in Australia demonstrated it may have been possible to concentrate dioxin during the distillation of contaminated water, based on laboratory recreations of the major aspects of the distillation systems used aboard most ships during the Vietnam War. The theoretical nature of this series of experiments and differences in U.S. and Australian Naval policies at the time, however, restrict the extrapolation of these findings in terms of representing the experience of U.S. Navy Veterans who served on the offshore waters of Vietnam.

The authors attempted to determine this by recreating the major principles of the distillation system in a laboratory setting and assessing the potential for the co-distillation of several chemicals. It is important to note that most of the variables in the experiments, including the concentrations of chemicals, were not chosen to directly mirror the conditions in the offshore waters of Vietnam but rather to evaluate the effects of the physico-chemical properties of water and different types of compounds on distillation in this type of system. Thus, it was not meant to model the exposure scenario in Vietnam but rather, the type of distillation system aboard the ships that were used. Based on the findings of the study, the authors concluded that "the distillation process of water contaminated with TCDD would result in contamination of potable water. Subsequent ingestion by sailors on board ships (as well as soldiers and airmen, who were passengers) is thus a vector for exposure to these chemicals. While it is unlikely that accurate exposure of the personnel on board ships can be estimated, the study findings suggest that the personnel on board ships were exposed to biologically-significant quantities of dioxins." This conclusion may be appropriate for the Royal Australian Navy members who served during the war, as their protocol at that time was to draw water for drinking from turbid, estuarine type waters (or those closer to shore), which would include higher levels of salt, suspended particles, and potentially, contaminants from herbicide spray drift, while reserving the drawing of more pristine waters that were several miles off shore exclusively for their steam engines. The U.S. Navy protocol, however, was starkly different during that conflict. Per Section 2.4.2 of the Naval Ships' Technical Manual (NAVMED P-5010-6; Department of the Navy, 1990), which is titled "Polluted Water," states that "unless determined otherwise, water in harbors, rivers, inlets, bays, landlocked waters, and the open sea within 12 miles of the entrance to these waterways, shall be considered to be polluted. The desalting of polluted harbor water or seawater for human consumption shall be avoided except in emergencies."

Therefore, U.S. Navy ships that served only on the offshore waters several (at least 12) miles off the coast of Vietnam were not likely to have drawn contaminated water for drinking.

2011 Institute of Medicine (IOM) Report

At VA's request, IOM reviewed the evidence on this topic and issued a report in 2011. In this comprehensive review, the committee detailed several factors that would affect the potential for TCDD-contaminated water to reach U.S. ships that were several miles offshore, including the following:

- It has been estimated that 87 percent of the Agent Orange sprayed reached the forest canopy, while only 13 percent was lost to drift, and of the 13 percent, an appreciable amount was likely degraded due to the Vietnamese environment.
- Agent Orange and TCDD would have entered waterways via riverbank spraying or runoff; however, a considerable fraction would absorb in organic materials that would be deposited in the delta regions or estuaries.
- Agent Orange and TCDD would have entered marine water from river discharge and spray drift; however, any amount in marine waters would be greatly reduced by the initial dilution in river water and dispersion in air and further dilution in coastal waters.

The committee also reviewed the Australian study and considered another theoretical model that appeared to support its findings on the potential to concentrate TCDD through the distillation process. The committee concluded that "it is theoretically possible to concentrate dioxin in distilled water, at least experimentally." While the committee noted that, based on the available science, "if Agent Orange-associated TCDD was present in the marine water that U.S. ships drew for drinking water, distilled potable water would be a plausible pathway of exposure," they ultimately concluded that "without information on the TCDD concentrations in the marine feed water, it is impossible to determine whether Blue Water Navy personnel were exposed to Agent Orange-associated TCDD via ingestion, dermal contact, or inhalation of potable water." Additionally, regarding the Australian study, the committee stated the following: "If the purpose of this experiment was to demonstrate the plausibility of TCDD exposure to sailors via distilled water, then this study is useful; however, the application of these findings to actual shipboard distillation systems requires knowledge of several factors not addressed in the experiment. The significance of this study's findings for contaminant exposures on Blue Water Navy ships is highly uncertain." Therefore, IOM did not corroborate the Australian study in terms of its applicability to U.S. Navy Veterans that served during the Vietnam War but they noted that the study findings do support that the concentration of TCDD during distillation aboard ships is theoretically plausible.

Current VA Study that may Provide Additional Scientific Evidence on Blue Water Navy

VA recently conducted a survey study on the health of Vietnam-era Veterans that included an "over-sampling" of Blue Water Navy Veterans as a subpopulation. The study will compare the health of this group to that of Vietnam Veterans, Vietnam-era Veterans, and the general U.S. population. In the absence of adequate exposure data, we hope to gain an understanding of the health of Blue Water Navy Veterans and may be able to make some determinations about whether outcomes they are experiencing could be related to exposure

to tactical herbicides during their service. The results are currently being analyzed and are slated to be published as early as 2019.

Question 2: What is the timeline for VA and OMB to act on the IOM recommendation regarding bladder cancer, Hypothyroidism, Parkinson's-like conditions, and hypertension?

VA Response: The National Academy of Medicine (NAM) issued a contracted Veterans and Agent Orange report in March 2016. VA organized work groups and deliberated, as it had under the Agent Orange Act. The workgroups made recommendations to then-Secretary Shulkin. Former Secretary Shulkin informally consulted with OMB/Office of Information and Regulatory Affairs (OIRA) concerning possible issuance of new presumptions under his general rulemaking authority, 38 U.S.C. § 501(a)(1), based on the NAM report and other evidence of association analyzed by VA scientists. Based on its own review of the scientific evidence and after consideration of the budgetary implications, OMB/OIRA deferred their review/concurrence of Secretary Shulkin's regulatory proposals.

Secretary Wilkie is currently reviewing the recommendations made to Secretary Shulkin; the proposal Secretary Shulkin sent to OMB/OIRA; and the OMB/OIRA response to Secretary Shulkin's proposal.

Question 3: Electronic Health Record - Please discuss how patient information will be housed under the new Electronic Health Record between DoD and VA? How will VA ensure that patient data is shared between community providers and VA? How will you ensure that the data is protected against cyber intrusion? Do you think that you have the appropriate team in place to implement the Cerner contract? Will you commit to keeping the Committee informed about the implementation of the contract?

VA Response to 3a: Patient information for DoD and VA will be physically housed at the Cerner Federal Hosted Enclave, which is comprised of two facilities. One facility serves as the failover and continuity of operations (COOP) back-up for the other. Data is encrypted at rest and in transit before it leaves the facility. Connectivity between the two facilities is achieved via redundant, high-speed networks.

VA Response to 3b: VA's new EHR will have the capability to connect and securely exchange patient data with community care providers, specifically, but not limited to, CommonWell Health Alliance and DirectTrust by supporting their specifications, security, and content specifications. Once VA EHR is deployed, the solution will participate in a Health Information Network (HIN) or Qualified Health Information Network (QHIN) that has agreed to the terms of the Trusted Exchange Framework and Common Agreement (TEFCA). Participation is defined as being in production with HIN or QHIN, under a participation agreement that aligns with the TEFCA.

VA Response to 3c: VA will deploy DoD-authorized security boundary protections using a combination of Cybersecurity Service Provider (CSSP) services and joint Department cybersecurity operations centers (CSOC) visibility and incident response capabilities. The joint electronic health record (EHR) system is stored within the DoD-authorized enclave (MHS

GENESIS) hosted at Cerner Corporation. MHS GENESIS risk management and continuous monitoring activities are supported through the Defense Health Agency (DHA), DoD Health Management System Modernization (DHMSM) Program Management Office (PMO), and Office of Electronic Healthcare Record Modernization (OEHRM) unified interagency cybersecurity programs.

VA Response to 3d: Yes, VA understands the importance of transparency and will continue to keep Congress informed about the Department's new EHR rollout.

Question 4: Office of Inspector General - Several members of the Committee have voiced concerns regarding the independence of the Office of the Inspector General; in fact, we approved an amendment to affirm the role of the Inspector General and to preclude VA from impeding in any IOG investigation. Since your confirmation, have you met with IG Missal? Have you reaffirmed VA's commitment to providing OIG with any and all documentation the office requests for investigations?

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

Question 5: Personnel - Currently there the Deputy Secretary and Under Secretary of Health Affairs positions are filled with someone in an acting capacity. How are you working with the Administration to find individuals to fill these senior leadership positions?

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

Secretary. The Secretary will then forward the recommendations to the President with appropriate comments for the President's consideration.

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

Question 6: Patient Safety - Does VA leadership review OIG reports related to patient safety with adverse outcomes? And if leadership does review these reports, are the recommendations and findings applied throughout the entire VA healthcare system?

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

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

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

Question 7: VA MISSION Act - As VA begins to implement the VA MISSION Act, can you discuss what metrics you will use to ensure care that veterans receive in the community is the same standard and timely? What metrics will you use to track whether community providers are trained in veteran specific conditions?

VA Response: VHA's Employee Education System (EES) currently tracks community provider completion of opioid training through TRAIN, which is the external system that houses community provider training. As additional community provider training courses become available (including traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), and Military Sexual Trauma (MST), as mandated by the MISSION Act) the courses will be uploaded into TRAIN and course completion will be cross-referenced with the list of community providers for tracking and reporting.

Questions for the Record from Senator Hirono

Question 1: VA Under Secretary for Health Vacancy - President Trump has yet to nominate someone for the important role of Under Secretary for Health. The Veterans Health Administration has a lot on its plate in the coming years including implementation of the new Veterans Community Care Program and Electronic Health Record modernization so a permanent, stable leader is vital. However, instead of moving toward a permanent lead, Dr. Carolyn Clancy, Acting Under Secretary for Health, was replaced in mid-July by Dr. Richard Stone. Could you please provide an explanation for that staffing change and an update on any progress toward a permanent Under Secretary?

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

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

Question 2: Mar-a-Lago - On April 20, 2018, as Acting Secretary, you traveled to West Palm Beach and attended a meeting with the "Mar-a-Lago Crowd" at Mar-a-Lago, a property owned by President Trump. Chief of Staff Peter O'Rourke also traveled with you on that trip. In documents obtained by ProPublica through the Freedom of Information Act, Mr. O'Rourke's expense report for the trip details that he stayed at Mar-a-Lago the night of April 19, 2018 at a cost of \$195. Mr. O'Rourke also incurred lodging fees of \$202.27 for that same night at a Holiday Inn, the original hotel that was canceled late on the same day as check in, resulting in a charge of one night's stay. In an email, it is explained that Mr. O'Rourke was "redirected by a White House task after the 24-hour cancellation period." Could the Department please provide additional information regarding what official task Mr. O'Rourke was directed to carry out that required him to redirect to one of the president's properties, at additional cost to taxpayers?

VA Response: The Chief of Staff was redirected to stay at this lodging in order to facilitate his attendance at a required meeting with the Secretary of Veterans Affairs.

Question 3: Provider Recruitment and Retention - The most recent data from the VA Office of the Inspector General shows that nationwide the VA is still dealing with staffing shortages. In Honolulu, psychiatry is the number one shortage and there are 42 clinical shortage areas. Can you provide an update on what VA is doing to improve provider recruitment and retention in Hawaii and nationally?

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

1. Initiate the hiring process immediately after being notified of an upcoming vacancy.
2. Utilize open continuous recruitment.
3. Expedite the credentialing and privileging process.
4. Maximize use of Recruitment/Retention/Relocation incentives (“3Rs”).
5. Maximize use of the Education Debt Reduction Program (EDRP).
6. Present salary offer early in the hiring process.
7. Utilize other recruitment events in addition to USAJobs.

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

Questions for the Record from Senator Manchin

Question 1: Each generation of veterans have had their own form of toxic exposure, whether Mustard Gas, Agent Orange, or any number of chemicals and hazardous environments our service personnel work in today.

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

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

- ILER will bridge this gap by providing an easily accessible and searchable electronic record of a Servicemember's occupational and environmental exposures (garrison and deployment-related) from initial entry to end of service.
- ILER will enable improvement of exposure knowledge, health care, epidemiological assessments of exposures, exposure-related medical research, and disability evaluation and claims processes for Servicemembers and Veterans.
- ILER will leverage and collate the exposure and deployment data available to present the most relevant information to DoD and VA. The ILER Pilot version 1.0.0.0 will leverage information provided from the following sources:
 - Defense Occupational and Environmental Health Readiness System – Industrial Hygiene (DOEHRS-IH)
 - Military Exposure Surveillance Library (MESL)
 - Military Health System (MHS) Data Repository (MDR)
 - Armed Forces Health Surveillance Branch (AFHSB)
 - Defense Manpower Data Center (DMDC)
 - Defense Enrollment Eligibility Reporting System (DEERS)
 - Contingency Tracking System (CTS)

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

1b. What steps can be taken to prepare the Department of Veterans Affairs and the next generation of veterans with toxic exposures for the next 20 years?

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

1c. Is the tracking of toxic exposures being considered in the design of the new Electronic Health Record?

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

Question 2: The Departments of Defense and Veterans Affairs previously attempted to replace their separate EHR systems with a single shared system through the Integrated EHR (iEHR) initiative, unfortunately this effort was abandoned in 2013. Communication and collaboration between the two departments will be essential for the success of the current, interoperable EHR rollout.

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

VA Response: VA and DoD are continuing to work closely together to advance transparency and hone governance through an interagency decision-making perspective through the DoD/VA Interagency Program Office (IPO) established by Congress. The Departments' Secretaries recently announced a joint statement reconfirming their commitment to a joint and interoperable EHR rollout. VA is currently working with DoD and the IPO to analyze and assess prospective additional efficiencies that may optimize the utilization of other resources across VA, DoD, and IPO's organizational EHR implementation and modernization portfolios.

Question 3: **It was reported that the DoD's rollout of the Cerner system in the Pacific Northwest was plagued with problems that significantly impacted patient care. Any rollout of a new EHR system is going to experience significant challenges, but it is important to learn from those and adjust future strategies.**

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

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

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

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

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

VA Response: VA, specifically OEHRM, is responsible for cataloguing and utilizing DoD's lessons learned to mitigate potential challenges throughout its deployment.

Question 4: One in ten Veterans Affairs jobs are currently unfilled. As of September 26th, there are 128 positions posted in USAJOBS for West Virginia Hospitals and Benefits offices, including for many important clinical and social work positions. Vacancies have the potential to increase the burn out rate of employees as well increase the number of veterans that need to be sent out into the community for care.

- a. In the 60 days that you have been in office, has there been discussion of developing and/or implementing a vacancy action plan?
- b. If no such plan is in place will you commit to working on one and reporting back to us?

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

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

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

VA Response: The current appeal process for VA benefit claims is broken and does not serve Veterans well, with average resolution times at 3 to 7 years depending upon whether the Veteran appeals to the Board of Veterans' Appeals (Board). To improve this process, VA worked closely with its stakeholders (including Veterans Service Organizations, private attorneys, and Congressional staff) to develop a new, more efficient, decision-review process for claims. The President signed this process into law as the Veterans Appeals Improvement and Modernization Act in August 2017. VA is on track to implement it in February 2019 for claimants who receive decisions on their claims after the February implementation date.

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

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

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

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

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

Question 6: The VA Office of the Inspector General reported that the claims backlog only covers about 79 percent of relevant cases, with a host of others misclassified, mistakenly excluded and, in some cases, only acknowledged as overdue after the files had finally been processed.

- a. What steps are being taken to more accurately count and report the number of claims awaiting decision for more than 125 days?

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

Additionally, OIG identifies a very small number of claims missing from backlog reporting due to human error. OIG identified situations where some claims are erroneously excluded from the backlog and other situations where claims are erroneously counted as backlog, when they are in fact not. However, OIG also acknowledged that VBA staff who discovered these errors made the necessary adjustments to properly reflect the backlog status. VBA has concurred in principle with the OIG's recommendation to consider revising which claims are included in VBA's reported disability claims backlog and will engage with stakeholders to ensure that any

proposed changes are well understood. VBA is currently reviewing how best to supplement or adjust reporting on the rating-related backlog, which has followed consistent rules since the backlog was defined and reporting began in 2009.

Question 7: The most recent data from HUD found that the number of homeless veterans increased by almost 2 percent from 2016 to 2017, the first time the number has risen since 2010. Meanwhile, over the past year, VA has issued and subsequently reconsidered proposals to terminate or reallocate funding within programs like Grant Per Diem and HUD-VASH. This has left providers in West Virginia concerned about whether their grants will be renewed and forced difficult decisions on staffing and capacity.

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

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

- May 14, 2018 - GPD National Program Office held a conference call reviewing the anticipated timeline regarding the grant selection process. This included the plans for notification via correspondence which was to occur at the end of the month of May. Presentation slides for this call were subsequently posted on the GPD provider Web site at https://www.va.gov/HOMELESS/GPD_ProviderWebsite.asp
- May 29, 2018 – Correspondence was mailed to all applicants noting whether their application was conditionally-selected or non-selected. Additional correspondence was sent to non-selected applicants that had a GPD grant award that would be ending on September 30, 2018, which provided instructions for winding down their grant projects. This included working with the local VAMC to ensure the placement of any homeless Veterans in the program to permanent housing or alternative services by September 30, 2018. In addition, the GPD National Program Office was in communication with the Directors of VHA's other homeless programs to alert them of coming changes and coordinate support with these program services to assist homeless Veterans, as needed.
- June 11, 2018 – GPD National Program Office held a conference call to review the notification correspondence that had been sent to grant applicants, as well as to review the status of grantees who were eligible for an option year renewal in FY 2019. The presentation slides were posted on the GPD provider Web site.
- The GPD National Program Office also responded to inquiries from applicants via phone call and a special email group available to communicate with the grant office.
- In addition to the notifications of grantees, the GPD National Program Office was in communication with the Network Homeless Coordinator for VISN 5 and the GPD liaison in Martinsburg, West Virginia (where Potomac Highlands Supported Services, a non-selected applicant with grant ending September 30, 2018, is located) to monitor the status of all the Veterans residing there and to ensure these Veterans were successfully placed. All the Veterans in the program were successfully placed by

September 5, 2018.

Question 8: Staffing shortages are a persistent challenge at the VA as well as many other Federal agencies. In order to fulfill its vital missions it is important that the VA is adequately staffed with well trained and highly motivated employees, in both clinical and non-clinical positions. A recently released Office of the Inspector General report stated the most commonly cited challenges to staffing at VHA facilities fit into three categories: (1) lack of qualified applicants, (2) non-competitive salary, and (3) high staff turnover. In a letter to congressional leaders announcing there would be no pay increases for Federal Employees in 2019 President Trump stated *“These alternative pay plan decisions will not materially affect our ability to attract and retain a well qualified Federal workforce.”*

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

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

Hearing Deliverables:

1. ...the DoD's initial rollout of Cerner's system in four medical facilities was plagued with significant problems.

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

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

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

Senator Manchin. And VistA will stay in place?

Secretary Wilkie. I believe. I will have to get--

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

Secretary Wilkie. Yeah, I will have to get back with

you on that as to what exactly will happen.

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

Department of Veterans Affairs
November 2018